TABLE 48: Objectives and Measures for the Promoting Interoperability Performance Category in 2020

Objective	Measure	Numerator	Denominator	Exclusion
e-Prescribing: Generate and transmit permissible prescriptions electronically	e-Prescribing: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.	Number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
e-Prescribing: Generate and transmit permissible prescriptions electronically.	Query of PDMP (bonus): For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	N/A (measure is Y/N)	N/A (measure is Y/N)	N/A
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a	Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care using CEHRT; and (2) electronically exchanges the summary of care record.	Number of transitions of care and referrals in the denominator where the summary of care record was created using CEHRT and exchanged electronically	Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Objective	Measure	Numerator	Denominator	Exclusion
new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.				
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.	Support Electronic Referral Loops by Receiving and Incorporating Health Information: For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, mediation allergy, and current problem list.	Number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: (1) Medication – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy – Review of the patient's known medication allergies; and (3) Current Problem List – Review of the patient's current and active diagnoses.	Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.	Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.
Provider to Patient Exchange: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information.	Provide Patients Electronic Access to Their Health Information: For at least one unique patient seen by the MIPS eligible clinician: 1. The patient (or the patient-authorized representative) is provided timely access to view online,	Number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the	Number of unique patients seen by the MIPS eligible clinician during the performance period.	N/A

Objective	Measure	Numerator	Denominator	Exclusion
	download, and transmit his or her health information; and 2.The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's CEHRT.	technical specifications of the API in the MIPS eligible clinician's CEHRT.		
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Immunization Registry Reporting: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1.does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period; OR 2.operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3. operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active	Syndromic Surveillance Reporting: The MIPS eligible clinician is in active engagement with a public health	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician 1.Is not in a category of health care providers from which ambulatory syndromic data is collected by their jurisdiction's syndromic surveillance system;

Objective	Measure	Numerator	Denominator	Exclusion
engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	agency to submit syndromic surveillance data from an urgent care setting.			OR 2.operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3.operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from MIPS eligible clinicians as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Electronic Case Reporting: The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1.Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period; OR 2.operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3. operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where	Public Health Registry Reporting: The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1.Does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS eligible clinician's jurisdiction during the performance period; OR 2.operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3.operates in a jurisdiction where no public health registry for which the

Objective	Measure	Numerator	Denominator	Exclusion
prohibited, and in accordance with applicable law and practice.				MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Clinical Data Registry Reporting: The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician 1. Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period; OR 2.operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3.operates in a jurisdiction where no clinical data registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.

BILLING CODE 4120–01–C

(e) Scoring Methodology

(i) Changes to the Scoring Methodology for the 2020 Performance Period

In the CY 2019 PFS final rule (83 FR 59785 through 59796), we finalized a new performance-based scoring methodology for the Promoting Interoperability performance category beginning with the performance period in 2019. As previously discussed in section III.K.3.c.(4)(d)(i) of this final rule, we are finalizing our proposals for CY 2020 to: (1) Make the Query of PDMP measure optional and eligible for five bonus points in CY 2020; (2) make the e-Prescribing measure worth up to 10 points in CY 2020, and (3) remove the Verify Opioid Treatment Agreement measure beginning in CY 2020. Table 49 reflects the proposals that we are finalizing, although the maximum points available do not include points that would be redistributed in the event that an exclusion is claimed.

TABLE 49: Scoring Methodology for the Performance Period in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing*	10 points
	Query of PDMP	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	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting* Electronic Case Reporting* Public Health Registry Reporting* Clinical Data Registry Reporting* Syndromic Surveillance Reporting*	10 points

* Exclusion available.

(f) Additional Considerations

(i) Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

In prior rulemaking (83 FR 59818 through 59819), we discussed our belief that certain types of MIPS eligible clinicians (NPs, PAs, CNSs, and CRNAs) may lack experience with the adoption and use of CEHRT. Because many of these non-physician clinicians were or are not eligible to participate in the Medicare or Medicaid EHR Incentive Program (now known as the Promoting Interoperability Program), we stated that we have little evidence as to whether there are sufficient measures applicable and available to these types of MIPS eligible clinicians under the advancing care information (now known as Promoting Interoperability) performance category. We established a policy at § 414.1380(c)(2)(i)(A)(5) for the performance periods in 2017, 2018, and 2019 under section 1848(q)(5)(F) of the Act to assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. We will assign a weight of zero only in the event that an NP, PA, CRNA, or CNS does not submit any data for any of the measures specified for the Promoting Interoperability performance category, but if they choose to report, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians, and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act. We stated our intention to use data from the first performance period (2017) to further evaluate the participation of these MIPS eligible clinicians in the Promoting Interoperability performance category and consider for subsequent years whether the measures specified for this category are applicable and available to these MIPS eligible clinicians.

We have analyzed the data submitted for the 2017 performance period for the Promoting Interoperability performance category, and have discovered that the vast majority of MIPS eligible clinicians submitted data as part of a group. While we are pleased that MIPS eligible clinicians utilized the option to submit data as a group, it does limit our ability to analyze data at the individual NPI level. For example, when a group of MIPS eligible clinicians chooses to report for MIPS as a group, the data submitted are representative of that entire group, as opposed to each individual MIPS eligible clinician in the group submitting data that exclusively reflect his/her own performance. Approximately 4 percent of MIPS eligible clinicians who are NPs, PAs, CRNAs, or CNSs submitted data individually for MIPS, and more than two-thirds of them did not submit data for the Promoting Interoperability performance category. Additionally, we are challenged because many of the measures that were available for submission for the 2017 performance period are now unavailable, due to our discontinuation of the Promoting Interoperability transition measure set, and the overhaul of the performance category that further reduced the number of available measures. For these reasons, we were unable to determine, at the time we were developing the CY 2020 PFS proposed rule, whether the measures currently specified for the Promoting Interoperability performance category for the 2020 performance period are applicable and available for NPs, PAs, CRNAs, and CNSs. However, as more data become available, we plan to reevaluate the measures and consider how we could ensure that there are sufficient measures applicable and available for these types of MIPS eligible clinicians.

Therefore, we proposed to continue the existing policy of reweighting the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs for the performance period in 2020, and to revise § 414.1380(c)(2)(i)(A)(*5*) to reflect this proposal.

We received public comments on our proposals and the following is a summary of the comments we received and our responses.

Comment: The majority of commenters supported our proposal to continue to reweight the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs for the performance period in 2020.

Response: We agree that reweighting the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs for CY 2020 is appropriate. We hope that in the future more of these clinician types will be utilizing CEHRT and will be able to submit data for this performance category.

After consideration of the comments, we are finalizing our proposal to

continue the existing policy of reweighting the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs for the performance period in 2020, and to revise § 414.1380(c)(2)(i)(A)(*5*) to reflect this policy.

(ii) Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologist, Qualified Audiologists, Clinical Psychologists, and Registered Dieticians or Nutrition Professionals

In the CY 2019 PFS final rule (83 FR 59819 through 59820), we adopted a policy at § 414.1380(c)(2)(i)(A)(4) to apply the same automatic reweighting policy we adopted for NPs, PAs, CNSs, and CRNAs for the performance periods in 2017 through 2019 to these new types of MIPS eligible clinicians (physical therapists, occupational therapists, qualified speech-language pathologist, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals) for the performance period in 2019. Because many of these clinician types were or are not eligible to participate in the Medicare or Medicaid Promoting Interoperability Programs, we have little evidence as to whether there are sufficient measures applicable and available to them under the Promoting Interoperability performance category.

For the reasons discussed in section III.K.3.c.(4)(f)(i) of the CY 2020 PFS proposed rule (84 FR 40776), for the performance period in 2020, we proposed to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologist, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals, and to revise § 414.1380(c)(2)(i)(A)(4) to reflect this proposal. We invited comments on this proposal.

We received public comments on our proposals. The following is a summary of the comments we received and our responses.

Comment: Most commenters supported CMS' reweighting of the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals.

Response: We appreciate the support for our proposal.

Comment: Several commenters expressed their concerns about there not being appropriate measures in place to accommodate the practices of NPPs.

Response: Currently, the data from physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals is too limited to support the addition of measures that are tailored to the specific practices of NPPs. However, we encourage stakeholders to submit their ideas and suggestions to us during our annual call for measures.

Comment: One commenter suggested adding chiropractic clinicians to the automatic reweighting of the Promoting Interoperability performance category that is currently available for physical therapists, occupational therapists, and qualified speech-language pathologists, until additional meaningful measures are available.

Response: We thank the commenter for the suggestion. However, chiropractors were eligible professionals under section 1848(o)(5)(C) of the Act, and thus were eligible to participate in the Medicare EHR Incentive Program, unlike the types of NPPs mentioned by the commenter. The same rationale for reweighting the Promoting Interoperability performance category does not apply to chiropractors.

After consideration of the comments, we are finalizing the proposal to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologist, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals, and to revise § 414.1380(c)(2)(i)(A)(4) to reflect this policy.

(iii) Hospital-Based MIPS Eligible Clinicians in Groups

We define a hospital-based MIPS eligible clinician under § 414.1305 as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of services identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), off campus outpatient hospital (POS 19), or emergency room (POS 23) setting, based on claims for the MIPS determination period (81 FR 77238 through 77240, 82 FR 53686 through 53687, 83 FR 59727 through 59730). We established under § 414.1380(c)(2)(i)(C)(6) that a MIPS eligible clinician who is a hospital-based MIPS eligible clinician as defined in § 414.1305 will be assigned a zero percent weight for the Promoting Interoperability performance category, and the points associated with the Promoting Interoperability performance category will be redistributed to another performance category or categories (81 FR 77238 through 77240, 82 FR 53684, 83 FR 59871). However, if a hospital-based MIPS eligible clinician chooses to report on the Promoting Interoperability performance category measures, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians, and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their Promoting Interoperability performance category score. We stated that this policy includes MIPS eligible clinicians choosing to report as part of a group or part of a virtual group (82 FR 53687).

Under § 414.1310(e)(2)(ii), individual eligible clinicians that elect to participate in MIPS as a group must aggregate their performance data across the group's TIN (81 FR 77058). For groups reporting on the Promoting Interoperability performance category, we stated that group data should be aggregated for all MIPS eligible clinicians within the group (81 FR 77214 through 77216, 82 FR 53687). We stated that this includes those MIPS eligible clinicians who may qualify for a zero percent weighting of the Promoting Interoperability performance category due to circumstances such as a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of NPPs (82 FR 53687). We established at § 414.1380(c)(2)(iii) that for MIPS eligible clinicians submitting data as a group or virtual group, in order for the Promoting Interoperability performance category to be reweighted, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting (82 FR 53687, 83 FR 59871). We have heard from several stakeholders that our policy for groups that include hospital-based MIPS eligible clinicians sets a threshold that is too restrictive for a variety of reasons. Some stated that due to high turnover rates for hospital medicine groups, many such groups rely on locum tenens clinicians who may practice in multiple settings. They stated that if a hospital medicine group includes only one MIPS eligible clinician who does not meet the definition of a hospital-based MIPS eligible clinician, it could prevent the group from qualifying for reweighting because not all of the MIPS eligible clinicians in the group would be considered hospital-based. A few acknowledged that while hardship

exceptions are available for MIPS eligible clinicians who lack control over CEHRT because they use the hospital's CEHRT, it is an administrative burden to have to submit a hardship exception application, especially if the clinician has a locum tenens relationship.

In the CY 2020 PFS proposed rule (84 FR 40776 through 40777), we stated our belief that hospital medicine groups may face unique circumstances due to the nature of their practice area and the staffing practices described by stakeholders. Thus, we proposed to revise the definition of a hospital-based MIPS eligible clinician under § 414.1305 to include groups and virtual groups. We proposed that, beginning with the 2022 MIPS payment year, a hospital-based MIPS eligible clinician under § 414.1305 means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.

We stated that we believe that a threshold of more than 75 percent is appropriate because it is consistent with the thresholds for groups in the definitions of facility-based MIPS eligible clinician and non-patient facing MIPS eligible clinician under § 414.1305. We proposed to revise § 414.1380(c)(2)(iii) to specify that for the Promoting Interoperability performance category to be reweighted for a MIPS eligible clinician who elects to participate in MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting, or the group or virtual group must meet the proposed revised definition of a hospital-based MIPS eligible clinician (or the definition of a non-patient facing MIPS eligible clinician in § 414.1305, as proposed in section III.K.3.c.(4)(f)(iv) of the proposed rule (84 FR 40777).

The following is a summary of the public comments we received and our responses.

Comment: Commenters appreciated our proposal to lower the percentage of MIPS eligible clinicians that need to be considered hospital-based for a group or virtual group to be considered hospital-based. Commenters stated that a threshold of 100 percent was very difficult to achieve and a threshold of more than 75 percent is much more achievable. Some commenters stated that a threshold of more than 75 percent is reasonable and aligns with the threshold that CMS uses in the facility-based measurement approach in the MIPS cost and quality performance categories. Others believed that the proposed change will increase flexibility for clinicians practicing in a hospital setting. Another commenter stated that the revised definition better reflects the realities of practice. One commenter appreciated the recognition that the previous definition of a hospital-based groups was confusing and difficult for clinicians to meet and thanked CMS for our responsiveness to stakeholder concerns. Several commenters stated that the ''all or nothing rule'' (requiring 100 percent of the MIPS eligible clinicians in the group or virtual group to qualify for reweighting) was unfair and penalizes hospital-based clinicians who work in multi-specialty groups.

Response: We appreciate the support for our proposal and agree that a threshold of more than 75 percent would account for the unique circumstances faced by hospital-based groups such as locum tenens arrangements and high turnover rates.

Comment: One commenter urged CMS to consider reweighting a group if more than 75 percent of the group qualifies for reweighting for any reason.

Response: We appreciate this suggestion, but we believe that hospital medicine groups may face unique circumstances due to the nature of their practice area that clinicians who practice in non-hospital settings would not experience, and thus we decline to adopt the commenter's suggestion.

After consideration of the public comments, we are finalizing the proposal to revise the definition of a hospital-based MIPS eligible clinician under § 414.1305 to include groups and virtual groups. We are finalizing the proposal that, beginning with the 2022 MIPS payment year, a hospital-based MIPS eligible clinician under § 414.1305 means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period. We are also finalizing the proposal to revise § 414.1380(c)(2)(iii) to specify that for the Promoting Interoperability performance category to be reweighted for a MIPS eligible clinician who elects to participate in MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting, or the group or virtual group must meet the definition of a hospital-based MIPS eligible clinician or a non-patient facing MIPS eligible clinician as defined in § 414.1305.

(iv) Non-Patient Facing MIPS Eligible Clinicians in Groups

We define a non-patient facing MIPS eligible clinician under § 414.1305 as an individual MIPS eligible clinician who bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act), as described in paragraph (3) of this definition, during the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician. We established under § 414.1380(c)(2)(i)(C)(5) that a MIPS eligible clinician who is a non-patient facing MIPS eligible clinician as defined in § 414.1305 will be assigned a zero percent weight for the Promoting Interoperability performance category, and the points associated with the Promoting Interoperability performance category will be redistributed to another performance category or categories (81 FR 77240 through 77243, 82 FR 53680–53682, 83 FR 59871). However, if a non-patient facing MIPS eligible clinician chooses to report on the Promoting Interoperability performance category measures, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians, and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their Promoting Interoperability performance category score. We stated that this policy includes MIPS eligible clinicians choosing to report as part of a group or part of a virtual group (82 FR 53687).

As noted in the CY 2020 PFS proposed rule (84 FR 40777), in connection with our discussion of hospital-based MIPS eligible clinicians in groups, under § 414.1380(c)(2)(iii), for

MIPS eligible clinicians submitting data as a group or virtual group, in order for the Promoting Interoperability performance category to be reweighted, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting. We proposed (84 FR 40777) to revise § 414.1380(c)(2)(iii) to account for groups and virtual groups that meet the revised definition of a hospital-based MIPS eligible clinician under § 414.1305, which would only require the group or virtual group to meet a threshold of more than 75 percent instead of a threshold of all of the MIPS eligible clinicians in the group or virtual group. In an effort to more clearly and concisely capture our existing policy for non-patient facing MIPS eligible clinicians, we proposed to revise § 414.1380(c)(2)(iii) to also account for a group or virtual group that meets the definition of a non-patient facing MIPS eligible clinician under § 414.1305, such that the group or virtual group only has to meet a threshold of more than 75 percent.

The following is a summary of the comments we received and our responses.

Comment: Commenters supported a definition of a non-patient facing group as one in which more than 75 percent of the group's members qualify as non-patient facing and eligible for Promoting Interoperability performance category reweighting. One commenter noted that the clarification is helpful for physician groups that have a small number of patient facing clinicians embedded in a much larger group of non-patient facing clinicians.

Response: We believe that our proposed revision to the regulation text would help to alleviate confusion surrounding our policy for groups and virtual groups that include non-patient facing MIPS eligible clinicians.

Comment: One commenter suggested that CMS should make it easier for groups to evaluate whether they may qualify as hospital-based or non-patient facing by enhancing the Quality Payment Program Participation Status Tool on the Quality Payment Program website to show eligibility and special statuses for TINs, in addition to NPIs.

Response: We appreciate this suggestion and have added the ability to check eligibility for all clinicians associated with a practice as a feature of our Quality Payment Program Participation Status Tool.

After consideration of the public comments that we received, we are finalizing our proposal to revise § 414.1380(c)(2)(iii) to also account for a group or virtual group that meets the definition of a non-patient facing MIPS eligible clinician under § 414.1305, such that the group or virtual group only has to meet a threshold of more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician.

(g) Future Direction of the Promoting Interoperability Performance Category

In the CY 2020 PFS proposed rule (84 FR 40777 through 40784), we included Requests for Information regarding several issues involving the Promoting Interoperability performance category. While we are not summarizing and responding to comments we received in this final rule, we thank the commenters for their responses and we may take them into account as we develop future policies for the Promoting Interoperability performance category.

(5) APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

(a) Overview

As codified at § 414.1370(a), the APM scoring standard is the MIPS scoring methodology applicable for MIPS eligible clinicians identified on the Participation List for the performance period of an APM Entity participating in a MIPS APM.

As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77246), the APM scoring standard is designed to reduce reporting burden for these clinicians by reducing the need for duplicative data submission to MIPS and their respective APMs, and to avoid potentially conflicting incentives between those APMs and MIPS.

We established at § 414.1370(c) that the MIPS performance period under § 414.1320 applies for the APM scoring standard. We finalized under § 414.1370(f) that the MIPS final score calculated for the APM Entity is applied to each MIPS eligible clinician in the APM Entity, and the MIPS payment adjustment is applied at the TIN/NPI level for each MIPS eligible clinician in the APM Entity group. Under § 414.1370(f)(2), if the APM Entity group is excluded from MIPS, all eligible clinicians within that APM Entity group are also excluded from MIPS.

As finalized at § 414.1370(h)(1) through (4), the performance category weights used to calculate the MIPS final score for an APM Entity group for the APM scoring standard performance period are: Quality at 50 percent; cost at 0 percent; improvement activities at 20 percent; and Promoting Interoperability at 30 percent.

(b) MIPS APM Criteria

We established at § 414.1370(b) that for an APM to be considered a MIPS APM, it must satisfy the following criteria: (1) APM Entities must participate in the APM under an agreement with CMS or by law or regulation; (2) the APM must require that APM Entities include at least one MIPS eligible clinician on a Participation List; (3) the APM must base payment on quality measures and cost/utilization; and (4) the APM must be neither a new APM for which the first performance period begins after the first day of the MIPS performance year nor an APM in the final year of operation for which the APM scoring standard is impracticable. In the CY 2019 PFS final rule (59820 through 59821), we clarified that we consider whether each distinct track of an APM meets the criteria to be a MIPS APM and that it is possible for an APM to have tracks that are MIPS APMs and tracks that are not MIPS APMs. We also clarified that we consider the first performance year for an APM to begin as of the first date for which eligible clinicians and APM entities participating in the model must report on quality measures under the terms of the APM.

Based on the MIPS APM criteria, we expect that the following 10 APMs will satisfy the requirements to be MIPS APMs for the 2020 MIPS performance period:

- Comprehensive ESRD Care Model (all Tracks).
- Comprehensive Primary Care Plus Model (all Tracks).
- Next Generation ACO Model.
- Oncology Care Model (all Tracks).
- Medicare Shared Savings Program (all Tracks).
- Medicare ACO Track 1+ Model.
- Bundled Payments for Care Improvement Advanced.
- Maryland Total Cost of Care Model (Maryland Primary Care Program).
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative).
- Independence At Home Model.

Final CMS determinations of MIPS APMs for the 2020 MIPS performance period will be announced via the Quality Payment Program website at *https://qpp.cms.gov/*. Further, we make these determinations based on the established MIPS APM criteria as specified in § 414.1370(b).

(c) Calculating MIPS APM Performance Category Scores

(i) Quality Performance Category

As noted, the APM scoring standard is designed to reduce reporting burden

for MIPS eligible clinicians participating in MIPS APMs by reducing the need for duplicative data submission to MIPS and their respective APMs, and to avoid potentially conflicting incentives between those APMs and MIPS. As discussed in the CY 2017 Quality Payment Program final rule (81 FR 77246), due to operational constraints, we did not require MIPS eligible clinicians participating in MIPS APMs other than the Shared Savings Program and the Next Generation ACO Model to submit data on quality measures for purposes of MIPS for the 2017 MIPS performance period. As discussed in the CY 2018 Quality Payment Program final rule (82 FR 53695), we designed a means of overcoming these operational constraints and required MIPS eligible clinicians participating in such MIPS APMs to submit data on APM quality measures for purposes of MIPS beginning with the 2018 MIPS performance period. We also finalized a policy to reweight the quality performance category to zero percent in cases where an APM has no measures available to score for the quality performance category for a MIPS performance period, such as where none of the APM's measures would be available for calculating a quality performance category score by the close of the MIPS submission period because measures were removed from the APM measure set due to changes in clinical practice guidelines. Although we anticipated different scenarios where quality would need to be reweighted, we did not anticipate at that time that the quality performance category would need to be reweighted regularly.

After several years of implementation of the APM scoring standard, we have found that for participants in certain MIPS APMs (as defined in § 414.1305), it often is not operationally possible to collect and score performance data on APM quality measures for purposes of MIPS because these APMs run on episodic or yearly timelines that do not always align with the MIPS performance periods and deadlines for data submission, scoring, and performance feedback. In addition, although we anticipated different scenarios where quality would need to be reweighted, we do not believe the quality performance category should be reweighted regularly.

To achieve the aims of the APM scoring standard, we believe it is necessary to consider new approaches to quality performance category scoring.

(A) Allowing MIPS Eligible Clinicians Participating in MIPS APMs To Report on MIPS Quality Measures

We proposed to allow MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures in a manner similar to our established policy for the Promoting Interoperability performance category under the APM scoring standard for purposes of the MIPS quality performance category beginning with the 2020 MIPS performance period.

Similar to our approach for the Promoting Interoperability performance category, we would allow MIPS eligible clinicians in MIPS APMs to receive a score for the quality performance category either through individual or TIN-level reporting based on the generally applicable MIPS reporting and scoring rules for the quality performance category. Under such an approach, we would attribute one quality score to each MIPS eligible clinician in an APM Entity by looking at both individual and TIN-level data submitted for the eligible clinician and using the highest reported score, excepting scores reported by a virtual group. Thus, we would use the highest individual or TIN-level score attributable to each MIPS eligible clinician in an APM Entity in order to determine the APM Entity score based on the average of the highest scores for each MIPS eligible clinician in the APM Entity.

As with Promoting Interoperability performance category scoring, each MIPS eligible clinician in the APM Entity group would receive one score, weighted equally with that of the other MIPS eligible clinicians in the APM Entity group, and we would calculate one quality performance category score for the entire APM Entity group. If a MIPS eligible clinician has no quality performance category score—if the individual's TIN did not report and the individual did not report—that MIPS eligible clinician would contribute a score of zero to the aggregate APM Entity group score.

We would use scores reported by an individual MIPS eligible clinician or a TIN reporting as a group; we would not accept virtual group level reporting because a virtual group level score is too far removed from the eligible clinician's performance on quality measures for purposes of the APM scoring standard.

We requested comment on our proposal.

We received several public comments on our proposal to use the highest TIN or individual score attributable to each MIPS eligible clinician, excepting virtual group level reporting, for purposes of the MIPS quality performance category beginning with the 2020 MIPS performance period. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our proposal to allow for MIPS quality measure reporting to be used in calculating a MIPS APM Entity score.

Response: We appreciate the commenters' support. We agree that this new approach will provide the best opportunity to score many MIPS eligible clinicians on quality performance.

Comment: Some commenters supported our proposal to allow scoring at the individual or group level to be rolled up to the APM Entity level, thereby allowing individuals in multi-specialty APMs to focus and be scored on measures most applicable to their practices.

Response: We thank commenters for their support. We agree that this approach would provide value by allowing individuals to be scored based on measures that are the most clinically relevant.

Comment: Some commenters expressed concerns about the additional reporting burden required to report on quality to both MIPS and their respective APMs. Some suggested that CMS make MIPS reporting optional for each APM Entity and create a quality category score only in situations where the APM Entity has elected to report.

Response: We acknowledge this proposed change in policy may introduce additional burden for some MIPS APM participants. We anticipate, however, this effect being limited to instances where participants' TINs do not already report separately to MIPS. We believe any potential burden will be further mitigated by our proposal to allow APM Entity-level quality reporting for MIPS, as discussed in section III.J.3.c.(5)(i)(C) of this final rule.

We remind commenters that we are required by section 1848(q)(5)(E)(i)(I) of the Act, to calculate a MIPS quality performance category score for MIPS eligible clinicians. As such, we cannot make MIPS reporting a wholly voluntary activity through regulatory action. Further, under a scenario in which no MIPS quality reporting was performed under any of the means available, section 1848(q)(5)(B)(i) of the Act requires the assignment of the lowest possible quality score.

After consideration of the comments, we are finalizing the proposal as proposed to require MIPS quality reporting by MIPS eligible clinicians in

MIPS APMs at either the APM Entity, TIN, or individual level.

(B) APM Quality Reporting Credit

We proposed to apply a minimum score of 50 percent, or an ''APM Quality Reporting Credit,'' under the MIPS quality performance category for certain APM entities participating in MIPS APMs where the APM quality data cannot be used for MIPS purposes as outlined below. Several provisions of the statute address the possibility of considerable overlap between the requirements of MIPS and those of an APM. Most notably, section 1848(q)(1)(C)(ii) of the Act excludes QPs and partial QPs who do not elect to participate in MIPS from the definition of a MIPS eligible clinician. In addition, under section 1848(q)(5)(C)(ii) of the Act, a MIPS eligible clinician's participation in an APM (as defined in section 1833(z)(3)(C) of the Act) earns such MIPS eligible clinician a minimum score of one-half of the highest potential score for the improvement activities performance category.

In particular, we believe that section 1848(q)(5)(C)(ii) of the Act reflects an understanding that APM participation requires significant investment in improving clinical practice, which may be duplicative with the requirements under the improvement activities performance category. We believe that MIPS APMs require an equal or greater investment in quality, which, due to operational constraints, cannot always be reflected in a MIPS quality performance category score. Accordingly, we proposed to apply a similar approach to quality performance category scoring under the APM scoring standard. We proposed that APM Entity groups participating in certain MIPS APMs receive a minimum score of one-half of the highest potential score for the quality performance category, beginning with the 2020 MIPS performance period. To clarify, our proposal was intended to apply specifically to those MIPS APMs that do not utilize MIPS measures and data collection types.

To the extent possible, we would calculate the final score by adding to the credit any additional MIPS quality score received on behalf of the individual NPI or the TIN. For the purposes of final scoring this credit would be added to any MIPS quality measure scores we receive. All quality category scores would be capped at 100 percent. For example, if the additional MIPS quality score were 40 percent, that would be added to the 50 percent credit for a total of 90 percent; if the quality score were 70 percent, that would be added to the 50 percent credit and because the result is 120 percent, the cap would be applied for a final score of 100 percent.

We received public comments on our proposal to calculate the quality performance category score for APM Entity groups participating in MIPS APMs where APM quality data cannot be used for MIPS purposes, to add to the applicable APM Entity level quality performance score a 50 percent quality reporting credit, for a total score of up to 100 percent. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our policy to provide a 50 percent quality reporting credit for those APM Entity groups that are participating in MIPS APMs that are already required to report quality measures for purposes of their APM, but for which the reported quality data cannot be used for MIPS purposes, to mitigate the duplicative reporting now required for MIPS quality scoring.

Response: We thank commenters for their support of our proposal.

Comment: A few commenters supported the use of an APM quality reporting credit, but urged CMS to make the credit 100 percent of the quality performance category.

Response: We appreciate the support for our proposed policy, but we do not believe that providing a quality reporting credit of 100 percent for the quality performance category would satisfy the statutory requirements at section 1848(q)(5)(E)(i)(I) of the Act that we measure ''performance'' on quality measures under the quality performance category. Furthermore, we do not believe that simply participating in a MIPS APM is a sufficient demonstration of performance on quality measures to warrant a score of 100 percent; rather, we interpret the statutory requirement at section 1848(q)(5)(D) of the Act to mean that we are to assess performance on quality measures not only for the sake of generating a score, but for the purpose of measuring year over year improvement, and rewarding those efforts as well. Therefore, we proposed to use a 50 percent quality reporting credit in combination with an achievement score in calculating an APM Entity's quality performance category score for APM Entity groups participating in MIPS APMs where quality data cannot be used for MIPS purposes.

Comment: Some commenters recommended that CMS increase the quality reporting credit to the minimum number of points required to ensure APM Entities receive a neutral payment adjustment under the APM scoring standard.

Response: We considered several different approaches for setting the APM Quality Reporting Credit, including an approach where the credit would be equal to the minimum number of points needed in the quality performance category which, when added to the automatic credit applied for the improvement activities performance category, would guarantee MIPS APM participants a MIPS score equal to or greater than the performance threshold for a given Quality Payment Program performance year. Upon further consideration, we found that such an approach would give MIPS APM participants a competitive advantage within MIPS as the performance threshold increased, but would function more as a safety net against a downward MIPS adjustment than as a reward for quality measure reporting that they had already done.

We believe that the APM Quality Reporting Credit of one-half of the performance category score better reflects the intent of rewarding a specific performance activity, reporting, than an approach where the primary purpose is to guarantee a specific outcome within the MIPS program.

Comment: Some commenters disagreed with our proposal to assign an APM Quality Reporting Credit for certain MIPS APM participants, as it would have the effect of raising the performance threshold and making it more difficult for other MIPS eligible clinicians to receive a top score.

Response: While we do anticipate that this APM Quality Reporting Credit may have an effect on APM Entities' quality performance category scores, our data suggest that the totality of our APM scoring standard policies should produce APM Entity quality performance category scores that are roughly equal to, or perhaps slightly lower than they would have been under the APM scoring standard rules if we had been able to implement them as finalized. We believe that the proposed approach would reward MIPS APM participants for the quality reporting they undertake within their APMs, which we had intended to but cannot use for purposes of MIPS, without unduly advantaging them relative to the MIPS performance threshold. With this in mind, we do not anticipate any negative impacts on other MIPS eligible clinicians as a result of this policy.

We are finalizing the policy to assign an APM Quality Reporting Credit of one-half of the quality performance category score under the APM scoring standard for APM Entity groups participating in MIPS APMs where

quality data cannot be used for MIPS purposes.

(aa) Exceptions From APM Quality Reporting Credit

Under this policy, we would not apply the APM Quality Reporting Credit to the APM Entity group's quality performance score for those APM Entities reporting only through a MIPS quality reporting data submission types according to the requirements of their APM, such as the Medicare Shared Savings Program, which requires participating ACOs to report through the CMS Web Interface and the CAHPS for ACOs survey measures. In these cases, no burden of duplicative reporting would exist, and there would not be any additional unscored quality measures for which to give credit.

In the case where an APM Entity group is in an APM that requires reporting through a MIPS quality reporting data submission type under the terms of participation in the APM, should the APM Entity group fail to report on required quality measures, the individual eligible clinicians and TINs that make up that APM Entity group would still have the opportunity to report quality measures to MIPS for purposes of calculating a MIPS quality performance category score as finalized for all MIPS APMs in accordance with § 414.1370(g)(1)(ii). However, as in these cases no burden of duplicative reporting would exist, they would not receive the APM Quality Reporting credit.

We did not receive any comments on this proposal, and we are finalizing as proposed.

(C) Additional Reporting Option for APM Entities

We recognize that some APM Entities may have a particular interest in ensuring that MIPS eligible clinicians in the APM Entity group perform well in MIPS, or in reducing the overall burden of joining the APM Entity. Likewise, we recognize that some MIPS APMs, such as the CMS Web Interface reporters, already require reporting on MIPS quality measures as part of participation in the APM. Therefore, we proposed that, in instances where an APM Entity has reported quality measures to MIPS through a MIPS submission type and using MIPS data collection type on behalf of the APM Entity group, we would use that quality data to calculate an APM Entity group level score for the quality performance category. We believe this approach best ensures that all participants in an APM Entity group receive the same final MIPS score while reducing reporting burden to the greatest extent possible. We received no public comments on our proposal that in instances where an APM Entity reports quality measures to MIPS through a MIPS submission type and using MIPS data collection type on behalf of the APM Entity group, we will use that quality data to calculate an APM Entity group level score for the quality performance category. We are finalizing the policy as proposed.

(D) Bonus Points and Caps for the Quality Performance Category

In the 2018 Quality Payment Program final rule (82 FR 53568, 53700), we finalized our policies to include bonus points in the performance category score calculation when scoring quality at the APM Entity group level. Because these adjustments would, under the policies we are finalizing in section III.J.3.d.(1)(b) of this final rule, already be factored in when calculating an individual or TIN-level quality performance category score before the quality scores are rolled-up and averaged to create the APM Entity group level score, we proposed not to continue to calculate these adjustments at the APM Entity group level in the case where an APM Entity group's quality performance score is reported by its composite individuals or TINs. However, in the case of an APM Entity group that chooses to or is required by its APM to report on MIPS quality measures at the APM Entity group level, we proposed to continue to apply any bonuses or adjustments that are available to MIPS groups for the measures reported by the APM Entity and to calculate the applicability of these adjustments at the APM Entity group level.

The following is a summary of the comments we received and our responses.

Comment: A commenter supported this policy, as it eliminates possible duplicative awards of bonus points.

Response: We appreciate the commenter's support.

We are finalizing this policy as proposed.

(E) Special Circumstances

In prior rulemaking, with regard to the quality performance category, we did not include MIPS eligible clinicians who are subject to the APM scoring standard in the automatic extreme and uncontrollable circumstances policy or the application-based extreme and uncontrollable circumstances policy that we established for other MIPS eligible clinicians (82 FR 53780–53783, 53895–53900; 83 FR 59874–59875). However, in the CY 2020 PFS proposed rule (84 FR 40786), we proposed to allow MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures and be scored for the MIPS quality performance category based on the generally applicable MIPS reporting and scoring rules for the quality performance category. We also had proposed that the same extreme and uncontrollable circumstances policies that apply to other MIPS eligible clinicians with regard to the quality performance category also should apply to MIPS eligible clinicians participating in MIPS APMs who would report on MIPS quality measures as proposed. Therefore, beginning with the 2020 MIPS performance period/2022 MIPS payment year and only with regard to the quality performance category, we proposed to apply the application-based extreme and uncontrollable circumstances policy (82 FR 53780–53783) and the automatic extreme and uncontrollable circumstances policy (83 FR 59874–59875) that we previously established for other MIPS eligible clinicians and codified at § 414.1380(c)(2)(i)(A)(6) and (8), respectively, to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standard and would report on MIPS quality measures as proposed in section III.J.3.c.(5)(c)(i) of the CY 2020 PFS proposed rule. We also proposed to limit the application of these policies to the quality performance category because the policy we then proposed and now are finalizing pertains to reporting on MIPS quality measures.

Under the previously established policies, MIPS eligible clinicians who are subject to extreme and uncontrollable circumstances may receive a zero percent weighting for the quality performance category in the final score (82 FR 53780–53783, 83 FR 59874–59875). Similar to the policy for MIPS eligible clinicians who qualify for a zero percent weighting of the Promoting Interoperability performance category (82 FR 53701 through 53702), we proposed that if a MIPS eligible clinician who qualifies for a zero percent weighting of the quality performance category in the final score is part of a TIN reporting at the TIN level that includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting, we would not apply the zero percent weighting to the qualifying MIPS eligible clinician. The TIN would still report on behalf of the entire group, although the TIN would not need to report data for the qualifying MIPS eligible clinician. All MIPS eligible clinicians in the TIN who

are participants in the MIPS APM would count towards the TIN's weight when calculating the aggregated APM Entity score for the quality performance category.

However, in this circumstance, if the MIPS eligible clinician is a solo practitioner and qualified for a zero percent weighting, or if the MIPS eligible clinician's TIN did not report at the group level and the MIPS eligible clinician is individually eligible for a zero percent weighting, or if all MIPS eligible clinicians in a TIN qualified for the zero percent weighting, neither the TIN nor the individual would be required to report on the quality performance category and would be assigned a weight of zero when calculating the APM Entity's quality performance category score.

If quality performance data were reported by or on behalf of one or more TIN/NPIs in an APM Entity group, a quality performance category score would be calculated for, and would be applied to, all MIPS eligible clinicians in the APM Entity group. If all MIPS eligible clinicians in all TINs of an APM Entity group qualify for a zero percent weighting of the quality performance category, the quality performance category would be weighted at zero percent of the MIPS final score.

We solicited comments from the public in this discussion of how best to address the technical infeasibility of scoring quality for many of our MIPS APMs, and whether the above described policy or some other approach may be an appropriate path forward for the APM entity group scoring standard in CY 2020.

Comment: Several commenters supported the greater uniformity within MIPS through this policy.

Response: We appreciate the commenters' support.

After consideration of public comments, we are finalizing the policy as proposed.

(F) Request for Comment on APM Scoring Beyond 2020

We also solicited comments on potential policies to potentially be included in future years' rulemaking to further address the changing statutory incentives for APM participation in coming years. We want the design of the APM scoring standard to continue to encourage appropriate shifts of MIPS eligible clinicians into MIPS APMs and Advanced APMs while ensuring fair treatment for all MIPS eligible clinicians.

We noted in the CY 2020 PFS proposed rule (84 FR 40787) and reiterate now that the QP threshold will be increasing in future years, potentially resulting in larger proportions of Advanced APM participants being subject to MIPS under the APM scoring standard. At the same time the MIPS performance threshold will be increasing annually, gradually reducing the impact of the APM scoring standard on participants' ability to achieve a neutral or positive payment adjustment under MIPS.

We received public comments with general support for finding new ways to continue to reward APM participation without giving APM participants an undue advantage within MIPS, without specific support for or opposition to any potential approach discussed below. We continue to seek input form the stakeholder community as we continue to consider these and other policies that may be included in future rulemaking.

(aa) Sunsetting the APM Quality Reporting Credit for APM Entities

One approach we indicated we may consider beginning in the 2021 performance year would be to apply the APM Quality Reporting Credit described above, if finalized, to specific APM Entities for a maximum number of MIPS performance years; this may be set for all APMs or tied to the end of each APM's initial agreement period.

We discussed our belief that this approach would create an incentive for new APM Entity groups to continue to form and join new MIPS APMs while maintaining the incentive for APM Entity groups and MIPS eligible clinicians to continue to strive to achieve QP status.

(bb) Sunsetting the APM Quality Reporting Credit for Non-Advanced APMs

Similar to the first approach, we may consider an approach whereby we would implement the above approach to quality scoring and then phase out the APM Quality Reporting Credit for MIPS APMs that are not also Advanced APM.

We would have the option to implement this change by removing the APM Reporting Credit for non-Advanced MIPS APMs entirely at the end of a set number of years for all non-Advanced APMs (for example, 2 years).

Alternately, we could tie this sunsetting of the APM Quality Reporting Credit for a non-Advanced APM to the initial agreement period of each APM, creating a well-timed incentive for movement into APM tracks that are Advanced APMs after the initial agreement period after the start of the APM. This approach also would complement the shift we are seeing within APMs, such as the Shared Savings Program, to require APM participants to move into two-sided risk tracks and Advanced APMs within 2 to 5 years of joining the model or program.

(cc) Sunsetting the APM Quality Reporting Credit for APM Entities in One-Sided Risk Tracks

One possible way of acknowledging the uncertainty involved with joining an APM without extending the APM Reporting Credit to all APM participants would be to retain the APM Quality Reporting Credit for all two-sided risk APM tracks but to remove this credit for participants in all one-sided risk tracks except for those APM Entities in the first 2 years—or first agreement period—of a MIPS APM.

We believe this approach would help ease the transition from MIPS to APM participation and ultimately into Advanced APM participation. However, this approach would continue to provide the APM Quality Reporting Credit for participants in two-sided risk APMs who have not reached the QP threshold. In this way, we could create an incentive for APM participants to move towards Advanced APMs, even in situations where it is unlikely the participant would be able to reach the QP threshold.

(dd) Retain Different APM Quality Reporting Credits for Advanced APMs and MIPS APMs

Another available option would be to apply an APM Reporting Credit, as described above to all MIPS APM participants but base the available credit on the level of risk taken on in the MIPS APM. For example, the maximum 50 percent credit may continue to be available to APM Entities in MIPS APMs that are Advanced APMs while the value of the credit may be limited to 25 percent for participants in MIPS APMs that are one-sided risk tracks, or otherwise not Advanced APMs. We solicited comments on how we might best divide these tracks and address the advent of two-sided risk MIPS APMs that do not meet the nominal amount and financial risk standards in order to be considered an Advanced APM, and what an appropriate reporting credit would be for these tracks.

(ee) Other Options

We solicited comments and suggestions on other ways in which we could modify the APM scoring standard to continue to encourage MIPS eligible clinicians to join APMs, with an emphasis on encouraging movement toward participation in two-sided risk APMs that may qualify as Advanced APMs.

(d) Excluding Virtual Groups From APM Entity Group Scoring

Due to concerns that virtual groups could be used to calculate APM Entity group scores, we have excluded virtual group MIPS scores when calculating APM Entity group scores. Previously, we have effectuated this exclusion through the use and application of terms defined in § 414.1305, specifically, ''APM Entity,'' ''APM Entity group,'' ''group,'' and ''virtual group.'' To improve clarity around the exclusion of virtual group scores in calculating APM Entity group scores, we proposed to effectuate this exclusion more explicitly, by amending § 414.1370(e)(2) to state that the score calculated for an APM Entity group, and subsequently the APM Entity, for purposes of the APM scoring standard does not include MIPS scores for virtual groups.

We did not receive any comments on this proposal. We are finalizing this policy as proposed.

(e) MIPS APM Performance Feedback

As we discussed in the CY 2017 and 2018 Quality Payment Program final rules (81 FR 77270, and 82 FR 53704 through 53705, respectively), MIPS eligible clinicians who are scored under the APM scoring standard will receive performance feedback under section 1848(q)(12) of the Act.

Regarding access to performance feedback, while split-TIN APM Entities and their participants can only access their performance feedback at the APM Entity group or individual MIPS eligible clinician level, MIPS eligible clinicians participating in the Shared Savings Program, which is a full-TIN APM, were able to access their performance feedback at the ACO participant TIN level for the 2017 performance period. However, due to confusion caused by the policy in cases, where not all eligible clinicians in a Shared Savings Program participant TIN received the APM Entity score, for example eligible clinicians that terminate before the first snapshot, we intend to better align treatment of Shared Savings Program ACOs and their participant TINs with other APM Entities and, where appropriate, with other MIPS groups. We will continue to allow ACO participant TIN level access to the APM Entity group level final score and performance feedback, as well as provide the APM Entity group level final score and performance feedback to individual MIPS eligible clinicians who bill through the TINs identified on the ACO's ACO participant list. However, we will also provide TIN level performance feedback to ACO participant TINs that will include the information that is available to all TINs participating in MIPS, including the applicable final scores for MIPS eligible clinicians billing under the TIN, regardless of their MIPS APM participation status.

(f) Regulation Text

Due to a clerical error, the regulation text corresponding with the proposals discussed in section III.J.3.c.(5) of this final rule was omitted from the publication of the proposed rule. The proposals were discussed at length in the preamble where we solicited public comment. This preamble text included a detailed explanation of the proposed changes to the regulation text. The preamble text also cross-referenced the missing regulation text, such as page 84 FR 40786, such that the intent to codify the proposals would have been apparent to readers. We received several detailed public comments on our proposals. These comments indicate that readers accurately understood the proposed policy and our intent to codify it, and as discussed in section III.J.3.c.(5) of this final rule, were generally supportive of the proposal. As such, we are finalizing the proposed policies, as explained above, including amending § 414.1370(g)(1) accordingly.

d. MIPS Final Score Methodology

(1) Performance Category Scores

(a) Background

For the 2022 MIPS payment year, we intend to continue to build on the scoring methodology we finalized for prior years, which allows for accountability and alignment across the performance categories and minimizes burden on MIPS eligible clinicians. The rationale for our scoring methodology continues to be grounded in the understanding that the MIPS scoring system has many components and various moving parts. As we transform MIPS through the MVP framework as discussed in section III.K.3.a. of this final rule, we may propose modifications to our scoring methodology in future rulemaking as we continue to develop a methodology that emphasizes simplicity and that is understandable for MIPS eligible clinicians.

In the CY 2020 PFS proposed rule (84 FR 40788 through 40792), we proposed policies to help eligible clinicians as they participate in the 2020 performance period/2022 MIPS payment year, and as we move beyond the transition years of the program.

(b) Scoring the Quality Performance Category for the Following Collection Types: Medicare Part B Claims Measures, eCQMs, MIPS CQMs, QCDR Measures, CMS Web Interface Measures, the CAHPS for MIPS Survey Measure and Administrative Claims Measures

We refer readers to § 414.1380(b)(1) for our policies regarding quality measure benchmarks, calculating total measure achievement and measure bonus points, calculating the quality performance category percent score, including achievement and improvement points, and the small practice bonus.

As we move towards the transformation of the program through the MVP Framework discussed in section III.K.3.a. of this final rule, we anticipate we will revisit and remove many of our scoring policies such as the 3-point floor, bonus points, and assigning points for measures that cannot be scored against a benchmark through future rulemaking. As we proposed to transform the MIPS program through the MVP framework, our goal was to incorporate ways to address these issues without developing special scoring policies. We refer readers to the 2020 PFS proposed rule (84 FR 40741 through 40742) for further discussion on scoring of MVPs.

In section III.K.3.d.(1) of this final rule, we discuss the limited proposals for our scoring policies as we anticipate future changes as we work to transform MIPS through the MVP framework. In the CY 2020 PFS proposed rule (84 FR 40788 through 40792), we proposed to: (1) Maintain the 3-point floor for measures that can be scored for performance; (2) develop benchmarks based on flat percentages in specific cases where we determine the measure's otherwise applicable benchmark could potentially incentivize inappropriate treatment; (3) continue the scoring policies for measures that do not meet the case-minimum requirement, do not have a benchmark, or do not meet the data-completeness criteria; (4) maintain the cap on measure bonus points for high-priority measures and end-to-end reporting; and (5) continue the improvement scoring policy. In addition, we requested comment on future approaches to scoring the CAHPS for MIPS survey measure if new questions are added to the survey.

(i) Assigning Quality Measure Achievement Points

We refer readers to § 414.1380(b)(1) for more on our policies for scoring performance on quality measures.

(A) Scoring Measures Based on Achievement

We established at § 414.1380(b)(1)(i) a global 3-point floor for each scored quality measure, as well as for the hospital readmission measure (if applicable). MIPS eligible clinicians receive between 3 and 10 measure achievement points for each submitted measure that can be reliably scored against a benchmark, which requires meeting the case minimum and data completeness requirements. In the CY 2017 Quality Payment Program final rule (81 FR 77282), we established that measures with a benchmark based on the performance period (rather than on the baseline period) would continue to receive between 3 and 10 measure achievement points for performance periods after the first transition year. For measures with benchmarks based on the baseline period, we stated that the 3-point floor was for the transition year and that we would revisit the 3-point floor in future years.

For the 2022 MIPS payment year, we proposed to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period. As we move towards the MVP framework discussed in section III.K.3.a. of this final rule, we anticipate we will revisit and possibly remove the 3-point floor in future years. As a result, we will wait until there is further policy development under the MVP framework before proposing to remove the 3-point floor. Accordingly, we proposed to amend § 414.1380(b)(1)(i) to remove the years 2019, 2020, and 2021 and adding in its place the years 2019 through 2022 to provide that for the 2019 through 2022 MIPS payment years, MIPS eligible clinicians receive between 3 and 10 measure achievement points (including partial points) for each measure required under § 414.1335 on which data is submitted in accordance with § 414.1325 that has a benchmark at paragraph (b)(1)(ii) of this section, meets the case minimum requirement at paragraph (b)(1)(iii) of this section, and meets the data completeness requirement at § 414.1340. The number of measure achievement points received for each measure is determined based on the applicable benchmark decile category and the percentile distribution. MIPS eligible clinicians receive zero measure achievement points for each measure required under § 414.1335 on which no data is submitted in accordance with § 414.1325. MIPS eligible clinicians that submit data in accordance with § 414.1325 on a greater number of measures than required under § 414.1335 are scored only on the required measures with the greatest number of measure achievement points. Beginning with the 2021 MIPS payment year, MIPS eligible clinicians that submit data in accordance with § 414.1325 on a single measure via multiple collection types are scored only on the data submission with the greatest number of measure achievement points.

We received public comments on our proposal to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported CMS' proposal to maintain the 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period for the 2022 MIPS payment year because they believe the consistency makes it easier for clinicians to understand MIPS scoring complexities, improves workflow processes, offers a reasonable backstop for unpredictable performance, encourages program participation, and is critical for small and rural practices that have less resources and require more time to advance quality initiatives.

Response: We thank commenters for their support. As stated in the 2020 PFS proposed rule (84 FR 40788), as we move towards implementation of the MVP framework, we anticipate we will revisit the 3-point floor in future years since this scoring policy was intended to be temporary.

After consideration of the comments, we are finalizing our proposal for the MIPS 2022 payment year to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period. We will amend § 414.1380(b)(1)(i) as proposed.

(B) Scoring Measures That Do Not Meet Case Minimum, Data Completeness, and Benchmark Requirements

We refer readers to § 414.1380(b)(1)(i)(A) and (B) for more on our scoring policies for a measure that is submitted but is unable to be scored because it does not meet the required case minimum, does not have a benchmark, or does not meet the data completeness requirement. A summary of the policies for the CY 2020 MIPS performance period is provided in Table 50.

TABLE 50: Quality Performance Category: Scoring Policies for the CY 2020 MIPS Performance Period*

Measure type	Description	Scoring rules
Class 1	For the 2020 MIPS performance period: Measures that can be scored based on performance. Measures that are submitted or calculated that meet all the following criteria: (1) Has a benchmark; (2) Has at least 20 cases; and (3) Meets the data completeness standard (generally 70 percent for 2020.)**	For the 2020 MIPS performance period: 3 to 10 points based on performance compared to the benchmark.
Class 2	For the 2020 MIPS performance period: Measures that are submitted and meet data completeness, but do not have either of the following: (1) A benchmark (2) At least 20 cases.	For the 2020 MIPS performance period: 3 points.
Class 3	For the 2020 MIPS performance period: Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum.	Beginning with the 2020 MIPS performance period: MIPS eligible clinicians other than small practices will receive zero measure achievement points. Small practices will continue to receive 3 points.

*The Class 2 and 3 measure scoring policies are not applicable to CMS Web Interface measures or administrative claims-based measures.

**We refer readers to section III.K.3.c.(1)(c) of this final rule for our policy to increase data completeness.

For the 2022 MIPS payment year, we proposed to again apply the special scoring policies for measures that meet the data completeness requirement but do not have a benchmark or meet the case minimum requirement. Accordingly, we proposed to amend § 414.1380(b)(1)(i)(A)(*1*) to remove the years 2019, 2020, and 2021 and add in its place the years 2019 through 2022 to provide that except as provided in paragraph (b)(1)(i)(A)(2) (which relates to CMS Web Interface measures and administrative claims-based measures), for the 2019 through 2022 MIPS payment years, MIPS eligible clinicians receive 3 measure achievement points for each submitted measure that meets the data completeness requirement, but does not have a benchmark or meet the case minimum requirement.

We received public comments on our proposal to again apply the special scoring policies for measures that meet the data completeness requirement, but do not have a benchmark or meet the case minimum requirement. The following is a summary of the comments we received and our responses.

Comment: One commenter supported our proposal to retain the 3-point floor for small practices who submit data, but do not meet the data completeness threshold.

Response: We appreciate the commenter's support. However, we stress that these policies are not meant to be permanent, and as clinicians continue to gain experience with the program, we will revisit the appropriateness of these policies in future rulemaking.

Comment: A few commenters recommended incentivizing clinicians to report on new measures and measures without benchmarks by eliminating the scoring cap for measures with no benchmarks and providing clear and prospective benchmarks for new measures so that benchmarking data can be gathered and used since providers have little control over CMS-established benchmarks. A few commenters noted that low reporting rates are not an indication of low value or non-meaningful measures and as scoring is designed now, clinicians must choose between submitting data on a less relevant measure, with the potential to earn 10 points, or receiving the capped 3 points for submitting a relevant measure with no benchmark. A few commenters recommended that CMS include a bonus for submitting on new measures to incentivize the use and increase data collection.

Response: We recognize stakeholders' concerns regarding the assignment of 3 points to measures without a benchmark. We will take them into consideration in the future. As stated in the CY 2018 PFS final rule (82 FR 53729), we selected the 3-point cap because we did not want to provide more credit for reporting a measure that cannot be reliably scored against a benchmark than for measures for which we can measure performance against a benchmark. We remind commenters that we only apply the 3-point cap if we cannot create a benchmark for a measure. For many new measures, we do anticipate that a benchmark will be able to be created which will allow for up to 10 points. As we stated in the proposed rule (84 FR 40788), we envision that the progression of the MIPS program under the MVP framework will allow us to remove

some of the scoring complexity associated with the MIPS program. We anticipate that removing caps and bonuses could be part of this framework. As the program implementation continues, we want to ensure that our policies align with our goal of improving quality and decreasing burden. As such, we do not believe that eliminating or altering the finalized cap on the points available under the quality performance category for the 2022 MIPS payment year would support that goal.

After consideration of the comments, we are finalizing our proposal for the MIPS 2022 payment year to again apply the special scoring policies for measures that meet the data completeness requirement but do not have a benchmark or meet the case minimum requirement. We will amend § 414.1380(b)(1)(i)(A)(*1*) as proposed.

(C) Modifying Benchmarks To Avoid the Potential for Inappropriate Treatment

We established at § 414.1380(b)(1)(ii) that benchmarks will be based on collection type, from all available sources, including MIPS eligible clinicians and APMs, to the extent feasible, during the applicable baseline or performance period. We also established at § 414.1380(b)(1)(i) that the number of measure achievement points received for each such measure is determined based on the applicable benchmark decile category and the percentile distribution.

We believe all the measures in the MIPS program are of high standard as they have undergone extensive review prior to their inclusion in the program. MIPS measures go through the rulemaking process, and QCDR measures have an approval process before they are included in MIPS. We also believe our benchmarking generally provides an objective way to compare performance differences across different types of quality measures. However, we have heard concerns from stakeholders that for a few measures, the benchmark methodology may incentivize the inappropriate treatment of certain patients, in order for a clinician to achieve a score in the highest decile. Our scoring system already provides some protection from inappropriate treatment because all clinicians in the top 10 percent of the distribution receive the same 10-point score, thus a clinician with performance in the 90th percentile has no incentive to go higher. However, for certain measures with benchmarks set at very high or maximum performance in the top decile, we are concerned that these levels may not be representative and may not provide the most appropriate incentives for clinicians. Specifically, there are some measures that may have the potential to encourage clinicians to alter the clinical interaction with patients inappropriately, regardless of the individual patient's circumstances, in order to achieve that top decile performance level, for example, intermediate outcome measures that may encourage clinicians to over treat patients in order to achieve the highest performance level. Patient safety is our primary concern; therefore, we proposed to establish benchmarks based on flat percentages in specific cases where we determine the measure's otherwise applicable benchmark can potentially incentivize treatment that can be inappropriate for a particular patient type (84 FR 40789 through 40790). Rather than develop benchmarks based on the distribution of scores we will base them on flat percentages such that any performance rate at or above 90 percent will be in the top decile and any performance rate above 80 percent will be in the second highest decile, and this will continue for the remaining deciles. We believe the measures that will fall under this methodology are high-priority or outcome measures for clinicians to focus on. However, we want to ensure that benchmarks are set to incentivize the most appropriate behavior, and ensure that our method for scoring against a benchmark accurately reflects performance and does not result in clinicians receiving low scores, despite adherence to the most appropriate treatment.

For the measures identified, we proposed to use a flat percentage, similar to how the Shared Savings Program uses flat percentages to set benchmarks for measures with high performance. We selected this methodology for the following reasons: First, it is a straight-forward and simple methodology that currently exists for some MIPS measures that are collected through the CMS Web Interface. Second, because we are applying this methodology to measures with very high performance, we believe this approach is consistent with the Shared Saving Program approach established at § 425.502(b)(2)(ii) of using flat percentages to set benchmarks when many reporters demonstrate high achievement on a measure. The Shared Savings Program uses this method to avoid penalizing high ACO performance; however, in this case, we will be applying the flat percentages to ensure that the benchmark does not result in inappropriate and potentially harmful patient treatment. We believe this adjustment will provide additional protection to patients and reduce the potential incentive for inappropriate treatment of patients.

We proposed that to determine whether a measure benchmark may not provide the most appropriate incentives for treatment, thus creating the potential for inappropriate treatment based on the patient's circumstances, CMS medical officers will assess if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure benchmark. This assessment will include reviews of factors such as whether the measure specifications allow for clinical judgment to adjust for inappropriate outcomes, if the benchmarks for any of the impacted measure's collection types could put these patients at risk by setting a potentially harmful standard for top decile performance, or whether the measure is topped out. The intent of the assessment is to have CMS medical officers determine whether certain measure benchmarks may have unintended consequences that put patients at risk and the measure benchmark should therefore move to a flat percentage. The assessment will take into account all available information, including from the medical literature, published practice guidelines, and feedback from clinicians, groups, specialty societies, and the measure steward. Before applying the flat percentage benchmarking methodology to any recommended measure, we will propose the modified benchmark for the applicable MIPS payment year through rulemaking. This policy will be effective beginning with the CY 2020 MIPS performance period (and thus the 2022 MIPS payment adjustment year). We also solicited comment on future actions we should take to help us in determining which measures to apply the flat percentage benchmarking to; for example, convening a technical expert panel.

We have identified two measures for which we believe we need to apply benchmarks based on flat percentages to avoid potential inappropriate treatment—MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control >9%) and MIPS #236 (NQF 0018): Controlling High Blood Pressure. Although there are protections built into both of these measures, such as the use of less stringent requirements than current clinical guidelines, they lack comprehensive denominator exclusions and risk-adjustment or risk-stratification, which can lead to the possible over treatment of patients in order to meet numerator compliance.

Overtreatment could lead to instances where the patient's blood sugar or blood pressure is lowered to a level that meets the measure standard but is too low for their optimum health given other coexisting medical conditions.

Because the factors for determining if a measure benchmark has the potential to cause inappropriate treatment may include both measure and benchmark considerations, we are concerned that all the benchmarks associated with the different collection types of a measure could be affected. Therefore, we proposed to use the flat percentage benchmarks as an alternative to our standard method of calculating benchmarks by a percentile distribution of measure performance rates under for all collection types where the top decile for any measure benchmark is higher than 90 percent under the performance-based benchmarking methodology at § 414.1380(b)(1)(ii) (84 FR 40790). We are limiting the application of the flat percentage methodology to all collection types where the top decile for any measure benchmark is higher than 90 percent so that our flat percentage methodology will actually reduce or remove the incentive for inappropriate care. If the top decile was originally below 90 percent, using the flat percentages would actually raise the level up to 90 percent, and therefore, provide a stronger incentive to provide inappropriate care in order to get the top score. We also solicited comment on whether we should use a criteria different than applying it to collection types where the top decile would be higher than 90 percent if the benchmark was based on a distribution. For the two measures we proposed to modify, we will not know which benchmarks and their associated collection types are impacted until we run our analysis; however, based on the benchmarks for the 2019 MIPS performance period, we anticipate using the modified benchmarks for the Medicare Part B claims and the MIPS CQM collection types.

We considered whether we should rerun the benchmarks excluding those in the top decile but are concerned that the approach will add complexity to the program overall. We solicited comment on whether we should consider different methodologies for the modified benchmarks such as excluding the top decile or increasing the required data completeness for the measure to a very high level (for example, 95 to 100 percent) and use performance period benchmarks rather than historical benchmarks.

We proposed to add paragraph § 414.1380(b)(1)(ii)(C) to state that beginning with the 2022 MIPS payment year, for each measure that has a benchmark that CMS determines has the potential to result in inappropriate treatment, we will set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology at § 414.1380(b)(1)(ii). We also proposed to revise the text at § 414.1380(b)(1)(ii) to provide exceptions and to clarify the requirement that benchmarks will be based on performance by collection type, from all available sources, including MIPS eligible clinicians and APMs, to the extent feasible, during the applicable baseline or performance period.

We received public comments on our proposals to set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure, and our proposal to apply the flat percentages to the following two measures: MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9) and MIPS #236 (NQF #0018), Controlling High Blood Pressure. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure. One commenter supported our proposal to apply the flat percentages to the following measure: MIPS #236 (NQF #0018), Controlling High Blood Pressure, to avoid inappropriate treatment. This commenter expressed concern that a one-size-fits-all blood pressure goal of < 140/90 mm Hg may erroneously suggest to patients and their clinicians that their treatment is adequate if they reach this goal. Another commenter supported our proposal to propose any specific measures to which they would apply this methodology through formal rulemaking to allow for stakeholder input.

Response: We appreciate the commenters' support. We believe identifying these measures through rulemaking provides a transparent process for the public to provide feedback.

Comment: One commenter suggested that CMS apply flat percentage benchmarks to otherwise ''topped out'' patient safety measures that should remain in the program due to their importance to patient safety.

Response: We intend to apply this policy to all measures with potential for inappropriate treatment based on the patient's circumstances. We believe it is important that we take a performance based approach to scoring, such that our benchmarks are based on a distribution of scores. We do not believe it would be appropriate to apply this standard broadly to a measure without this analysis. We recommend that stakeholders contact us through our service center if they have identified a measure that they believe would meet the requirements to apply flat percentage benchmarks so that we may consider it for future rulemaking. We may consider in future years revisiting flat percentage benchmarks as we transform MIPS through the implementation of the MVP framework discussed in section III.K.3.a. of this final rule. We also note that the measures that we selected to apply the flat percentage benchmarks to are not topped out for any of the collection types.

Comment: Several commenters recommended different methodologies that CMS could consider for the modified benchmarks. Several commenters encouraged CMS to use an approach where certain thresholds are determined based on expert opinion but interim values are informed by actual performance. Recognizing that this would be a more complex approach, these commenters believed that the thresholds should always be determined in part by data driven aspects such as peer performance and clinical evidence, in addition to manually fixed thresholds to ensure clinical relevance and fairness of measure benchmarks.

A few commenters encouraged CMS to use other methods of setting benchmarks, such as adding exclusions or risk stratifications to all measures, or reducing all benchmarks for all measures, including all collection types, by a certain percentage, an equivalent number of points. One commenter suggested that CMS consider developing benchmarks based on actual performance, with a cap based on rates for the highest performers and partial credit for achieving progress toward the target.

Response: We agree with commenters that using a data driven approach to benchmarks is preferred. While we received some information about the different methods, we do not believe we have sufficient information to conduct the analysis suggested for the measures we proposed to operationalize the alternatives for the 2020 MIPS

performance period. However, we are interested in working with stakeholders to better understand these alternative methods and would consider revising this policy through future rulemaking. Additionally, we plan to continue working with measure stewards to ensure the measures include appropriate exclusions or risk stratifications.

Comment: Several commenters did not support our proposal to set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure. While commenters recognized the need for a specialized approach, they expressed concerns regarding the consequences of this approach. Specifically, one commenter expressed concern that the measures proposed for the application of the flat percentages are claims based measures and MIPS CQMs, and that the application of the flat benchmark may unfairly lower the bar for clinicians utilizing the claims-based and MIPS CQM versions of the measures, without providing the same adjustment to all collection types. Another commenter expressed concern that the approach would lead to inconsistent evaluation of clinicians, as clinicians would be compared to their peers on some measures, but compared on flat thresholds on other measures that are unrelated to peer performance.

Response: We recognize that not applying the same benchmarking methodology to all collection types may create some inconsistent evaluation between collection types for a single measure. On the other hand, we know there are differences in performance by data collection type, and we are concerned that if we apply this method to all collection types without regard to the collection type distribution, then we would harm those with top performance for certain collection types. Given this tension, we believe it is better to limit the benchmark proposal to those collection types where the top decile is 90 percent or higher. We also intend to apply this policy in very limited circumstances where there is a concern with incentives for inappropriate treatment. At this time, we are proceeding cautiously with this approach by limiting application of this policy to two measures and two collections types. We may revisit this policy through future rulemaking.

Comment: A few commenters did not support our proposal to apply the flat percentages to the following measures: MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9) and MIPS #236 (NQF #0018), Controlling High Blood Pressure. These commenters expressed concern that the approach would not address the issue of potential inappropriate care, inappropriate treatment is rare for these measures, and our approach could potentially discourage appropriate care. A few commenters suggested that addressing exclusions for these measures might solve the issue of potential inappropriate care. However, another commenter cautioned against an approach based on exclusions. This commenter expressed concern that exclusions would not address every possible circumstance for each measure, and that expanding exclusions may have the inverse consequence of having systems focus on documentation improvements instead of clinical quality improvements.

Response: For these two measures, we have heard concern from stakeholders that clinicians may feel pressure to meet the measures standards at a high level, which could result in inappropriate treatments in patients for whom the specified level of control of blood pressure or blood sugar may be different from the precise measure specifications. As long as the percent of these patients (those who may be at risk because they fall in this category) is less than 10 percent of the practice's eligible cases, our flat benchmark approach can completely remove any potential incentive to over-treat. While this approach would allow the same score (10 points) for any clinician who chose to lower their performance down to 90 percent from a higher level, we believe that the clinicians for whom this would be possible are already high performing clinicians who would not knowingly undertreat their patients. Regarding commenters' concerns around exclusions, the measure steward for these two measures has advised CMS of additional denominator exclusions for the 2022 MIPS payment year and future years. We refer readers to Appendix 1, Table Group D (Previously Finalized Quality Measures with Substantive Changes Finalized for the 2022 MIPS Payment Year and Future Years) for additional details regarding these changes to the measures. We plan to continue working with measure stewards to ensure the measures include appropriate exclusions or risk stratifications. Additionally, we will work with stakeholders to better understand alternative methods and we may revisit this policy through future rulemaking.

Comment: One commenter recommended that when CMS determines a collection type for a measure where the top decile is higher than 90 percent under the methodology if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure, then CMS should either remove the measure from that specific collection type or modify the measure so that inappropriate actions do not count positively, or remove and replace the measure.

Response: As noted in the CY 2020 Quality Payment Program proposed rule (84 FR 40751) and referred to in section III.K.3.c.(1)(d)(iv) of this final rule, we have established a robust set of removal criteria for quality measures. We will continue to work with quality measure stewards on future modifications of the measures and may consider removing or replacing any measures through notice and comment rulemaking as appropriate. At this time, we believe that the flat percentage benchmarks will allow the measure to stay in the program without incentivizing inappropriate care. We did not propose that we would substantively change the measures from their original state, as would be done if we were to no longer count patients that meet the requirements of the numerator when performance is high, as suggested by the commenter. However, we may consider this approach and consider removal of collection types through future rulemaking. We encourage stakeholders to develop meaningful measures that promote the quality outcomes and interactions for patients, additional viable quality measures, and robust performance data.

After consideration of public comments, we are finalizing a policy to use the flat percentage benchmarks as an alternative to our standard method of calculating benchmarks by a percentile distribution of measure performance rates for all collection types where the top decile for any measure benchmark is higher than 90 percent and when CMS medical officers assess that there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure benchmark. We will revise the text at § 414.1380(b)(1)(ii) as proposed and add paragraph § 414.1380(b)(1)(ii)(C) to state that beginning with the 2022 MIPS payment year, for each measure that has a benchmark that CMS determines has the potential to result in inappropriate treatment, we will set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology at § 414.1380(b)(1)(ii). We are also finalizing our proposal to apply the flat percentages to the following two

measures: MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and MIPS #236 (NQF #0018): Controlling High Blood Pressure.

(ii) Request for Feedback on Additional Policies for Scoring the CAHPS for MIPS Survey Measure

We refer readers to § 414.1380(b)(1)(vii)(B) for more on our policy on reducing the total available measure achievement points for the quality performance category by 10 points for groups that submit 5 or fewer quality measures and register for the CAHPS for MIPS survey, but do not meet the minimum beneficiary sampling requirements.

In the CY 2020 PFS proposed rule (84 FR 40791), we did not propose any changes to the scoring of the CAHPS for MIPS survey measure. However, to the extent consistent with our authority to collect such information under section 1848(q) of the Act, we considered expanding the information collected in the CAHPS for MIPS survey measure, described in section III.K.3.c.(1) of this final rule, and solicited comment on scoring. One consideration is adding narrative questions to the CAHPS for MIPS survey measure, which would invite patients to respond to a series of questions in free text, such as responding to open ended questions and describing their experience with care in their own words. We believe narratives from patients about their health care experiences would be helpful to other patients when selecting a clinician and can provide a valuable complement to standardized survey scores, both to help clinicians understand what they can do to improve care and to engage and inform patients about differences among their experiences of care. On the other hand, there may be concerns about the accuracy and usefulness of narrative information reported by patients. For more information on the rationale for adding narrative questions, we refer readers to the CY 2020 PFS proposed rule (84 FR 40746 through 40747). In addition, we are interested in learning from organizations with experience scoring narrative information, including methodologies. We will work with stakeholders on user testing before proposing any such methodology in future rulemaking. We also considered adding an additional CAHPS for MIPS survey question allowing patients to provide a score for their overall experience and satisfaction rating with a recent health care encounter, to capture the patient ''voice'' and provide patients with information useful to making a decision on clinicians, as detailed in the CY 2020 PFS proposed rule (84 FR 40744). We received feedback regarding how to score this measure and on new questions that could potentially be added to the calculation for a score for the CAHPS for MIPS survey measure. We will consider the feedback received for future notice and comment rulemaking.

(iii) Scoring for MIPS Eligible Clinicians That Do Not Meet Quality Performance Category Criteria

In the CY 2019 PFS final rule (83 FR 35950), we finalized our proposal to modify our validation process to provide that it only applies to MIPS CQMs and the claims collection type, regardless of the submitter type chosen.

In the CY 2020 PFS proposed rule (84 FR 40791), we did not propose any changes to this policy. However, we refer readers to section III.K.3.d.(2)(b)(ii)(A) of this final rule for discussion on the rare circumstances when we are unable to calculate a quality performance category score for a MIPS eligible clinician because they do not have applicable or available quality measures. If we are unable to score the quality performance category for a MIPS eligible clinician, then we will reweigh the clinician's quality performance category score according to the reweighting policies described in sections III.K.3.d.(2)(b)(iii) of this final rule.

(iv) Incentives To Report High-Priority Measures

We refer readers to § 414.1380(b)(1)(v)(A) for more on the cap on high-priority measure bonus points for the first 3 years of MIPS at 10 percent of the denominator (total possible measure achievement points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category.

In the CY 2019 PFS final rule (83 FR 59851), we finalized technical updates to § 414.1380(b)(1) to more clearly and concisely capture previously established policies in the section. During this effort we inadvertently added that a high priority measure must have a benchmark. This was not intended to be a policy change. We are clarifying that in order for a measure to qualify for high priority bonus points it must meet case minimum and data completeness and not have a zero percent performance. The measure does not need to have a benchmark. Accordingly, we proposed to revise § 414.1380(b)(1)(v)(A)(*1*)(*i*) to provide that each high priority measure must meet the case minimum requirement at paragraph (b)(1)(iii) of this section, meet the data completeness requirement at § 414.1340, and have a performance rate that is greater than zero (84 FR 40791).

We also removed high priority bonus points for CMS Web interface reporters in the CY 2019 PFS final rule (83 FR 59850 through 59851). We refer readers to the CY 2019 PFS final rule for further discussion on this policy.

In the CY 2020 PFS proposed rule (84 FR 40791), we proposed to maintain the cap on measure points for reporting high priority measures for the 2022 MIPS payment year. Accordingly, we proposed to revise § 414.1380(b)(1)(v)(A)(*1*)(*ii*) to remove the years 2019, 2020, and 2021 and adding in its place the years 2019 through 2022 to provide that for the 2019 through 2022 MIPS payment years, the total measure bonus points for high priority measures cannot exceed 10 percent of the total available measure achievement points.

We received public comments on our proposal to clarify that a measure does not need to have a benchmark in order to qualify for high priority bonus points and our proposal to maintain the cap on measure points for reporting high priority measures for the 2022 MIPS payment year. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported the high priority bonus and CMS' proposal to maintain the cap on measure points for reporting high priority measures for the 2022 MIPS payment year. One commenter cited an example cap at 10 percent of the total available measure achievement points through 2022 and expressed its belief that these points are helpful to the reporting of outcome and high priority measures and also that the consistency of scoring policy assists with provider understanding and approval of the program. A few commenters recommended that CMS continue to incentivize reporting by awarding MIPS bonus points or cross-category credit.

One commenter recommended further incentivizing bonus points for high priority measures because in some cases MIPS CQMs score higher than QCDR measures without the bonus points.

Response: We appreciate the recommendations. We agree that continuing the scoring policy provides consistency and will take the recommendations into consideration in the future rulemaking as we move toward the implementation of the MVP framework. We believe that our current policy of capping the high-priority measure bonus at 10 percent of the denominator prevents incentivizing the reporting of additional measures over a

focus on performance in relevant clinical areas, and mask poor performance with higher bonus points.

After consideration of the comments, we are finalizing our proposal to clarify that a measure does not need to have a benchmark in order to qualify for high priority bonus points and our proposal to maintain the cap on measure points for reporting high priority measures for the 2022 MIPS payment year. We will revise § 414.1380(b)(1)(v)(A)(*1*)(*i*) and (b)(1)(v)(A)(*1*)(*ii*) as proposed.

(v) Incentives To Use CEHRT To Support Quality Performance Category Submissions

We refer readers to § 414.1380(b)(1)(v)(B) for more on our policy assigning one bonus point for each quality measure submitted with end-to-end electronic reporting, under certain criteria.

In the CY 2020 PFS proposed rule (84 FR 40791), we proposed to continue to assign and maintain the cap on measure bonus points for end-to-end electronic reporting for the 2022 MIPS payment year. We believe with the framework for transforming MIPS through the MVPs discussed in the 2020 PFS proposed rule (84 FR 40739), we can find ways in future years to incorporate eCQM measures without needing to incentivize end-to-end reporting with bonus points. As a result, we will wait until there is further policy development under the framework before proposing to remove our policy of assigning bonus points for end-to-end electronic reporting. Accordingly, we proposed to revise § 414.1380(b)(1)(v)(B)(*1*)(*i*) to remove the years 2019, 2020, and 2021 and add in its place the years 2019 through 2022 to provide that for the 2019 through 2022 MIPS payment years, the total measure bonus points for measures submitted with end-to-end electronic reporting cannot exceed 10 percent of the total available measure achievement points.

We received public comments on our proposal to continue to assign and maintain the cap on measure bonus points for end-to-end electronic reporting for the 2022 MIPS payment year. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported the proposal to continue the end-to-end electronic reporting bonus points for providers utilizing electronic tools for MIPS reporting.

Response: We appreciate the commenters' support.

*Commen*t: A few commenters opposed the proposal to maintain the 10 percent cap on end-to-end electronic reporting points. Some commenters suggested that the MIPS scoring methodology should award credit across multiple MIPS performance categories and that continuing the cap on the bonus in the quality performance category would be counter to incentives to build capacity for digital data. A few commenters suggested that bonus points should be awarded in the PI performance category in addition to bonus points in the quality performance category.

Response: We appreciate commenters' concerns and will take their recommendations into consideration for the future. As we stated in the proposed rule (84 FR 40791), we envision that the progression of the MIPS program under the MVP framework will allow us to remove some of the scoring complexity associated with the MIPS program. We anticipate that removing bonuses would be part of this framework. As such, we do not believe that eliminating or altering the cap on the bonus points available under the quality performance category for the 2022 MIPS payment year would support that goal. We also understand the interest in being as flexible as possible in awarding clinicians for supporting the goals of the program such as reporting through end-to-end CEHRT. We will continue to consider the best ways to support this goal in future rulemaking.

After consideration of the comments, we are finalizing our proposal to continue to assign and maintain the cap on measure bonus points for end-to-end electronic reporting for the 2022 MIPS payment year. We will revise § 414.1380(b)(1)(v)(B)(*1*)(*i*) as proposed.

(vi) Improvement Scoring for the MIPS Quality Performance Category Percent Score

We refer readers to § 414.1380(b)(1)(vi)(C)(*4*) for more on our policy stating that for the 2020 and 2021 MIPS payment year, we will assume a quality performance category achievement percent score of 30 percent if a MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent in the previous year.

In the CY 2020 PFS proposed rule (84 FR 40791 through 40792), we proposed to continue our previously established policy for the 2022 MIPS payment year and to revise § 414.1380(b)(1)(vi)(C)(*4*) to remove the phrase ''2020 and 2021 MIPS payment year'' and adding in its place the phrase ''2019 through 2022 MIPS payment years'' to provide that for the 2020 through 2022 MIPS payment years, we will assume a quality performance category achievement percent score of 30 percent if a MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent in the previous year. However, we misstated the replacement phrase, and clarify here that we will revise § 414.1380(b)(1)(vi)(C)(*4*) to remove the phrase ''2020 and 2021 MIPS payment year'' and add in its place the phrase ''2020 through 2022 MIPS payment years''. Specifically, for the 2022 MIPS payment year, we will compare the MIPS eligible clinician's quality performance category achievement percent score for the 2020 MIPS performance period to an assumed quality performance category achievement percent score of 30 percent if the MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent for the 2019 MIPS performance period.

The following is a summary of the comments we received and our responses.

Comment: One commenter supported CMS' proposal to assume the quality performance category achievement score equals 30 percent if MIPS eligible clinicians earned a quality performance category score less than or equal to 30 percent in the previous year.

Response: We thank the commenter for their support.

After consideration of the comments, we are finalizing our proposal to continue assume a quality performance category achievement percent score of 30 percent if a MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent in the previous year. Consistent with our proposal, we will revise § 414.1380(b)(1)(vi)(C)(*4*) to remove the phrase ''2020 and 2021 MIPS payment year'' and add in its place the phrase ''2020 through 2022 MIPS payment years''.

(c) Facility-Based Measurement Scoring Option for the Quality and Cost Performance Categories for the 2022 MIPS Payment Year

(i) Background

For our previously established policies regarding the facility-based measurement scoring option, we refer readers to both the CY 2018 Quality Payment Program final rule (82 FR 53752 through 53767) and the CY 2019 PFS final rule (83 FR 59856 through 59867). In the CY 2019 PFS proposed rule (83 FR 35962 through 35963), we requested comments on a number of issues and topics related to whether we should expand the facility-based scoring option to other facilities and programs in future years, particularly the use of end-stage renal disease (ESRD) and post-

acute care (PAC) settings as the basis for facility-based measurement and scoring. We appreciate the many comments we received in response to this request. We did not propose an expansion to other facility types as part of this rule but may consider addressing this issue in future rulemaking.

(ii) Facility-Based Measurement Eligibility

In the CY 2019 PFS final rule (83 FR 59856 through 59860), we established the policies that determine eligibility for scoring for facility-based measurement as an individual and as a group. In the CY 2019 PFS final rule, we established at § 414.1380(e)(2)(i)(C) that a MIPS eligible clinician is facility-based if the clinician can be attributed, under the methodology specified in § 414.1380(e)(5), to a facility with a value-based purchasing score for the applicable period. While we did not propose any changes to the eligibility of facility-based measurement for individuals or groups, we proposed to amend § 414.1380(e)(2)(i)(C) to improve clarity (84 FR 40792). Specifically, we proposed to amend § 414.1380(e)(2)(i)(C) to state that a MIPS eligible clinician is facility-based if the clinician can be assigned, under the methodology specified in § 414.1380(e)(5), to a facility with a value-based purchasing score for the applicable period. We hope to avoid any ambiguity as we have used the term ''attribute'' and ''attribution'' in two ways. We have used the term to refer to the use of the facility's performance in place of the clinician's own performance (83 FR 59857). We have also used the term at § 414.1380(e)(2)(i)(C) to reference our method of connecting clinicians to a facility and indicate that the facility score will be the clinician's score. We believe these are related but distinct concepts; therefore, we proposed to revise § 414.1380(e)(2)(i)(C) to use the term ''assign'' instead of ''attribute.'' We believe this change in language more clearly describes how a clinician receives a score under facility-based measurement while avoiding making any changes to our methods in determining eligibility for facility-based measurement or their score. This does not constitute a change in policy.

We received public comments on our proposal to amend § 414.1380(e)(2)(i)(C) to state that a MIPS eligible clinician is facility-based if the clinician can be assigned, under the methodology specified in § 414.1380(e)(5), to a facility with a value-based purchasing score for the applicable period. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported our technical proposal which clarifies that a MIPS eligible clinician is facility-based if the clinician can be assigned to a facility, as opposed to saying attributed.

Response: We thank the commenter for their support.

After consideration of the public comments, we are finalizing our proposal to amend § 414.1380(e)(2)(i)(C) to state that a MIPS eligible clinician is facility-based if the clinician can be assigned, under the methodology specified in § 414.1380(e)(5), to a facility with a value-based purchasing score for the applicable period.

(iii) Facility-Based Measures for CY 2020 MIPS Performance Period/2022 MIPS Payment Year

For informational purposes, we are providing in Table 51 a list of the measures included in the FY 2021 Hospital VBP Program measure set that will be used in determining the quality and cost performance category scores for the CY 2020 MIPS performance period/ 2022 MIPS payment year. The FY 2021 Hospital VBP Program has adopted 12 measures covering 4 domains (83 FR 20412 through 20413). The performance period for measures in the Hospital VBP Program varies depending on the measure, and some measures include multi-year performance periods. These measures are determined through separate rulemaking; the applicable rulemaking is usually the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule. We are using these measures, benchmarks, and performance periods for the purposes of facility-based measurement in accordance with § 414.1380(e)(1). The measures for FY 2021 Hospital VBP Program were summarized in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 41454 through 41455).

TABLE 51: FY 2021 Hospital VBP Program Measures

Short Name	Domain/Measure Name	NQF #	Performance Period
Person and Community Engagement Domain			
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (including Care Transition Measure)	0166 (0228)	January 1, 2019-December 31, 2019
Clinical Outcomes Domain			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230	July 1, 2016-June 30, 2019
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229	July 1, 2016-June 30, 2019
MORT-30-PN (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0468	September 1, 2017-June 30, 2019
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization.	1893	July 1, 2016-June 30, 2019
THA/TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550	April 1, 2016-March 31, 2019
Safety Domain			
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	0138	January 1, 2019-December 31, 2019
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	January 1, 2019-December 31, 2019
Colon and Abdominal Hysterectomy SSI	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.	0753	January 1, 2019-December 31, 2019
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716	January 1, 2019-December 31, 2019
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717	January 1, 2019-December 31, 2019
Efficiency and Cost Reduction Domain			
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158	January 1, 2019-December 31, 2019

(d) Scoring the Improvement Activities Performance Category

For our previously established policies regarding scoring the improvement activities performance category, we refer readers to § 414.1380(b)(3), the CY 2018 Quality Payment Program final rule (82 FR 53767 through 53769), and the CY 2019 PFS final rule (83 FR 59867 through 59868). We also refer readers to § 414.1355 and the CY 2017 Quality Payment Program final rule (81 FR 77177 through 77199), the CY 2018 Quality Payment Program final rule (82 FR 53648 through 53662), and the CY 2019 PFS final rule (83 FR 59776 through 59785) for our previously established policies regarding the improvement activities performance category generally and section III.K.3.c.(3) of this final rule, where we discuss our final policies for the improvement activities performance category.

(e) Scoring the Promoting Interoperability Performance Category

We refer readers to section III.K.3.c.(4) of this final rule, where we discuss our final policies for the Promoting Interoperability performance category.

For our previously established policies regarding scoring the Promoting Interoperability‘ performance category, we refer readers to § 414.1380(b)(4), the CY 2017 Quality Payment Program final rule (81 FR 77216–77227), the CY 2018 Quality Payment Program final rule (82 FR 53663 through 53670), and the CY 2019 PFS final rule (83 FR 59785 through 59796). We also refer readers to § 414.1375 and the CY 2017 Quality Payment Program final rule (81 FR 77199 through 77245), the CY 2018 Quality Payment Program final rule (82 FR 53663 through 53688), and the CY 2019 PFS final rule (83 FR 59785 through 59820) for our previously established policies regarding the Promoting Interoperability (formerly the advancing care information) performance category generally.

(2) Calculating the Final Score

For a description of the statutory basis and our policies for calculating the final score for MIPS eligible clinicians, we refer readers to § 414.1380(c) and the discussion in the CY 2017 Quality Payment Program final rule (81 FR 77319 through 77329), CY 2018 Quality Payment Program final rule (82 FR

53769 through 53785), and CY 2019 PFS final rule (83 FR 59868 through 59878). In the CY 2020 PFS proposed rule (84 FR 40793 through 40800), we proposed to continue the complex patient bonus for the 2022 MIPS payment year and proposed performance category reweighting policies for the 2022, 2023, and 2024 MIPS payment years. These proposals are discussed in more detail in this section of the final rule.

(a) Complex Patient Bonus for the 2022 MIPS Payment Year

In the CY 2019 PFS final rule (83 FR 59869 through 59870), under the authority in section 1848(q)(1)(G) of the Act, we finalized at § 414.1380(c)(3) to maintain the complex patient bonus, which we previously finalized in the CY 2018 Quality Payment Program final rule (82 FR 53771 through 53776), of up to five points to be added to the final score for the 2021 MIPS payment year. The complex patient bonus was developed as a short-term solution to address the impact patient complexity may have on MIPS scoring that we would revisit on an annual basis while we continue to work with stakeholders on methods to account for patient risk factors. Our overall goal for the complex patient bonus was twofold: (1) To protect access to care for complex patients and provide them with excellent care; and (2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while we review the completed studies and research to address the underlying issues. For a detailed description of the complex patient bonus finalized for prior MIPS payment years, please refer to the CY 2018 Quality Payment Program final rule (82 FR 53771 through 53776) and CY 2019 PFS final rule (83 FR 59869 through 59870).

For the 2020 MIPS performance period/2022 MIPS payment year, we proposed (84 FR 40793) to continue the complex patient bonus as finalized for the 2019 MIPS performance period/2021 MIPS payment year and to revise § 414.1380(c)(3) to reflect this policy. In the CY 2020 PFS proposed rule (84 FR 40794), we noted that although we intended to maintain the complex patient bonus as a short-term solution, we did not believe we had sufficient information available to develop a long-term solution to account for patient risk factors in MIPS such that we would be able to include a different approach in the proposed rule. Section 1848(q)(1)(G) of the Act requires us to consider risk factors in our scoring methodology for MIPS. Specifically, it provides that the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on individuals' health status and other risk factors, assess appropriate adjustments to quality measures, cost measures, and other measures used under MIPS and assess and implement appropriate adjustments to payment adjustments, final scores, scores for performance categories, or scores for measures or activities under MIPS. In doing so, the Secretary is required to take into account the relevant studies conducted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185, enacted October 6, 2014) and, as appropriate, other information, including information collected before completion of such studies and recommendations. ASPE completed its first report [116] in December 2016, which examined the effect of individuals' socioeconomic status on quality, resource use, and other measures under the Medicare program, and included analyses of the effects of Medicare's current value-based payment programs on providers serving socially at-risk beneficiaries and simulations of potential policy options to address these issues. In the CY 2020 PFS proposed rule (84 FR 40794), we noted the second ASPE report is expected in October 2019. At the time of publication of this final rule, the report has not been released. When the report becomes available, we intend to consider its recommendations for future rulemaking. At the time of publication of the CY 2020 PFS proposed rule, we did not believe additional data sources were available that would be feasible to use as the basis for a different approach to account for patient risk factors in MIPS. We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

In the CY 2020 PFS proposed rule (84 FR 40794), we considered whether the data still support the complex patient bonus at the final score level. We replicated analyses similar to the ones presented in Table 27 of the CY 2018 Quality Payment Program final rule (82 FR 53776). These analyses used the data submitted for the Quality Payment Program for the 2017 MIPS performance period and assessed eligibility and final scores based on the proposals we made for the 2020 MIPS performance period/2022 MIPS payment year using the methodology described in the Regulatory Impact Analysis in section VI. of the CY 2020 PFS proposed rule (84 FR 40898 through 40900).

Overall, the analysis of preliminary data referenced in the CY 2020 PFS proposed rule (84 FR 40793 through 40795) shows a consistent relationship between the dual eligible ratio quartiles and the average MIPS final scores only for individuals, where the average MIPS final score decreases as the quartile increases. We saw slight differences in the average HCC risk score and dual eligible ratio quartiles for groups, but virtually no difference for average HCC risk score for individuals. However, we had only 1 year of data and we noted more recent data may bring different results. In addition, at the time of publication of the proposed rule, we were awaiting a second report from ASPE in October 2019 that we expected would provide more direction for our approach to accounting for risk factors in MIPS. We were concerned that without the information from ASPE and without observing a clear trend that would require a change in our methodology, making any changes beyond our proposal to continue this policy would be premature.

We received public comments on our proposal to continue the complex patient bonus for one additional year. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to continue the complex patient bonus for the 2022 MIPS payment year. One commenter urged CMS to exercise caution in updating the complex patient bonus based on MIPS final scores from the 2017 MIPS performance period because these scores did not include cost measures and do not fully capture scoring variation based on clinical or social risk factors. The commenter also indicated that additional policy changes could impact MIPS final scores.

Response: We agree that scoring changes over the different MIPS payment years could impact MIPS final scores. We clarify that our analysis in the CY 2020 PFS proposed rule (84 FR 40793 through 40795) used data submitted for the 2017 performance period but estimated eligibility and final scores for the 2020 performance period by proxying a score using the methods described in the CY 2020 PFS proposed

[116] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs (2016). Available at *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

rule (84 FR 40894 through 40901) to supplement the gap in data needed to estimate scores for the 2020 performance period. The additional data sources included the following cost measures: Total per capita cost measure performance based on the proposed revised measure using claims data from October 2016 through September 2017; and the proposed revised MSPB clinician measure and the 10 proposed episode-based measures based on claims data from January through December of 2017 (84 FR 40898). Therefore, the estimates did include the cost measures that would apply for the 2020 performance period. The methodology in the Regulatory Impact Analysis of the CY 2020 PFS proposed rule (84 FR 40894 through 40901) also included the complex patient bonus from the 2018 performance period (84 FR 40899); however, we did not include that bonus in the final score used for this analysis because we wanted to assess the difference in final scores prior to the application of the complex patient bonus. This is consistent with our original analysis when we proposed the complex patient bonus in the CY 2018 Quality Payment Program proposed rule (82 FR 30136).

We have updated this analysis with the most recent data in Table 52. Specifically, as described in section VII.F.10 of this final rule, we used data submitted for the 2018 MIPS performance period as an input to estimate the 2020 MIPS performance period final scores.

TABLE 52: MIPS Simulated Average Final Score * BY HCC and Dual Eligible Ratio Quartiles for Individuals with 6+ Measures and Groups**

	Individuals with 6+ Measures	Group
HCC Quartile		
Quartile 1 – Lowest Average HCC	74.21	76.10
Quartile 2	73.87	79.48
Quartile 3	74.24	77.83
Quartile 4 – Highest Average HCC	74.80	73.31
Dual Eligible Ratio		
Quartile 1- Low Proportion of Dual	74.99	76.64
Quartile 2	73.24	79.18
Quartile 3	74.43	76.86
Quartile 4 – Highest Proportion of Dual Status	73.61	74.35

* Estimated final score prior to the application of the complex patient bonus using the methodology described in section VII.F.10 of this final rule.

** We restricted our analysis to individuals who reported 6 or more measures because we wanted to look at differences in performance for those who reported the 6 measures which are generally required under MIPS if there are six measures that apply to the MIPS eligible clinician, rather than differences in scores due to MIPS eligible clinicians not fully reporting for MIPS.

The updated analysis reinforces findings from the analysis in the CY 2020 PFS proposed rule (84 FR 40795), again failing to find a consistent linear relationship between HCC quartiles and MIPS final scores, or dual eligible ratio quartiles and MIPS final scores. In the earlier analysis a consistent linear relationship was still found for MIPS final scores for individual reporters and dual eligible ratio quartiles. In the updated analysis, we did not observe a consistent linear relationship for any reporting type or complexity measure. For example, for groups, we estimate mean MIPS final scores to be higher for groups in the second quartile of dual eligible ratio or HCC quartile, than for groups in the first, lowest quartile. For individuals, mean MIPS final scores are estimated to be slightly higher for those with the highest average HCC, than for those with the lowest average HCC. It appears that other, unmeasured factors in addition to HCC and dual eligible ratio may be impacting MIPS scores in the 2018 data. We do see differences from the top and bottom quartile in three of the four comparisons (individual-dual eligible quartiles, and in both group reporting comparisons), so we are intending to finalize as proposed. However, given the inconsistent findings, we intend to revisit the size and structure of the complex patient bonus through future rulemaking.

Comment: A few commenters pointed out perceived limitations in the use of the HCC risk score in calculating the complex patient bonus; specifically, they believed it does not fully capture factors that increase risk or complexity for many specialties. One commenter suggested that CMS identify new data sets and strategies to better represent clinical and social complexity. One commenter suggested that CMS use geographic location as a proxy for social risk because geographic location is often associated with available resources and access to medical care.

Response: We thank the commenters for their suggestions and will take them into consideration as we consider options for updating the complex patient bonus in future years. We hope to be able to reference the ASPE report findings in future rulemaking. The complex patient bonus was intended to be a temporary solution while more permanent solutions were identified. We understand that both HCC risk scores and dual eligibility have some limitations as proxies for social risk factors. However, we are not aware of data sources for indicators such as income and education that are readily available for all Medicare beneficiaries that would be more complete indices of a patient's complexity. Therefore, we have decided to pair the HCC risk score

with the proportion of dual eligible patients to create a more complete complex patient indicator than can be captured using HCC risk scores alone. We will evaluate additional options in future years based on any updated data or additional information to better account for social risk factors while minimizing unintended consequences and consider these as we move forward.

After consideration of public comments, we are finalizing our proposal for the 2020 MIPS performance period/2022 MIPS payment year, to continue the complex patient bonus as finalized for the 2019 MIPS performance period/2021 MIPS payment year, as well as our proposed revisions to § 414.1380(c)(3).

(b) Final Score Performance Category Weights

(i) General Weights

Section 1848(q)(5)(E)(i) of the Act specifies weights for the performance categories included in the MIPS final score: In general, 30 percent for the quality performance category; 30 percent for the cost performance category; 25 percent for the Promoting Interoperability performance category; and 15 percent for the improvement activities performance category. For more of the statutory background and descriptions of our current policies, we refer readers to the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77320 through 77329 and 82 FR 53779 through 53785, respectively), as well as the CY 2019 PFS final rule (83 FR 59870 through 59878). As finalized in section III.K.3.c.(2)(a) of this final rule, the cost performance category will make up 15 percent of a MIPS eligible clinician's final score for the 2022 MIPS payment year. As finalized in section III.K.3.c.(1)(b) of this final rule, the quality performance category will thus make up 45 percent of a MIPS eligible clinician's final score the 2022 MIPS payment year. As described in sections III.K.3.c.(2)(a) and III.K.3.c.(1)(b) of this final rule, we are not finalizing weights for the cost and quality performance categories for the 2023 and 2024 MIPS payment years. Table 53 summarizes the finalized weights for each performance category.

TABLE 53—WEIGHTS BY MIPS PERFORMANCE CATEGORY FOR THE 2022 MIPS PAYMENT YEAR

Performance category	2022 MIPS payment year (percent)
Quality	45
Cost	15
Improvement Activities	15
Promoting Interoperability	25

(ii) Flexibility for Weighting Performance Categories

Under section 1848(q)(5)(F) of the Act, if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician involved, the Secretary shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable to the type of MIPS eligible clinician involved and for each measure and activity for each performance category based on the extent to which the measure or activity is applicable and available to the type of MIPS eligible clinician involved. Under section 1848(q)(5)(B)(i) of the Act, in the case of a MIPS eligible clinician who fails to report on an applicable measure or activity that is required to be reported by the clinician, the clinician must be treated as achieving the lowest potential score applicable to such measure or activity. In this scenario of failing to report, the MIPS eligible clinician generally would receive a score of zero for the measure or activity, which would contribute to the final score for that MIPS eligible clinician. Under certain circumstances, however, a MIPS eligible clinician who fails to report could be eligible for an assigned scoring weight of zero percent and a redistribution of the performance category weights. For a description of our existing policies for reweighting performance categories, please refer to § 414.1380(c)(2) and the CY 2019 PFS final rule (83 FR 59871 through 59876).

(A) Reweighting Performance Categories Due to Data That Are Inaccurate, Unusable, or Otherwise Compromised

In the proposed rule (84 FR 40796 through 40797), we discussed our belief that measures and activities may not be available to a MIPS eligible clinician for the quality, cost, and improvement activities performance categories under section 1848(q)(5)(F) of the Act when data related to the measures and activities are inaccurate, unusable or otherwise compromised due to circumstances that are outside of the control of the MIPS eligible clinician or its agents. In addition, we discussed our belief that data that are inaccurate, unusable or otherwise compromised due to circumstances that are outside of the control of the MIPS eligible clinician or its agents could constitute a significant hardship for purposes of the Promoting Interoperability performance category under section 1848(o)(2)(D) of the Act. We proposed a new policy to allow reweighing for any performance category if, based on information we learn prior to the beginning of a MIPS payment year, we determine data for that performance category are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the MIPS eligible clinician or its agents. For more information on our reasons for this proposal, please refer to the proposed rule (84 FR 40796 through 40797).

For purposes of this reweighting policy, we proposed that reweighting would take into account both what control the clinician had directly over the circumstances and what control the clinician had indirectly through its agents. We intended the term agent to include any individual or entity, including a third party intermediary as described in § 414.1400, acting on behalf of or under the instruction of the MIPS eligible clinician. We solicited comments on this approach and possible alternatives for balancing efforts to allow reweighting in circumstances in which clinicians are not culpable for compromised data while maintaining financial incentives for clinicians, third party intermediaries and other parties to prevent and correct compromised data.

We proposed that our determination of whether reweighting will be applied under this policy could take into account any information known to the agency and we would consider the information we obtain on a case-by-case basis for reweighting. We anticipated considering information provided to us through routine communication channels for the Quality Payment Program by any submitter type as defined under § 414.1305, as well as other relevant information sources of which we are aware. We requested that third party intermediaries, to the extent feasible, inform MIPS eligible clinicians if the third party intermediary believes their data may have been compromised. To the extent third party intermediaries believe that MIPS data may be compromised, we encouraged them to provide us with a list of or other identifying information for all MIPS eligible clinicians who may have been affected by such issues, so that we may evaluate the circumstances in a timely

manner. We also encouraged MIPS eligible clinicians to contact us and self-identify if they believe they have compromised data; they should not rely solely on a third party intermediary to do so. We recognized that there may be scenarios when a MIPS eligible clinician or one or more of its agents becomes aware of potential data issues prior to submission of data. We solicited comment on whether and how our proposed reweighting policy should apply to these circumstances. We noted that compromised data are not true, accurate or complete for purposes of § 414.1390(b) or § 414.1400(a)(5) and knowing submission of compromised data may result in remedial action against the submitter. We noted that a MIPS eligible clinician should not submit data and should not allow the submission of his or her data if the MIPS eligible clinician knows that the data are inaccurate, unusable, or otherwise compromised.

We proposed to determine whether the requirements for reweighting are met by assessing if: (1) The MIPS eligible clinician's data are inaccurate, unusable, or otherwise compromised; and (2) the data are compromised due to circumstances outside of the control of the MIPS eligible clinician or agent. We would make the determination of whether the clinician's data are inaccurate, unusable or otherwise compromised based on documentation of the issue and its demonstrated effect on data of the particular MIPS eligible clinician. As noted above, we proposed to limit this policy to cases where data are compromised outside the control of the clinician or its agent because we do not want to create incentives for clinicians or third party intermediaries to knowingly submit compromised data and want to encourage clinicians and their agents to take reasonable efforts to correct data that they believe maybe not compromised. Factors relevant to whether the circumstances were outside the control of the clinician and its agents include: whether the affected MIPS eligible clinician or its agents knew or had reason to know of the issue; whether the affected MIPS eligible clinician or its agents attempted to correct the issue; and whether the issue caused the data submitted to be inaccurate or unusable for MIPS purposes. We solicited feedback on these factors and whether there are additional factors we should consider to determine if there should be reweighing based on compromised data. If we determine that a MIPS eligible clinician's data were compromised and the conditions for reweighting are met, we proposed to notify the clinician of this determination through the performance feedback that we provide under section 1848(q)(12) of the Act if feasible, or through routine communication channels for the Quality Payment Program. We emphasized that the proposed reweighting policy is solely intended to mitigate the potential adverse financial impact of compromised data on the MIPS eligible clinician; a determination under this policy that data are compromised due to circumstances outside of the control of the MIPS eligible clinician and its agent, and therefore, that reweighting will occur for that clinician does not indicate and should not be interpreted to suggest that a third party intermediary or other individual or entity could not be held liable for the compromised data.

We proposed to apply reweighting only in cases when we learn of the compromised data before the beginning of the associated MIPS payment year because we want to encourage MIPS eligible clinicians and their agents to inform us of these concerns in a timely basis so we can update our data sets timely, while minimizing the impacts to other stakeholders who utilize MIPS data. For example, the Physician Compare website utilizes MIPS data to provide information to patients, consumers and other stakeholders when selecting a clinician or group. We noted our concern that without the appropriate incentive to notify us in a timely manner, clinicians and their agents may delay disclosures that data may be compromised and with these delays the MIPS data could be in an increased state of flux which will reduce the usefulness of the data to stakeholders. We were interested in feedback on whether there are other factors we should consider when adopting a timeline for reweighting due to compromised data and whether the period should be broader. We solicited comment on whether we should restrict our reweighting due to compromised data to instances when we learn the relevant information prior to the beginning of the MIPS payment year and whether there are other incentives for MIPS eligible clinicians to alert us to concerns about compromised data. We emphasized that if we determine a MIPS eligible clinician has submitted compromised data for a performance category during the associated payment year or at a later point, the MIPS eligible clinician would not qualify for reweighting under this proposal. Instead, for the performance categories with compromised data, the clinician's performance category score would be zero and the scoring weight for the category would not be redistributed.

In summary, under the authority in sections 1848(q)(5)(F) and 1848(o)(2)(D) of the Act, we proposed at § 414.1380(c)(2)(i)(A)*(9),* and (c)(2)(i)(C)*(10),* beginning with the 2018 MIPS performance period and 2020 MIPS payment year, to reweight the performance categories for a MIPS eligible clinician who we determine has data for a performance category that are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. In addition, we proposed to amend § 414.1380(c)(2)(i)(C) to ensure that the reweighting proposed at § 414.1380(c)(2)(i)(C)*(10),* would not be voided by the submission of data for the Promoting Interoperability performance category as is the case with other significant hardship exceptions. We solicited comment on this proposal and alternatives to potentially mitigate the impact on MIPS eligible clinicians who through no fault of their own have data in a performance category that are inaccurate, unusable or are otherwise compromised.

We received public comments on our proposal and alternatives to potentially mitigate the impact on MIPS eligible clinicians who through no fault of their own have data in a performance category that are inaccurate, unusable or are otherwise compromised. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal to reweight MIPS eligible clinicians impacted by data that are inaccurate, unusable, or otherwise compromised. Commenters indicated that in instances when data are inaccurate, unusable, or otherwise compromised outside of the control of the MIPS eligible clinician, relief for the clinician is appropriate.

Response: We appreciate the commenters' support of our proposal.

Comment: One commenter supported our policy to apply reweighting beginning with the 2018 MIPS performance period and the 2020 MIPS payment year so that MIPS eligible clinicians impacted by circumstances during that year can be provided with relief.

Response: We appreciate the commenter's support. We believe it is important to apply this policy beginning with the 2018 performance period/2020 MIPS payment year in case any circumstances have occurred that impact this payment year that have been

recently discovered. MIPS eligible clinicians and third party intermediaries can alert CMS through the help desk at *QPP@cms.hhs.gov* regarding any data that they believe may be inaccurate, unusable or otherwise compromised.

Comment: One commenter supported our proposal that submission of data for the Promoting Interoperability performance category would not nullify reweighting under the proposed policy.

Response: We appreciate the commenter's support.

Comment: One commenter supported the proposal because the commenter believed it would promote competition among EHR vendors by removing a significant obstacle to switching vendors during performance periods.

Response: We thank the commenter for their support. However, we note that our goal for this proposal was to mitigate for MIPS eligible clinicians the potential adverse scoring impact of data that are inaccurate, unusable, or otherwise compromised, and we did not intend for the proposal to impact competition among vendors.

Comment: A few commenters provided suggestions for the types of circumstances where they believe actions by their third party intermediary could lead to data being inaccurate, unusable, or otherwise compromised outside of the control of the clinician or its agents. These include instances when the third party intermediary goes out of business, makes a data submission error, or experiences a loss of data (examples may include storage malfunction; or the vendor not capturing data appropriately, resulting in incorrect measure data).

Response: We believe that, depending on the specific circumstances and timing, these circumstances could be covered under this policy. We encourage MIPS eligible clinicians and their agents experiencing these types of circumstances to communicate with us as early as possible to provide details about the circumstances surrounding these events. We also note that, depending on the specific circumstances, we may determine that the conduct of the third party intermediary warrants taking remedial action or terminating the third party intermediary in accordance with § 414.1400(f).

Comment: One commenter expressed the belief that we should include circumstances under this policy where a third party intermediary experiences a cyberattack causing any of the following: loss of data, loss of access to data, inability to analyze data, inability to package data, inability to transmit data to CMS, or any other significant obstacle to data collection or submission. The commenter also suggested this policy should include circumstances when a third party intermediary experiences an extreme and uncontrollable event, such as a natural disaster.

Response: We believe that our policy could apply in cases when a MIPS eligible clinician or their agent is impacted by a cyberattack that causes the eligible clinician's data to be inaccurate, unusable, or otherwise unusable. We clarify that this could apply even in cases where data are not able to be submitted as a result of the attack. We note that eligibility for reweighting would depend on the specific circumstances and timing, including the safeguards that were in place to prevent such attacks. We further emphasize that there is an expectation that third party intermediary take reasonable steps to prevent these attacks from occurring, and that, depending on the circumstances, CMS may determine that the conduct of the third party intermediary warrants taking remedial action or terminating the third party intermediary in accordance with § 414.1400(f). Finally, we agree with the commenter that our policy could apply in cases when a third intermediary experiences a natural disaster that causes the MIPS eligible clinician's data to be inaccurate, unusable, or otherwise unusable.

Comment: One commenter urged us to consider applying the proposed policy to scenarios where hospital-based clinicians are impacted by changes in hospital contracts that occur midway through the year. One example provided was when a hospital contract with a group ends, and the group may only have incomplete data from that hospital and may not be able to fully or accurately report. Another example provided was where a group begins a new contract with a hospital late in the year and may not be able to receive enough data from the new or prior hospital to fully and accurately report for MIPS.

Response: We believe that our policy could apply in cases where a clinician's data are rendered inaccurate, unusable, or otherwise compromised due to changes in hospital contracts that are outside the control of the clinician or its agents; however, in the examples provided it is not clear that the data issues associated with the contract changes would meet these criteria. In cases where MIPS eligible clinicians undergo transitions in hospital contracts, we encourage MIPS eligible clinicians to work with their contracting hospital to obtain data, including in cases where the MIPS eligible clinician may terminate a contract or may initiate a new contract.

Comment: One commenter suggested that we ensure that the requirements for MIPS eligible clinicians to alert us of relevant information are not unduly burdensome. For instance, the commenter proposed that each MIPS eligible clinician associated with a single third party intermediary that has compromised its users' data should not be required to submit evidence to CMS that their data were impacted.

Response: We intend for our reweighting determinations to take into account information that we learn of from a variety of channels, including through various communication channels and through third party intermediaries. To the extent possible, when we learn of data that have been compromised and receive sufficient information to determine the conditions for reweighting have been met for a MIPS eligible clinician, we intend to provide reweighting without requiring any action on the part of the MIPS eligible clinician. However, there may be some circumstances under which we will be unable to reach a conclusion regarding reweighting unless the MIPS eligible clinician provides us with information. For example, if we become aware that a third party intermediary has a data integrity issue that has resulted in compromised data for some but not all of its customers, MIPS eligible clinicians could help us reach a determination regarding potential reweighting by providing us with information, such as their clinician identifiers (for example, TIN/NPI or other identifiers) and submission type, through the Quality Payment Program help desk.

Comment: A few commenters urged us to notify MIPS eligible clinicians as early as possible if the agency receives reports suggesting they may have compromised data and provide them with information to understand how they can correct the problem going forward. Commenters also suggested that we work with impacted MIPS eligible clinicians to identify alternative reporting options, if feasible.

Response: When we learn of circumstances that suggest MIPS data are inaccurate, unusable or otherwise compromised, we will aim to provide information to the MIPS eligible clinicians whose data may have been compromised on an ongoing and timely basis. In cases where the data concern is associated with a third party intermediary and the issue is identified prior to the data submission deadline,

we agree that it would be ideal for MIPS eligible clinicians to identify alternate arrangements if any that may allow them to submit uncompromised data. For example, in scenarios where the underlying source data are uncompromised a MIPS eligible clinician may be able to identify a new third party intermediary that may be able to utilize their source data.

Comment: One commenter indicated that we should not apply reweighting in cases when a MIPS eligible clinician knowingly submitted data that are inaccurate, unusable, or otherwise compromised.

Response: A MIPS eligible clinician who has submitted compromised data would receive a score of zero for the performance category. Eligible clinicians who unknowingly submitted compromised data, or were not able to submit data due to their data being compromised may be able to receive reweighting if the circumstances were outside their control. However, an eligible clinician who knowingly submits compromised data would not be eligible for reweighing because the submission of compromised data was within the clinician's control. In addition, we note that compromised data are not true, accurate, or complete for purposes of § 414.1390(b) or § 414.1400(a)(5), and knowing submission of compromised data may result in remedial action against the submitter.

Comment: One commenter requested clarification as to how we would determine what constitutes compromised data and whether the circumstances were outside the control of the MIPS eligible clinician.

Response: We appreciate the request for clarification. We intend to make this determination on a case-by-case basis based on information known to the agency.

Comment: One commenter suggested that we stipulate that we will not hold third party intermediaries who inform CMS of relevant circumstances liable under current fraud, waste, and abuse laws and regulations or current laws and regulations governing the certification of their products. The commenter pointed to policies elsewhere in HHS under which parties can limit their liability by self-disclosing prior misconduct as a potential guide for policy in MIPS. The commenter suggested a framework under which a health IT developer or third-party intermediary would not face liability in connection with compromised data if it discloses the issue to CMS and eligible clinicians in good faith.

Response: We intended for this policy to provide flexibility for MIPS eligible clinicians whose data are inaccurate, unusable, or otherwise compromised due to circumstances outside the control of clinicians and their agents. We did not develop this policy to hold harmless third party intermediaries or other agents for any role they play in data inaccuracies. CMS does not have authority to waive liability as it relates to fraud, waste, and abuse laws or to alter the certification requirements of health information technology. Furthermore, we plan to share information as appropriate with law enforcement and with ONC to the extent we learn of concerns involving CEHRT, as defined at § 414.1305. We also note that third party intermediaries that submit data that are inaccurate, unusable or otherwise compromised may be subject to remedial action or termination in accordance with § 414.1400(f).

Comment: One commenter suggested that CMS apply this policy when MIPS eligible clinicians or third party intermediaries become aware of relevant information prior to the end of the MIPS data submission period, because doing so would encourage MIPS eligible clinicians, health IT vendors, and third party intermediaries to inform CMS of relevant information in a timely manner. One commenter suggested that CMS consider the timing of the discovery of the compromised data when making a determination of whether to apply reweighting.

Response: We agree that MIPS eligible clinicians and third party intermediaries should alert CMS of relevant information in a timely manner. If a MIPS eligible clinician with compromised data requests reweighting under this policy, we would consider both the timing of when the clinician learned the data were compromised and the state of the data to determine whether reweighting is appropriate. We believe there may be some circumstances where a MIPS eligible clinician learns that their data is inaccurate, unusable, or otherwise compromised before the end of the data submission period and the source data is unaffected. In these instances, we believe the MIPS eligible clinician should explore alternatives and if possible submit data that are uncompromised.

Comment: One commenter supported our proposal to limit the policy to information we learn of prior to the beginning of the applicable MIPS payment year.

Response: We thank the commenter for their support of our proposal.

Comment: One commenter requested that we ensure the terms ''any individual or entity'' within the definition of ''agent'' for purposes of this policy include practice staff, billing vendors, practice vendors, consultants, chart abstractors, and the like because these entities are often the root cause of data errors or incomplete reporting.

Response: We proposed that the term agent include any individual or entity, including a third party intermediary as described in § 414.1400, acting on behalf of or under the instruction of the MIPS eligible clinician (84 FR 40796). In reviewing individual circumstances to determine if reweighting is warranted, we will consider the specific circumstances that led to data being inaccurate, unusable, or otherwise compromised and will consider whether individuals or entities involved in the data errors were working in a capacity within the control of the clinician and whether quality control processes should have been in place to prevent errors.

Comment: One commenter requested that we extend the policy into the payment year for instances when the MIPS eligible clinician learns about the data issue after receiving payment adjustments.

Response: We continue to believe it is appropriate to apply reweighting only in cases when we learn of the compromised data before the beginning of the associated MIPS payment year because we want to encourage MIPS eligible clinicians and their agents to inform us of these concerns in a timely manner so we can update our data sets timely, while minimizing the impacts to other stakeholders who utilize MIPS data.

After consideration of the comments we received, we are finalizing our proposal at § 414.1380(c)(2)(i)(A)(9) and (c)(2)(i)(C)(10) to, beginning with the 2018 MIPS performance period and 2020 MIPS payment year, reweight the performance categories for a MIPS eligible clinician we determine has data for a performance category that are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. In addition, we are finalizing our proposed amendment to § 414.1380(c)(2)(i)(C) to ensure that the reweighting at § 414.1380(c)(2)(i)(C)(10) will not be voided by the submission of data for the Promoting Interoperability performance category.

We note that we previously finalized at § 414.1380(c) that if a MIPS eligible

clinician is scored on fewer than two performance categories, he or she will receive a final score equal to the performance threshold (81 FR 77326 through 77328 and 82 FR 53778 through 53779). Therefore, if a MIPS eligible clinician is scored on fewer than two performance categories as a result of reweighting due to compromised data, he or she would receive a final score equal to the performance threshold.

(iii) Redistributing Performance Category Weights

In the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77325 through 77329 and 82 FR 53783 through 53785, 53895 through 53900), in the CY 2019 PFS final rule (83 FR 59876 through 59878), and at § 414.1380(c)(2)(ii), we established policies for redistributing the weights of performance categories for the 2019, 2020, and 2021 MIPS payment years in the event that a scoring weight different from the generally applicable weight is assigned to a category or categories. Under these policies, we generally redistribute the weight of a performance category or categories to the quality performance category because of the experience MIPS eligible clinicians have had reporting on quality measures under other CMS programs.

In the CY 2020 PFS proposed rule (84 FR 40798), we discussed our belief that it would not be appropriate to redistribute weight from the other performance categories to the cost performance category for the 2022 MIPS payment year, except in scenarios in which the only other scored performance category is the improvement activities performance category. We noted that we had proposed substantial changes to the MSPB and total per capital cost measures, as well as adding 10 new episode-based measures (84 FR 40753 through 40762). We stated that we believed it is appropriate to provide MIPS eligible clinicians additional time to adjust to these changes prior to redistributing weight to the cost performance category. Under the proposals we made in the proposed rule, as described in more detail below, we would begin to redistribute more weight to the cost performance category beginning with the 2023 MIPS payment year, because MIPS eligible clinicians will have had more experience being scored on cost measures at that point, and will have had time to adjust to the changes to existing measures and new episode-based measures that we proposed.

Beginning with the 2022 MIPS payment year, we proposed to not redistribute performance category weights to the improvement activities performance category in any scenario (84 FR 40798). For the improvement activities performance category, we are only assessing whether a MIPS eligible clinician completed certain activities (83 FR 59876 through 59878). Because MIPS eligible clinicians will have had several years of experience reporting under MIPS, we stated that we believe it is important to prioritize performance on measures that show a variation in performance, rather than the activities under the improvement activities performance category, which are based on attestation of completion. Therefore, we stated that we believe it is no longer appropriate to increase the weight of the improvement activities performance category above 15 percent under our redistribution policies. We noted that in situations where the weights of both the quality and Promoting Interoperability performance categories are redistributed, cost would be weighted at 85 percent and improvement activities would be weighted at 15 percent. We stated that we believe this would help to reduce incentives to not report measures for the quality performance category in circumstances when a clinician may be able to report but chooses not to do so. For example, when a clinician may be able to report on quality measures, but chooses not to report because they are located in an area affected by extreme and uncontrollable circumstances as identified by CMS and qualify for reweighting under § 414.1380(c)(2)(i)(A)(8).

For the 2022 MIPS payment year, we proposed at § 414.1380(c)(2)(ii)(D) similar redistribution policies to our policies finalized for the 2021 MIPS payment year (83 FR 59876 through 59878), with minor modifications, as shown in Table 54 (84 FR 40798). First, we adjusted our redistribution policies to account for a cost performance category weight of 20 percent for the 2022 MIPS payment year. We also proposed, in scenarios when the cost performance category weight is redistributed while the Promoting Interoperability performance category weight is not, to redistribute a portion of the cost performance category weight to the Promoting Interoperability performance category, as well as to the quality performance category. We stated that we believe this is appropriate given our current focus on working with the Office of the National Coordinator for Health IT (ONC) on implementation of the interoperability provisions of the 21st Century Cures Act (the Cures Act) (Pub. L. 115–233, enacted December 13, 2016) to ensure seamless but secure exchange of health information for clinicians and patients. While we have previously redistributed all of the cost performance category weight to the quality performance category (83 FR 59876 through 59878), we proposed to redistribute 15 percent to the quality performance category and 5 percent to the Promoting Interoperability performance category for the 2022 MIPS payment year (*see* Table 54). This proposed change would emphasize the importance of interoperability without overwhelming the contribution of the quality performance category to the final score. We also proposed to weight the improvement activities performance category at 15 percent and to weight the Promoting Interoperability performance category at 85 percent for the 2022 MIPS payment year when the quality and cost performance categories are each weighted at zero percent, to align with our focus on interoperability and pursuant to our proposal of not redistributing weight to the improvement activities performance category (84 FR 40798).

TABLE 54: Performance Category Redistribution Policies Proposed for the 2022 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	40%	20%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	65%	20%	15%	0%
-No Quality	0%	20%	15%	65%
-No Improvement Activities	55%	20%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	85%	15%	0%
-No Promoting Interoperability and no Improvement Activities	80%	20%	0%	0%
-No Quality and no Improvement Activities	0%	20%	0%	80%

We received public comments on our proposed redistribution policies for the 2022 MIPS payment year. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported our proposal to generally not redistribute weight to the cost performance category for the 2022 MIPS payment year.

Response: We appreciate the commenters' support. We are finalizing this policy with a minor modification, which is discussed in more detail below, to decrease the amount of weight redistributed to the cost performance category when the cost and improvement activities performance categories are the only performance categories scored.

Comment: Several commenters expressed concern with our proposal to no longer redistribute weight to the improvement activities performance category and in particular expressed concern when only cost and improvement activities performance categories are scored because cost would be 85 percent of the final score. Commenters also stated that it will not necessarily be a rare occurrence for a MIPS eligible clinician to be scored on only cost and improvement activities, and expressed concerns with the attribution methodologies used in cost measures. A few commenters expressed concerns about redistributing to the cost category due to issues with cost measures, such as attribution, reliability, and actionability. Commenters further noted that cost measures are fairly new and even those with which they have had experience (TPCC and MSPB) were having major updates to their specifications. One commenter did not agree with our assertion that this policy would reduce incentives to not report measures for the quality performance category, but did not provide further details. One commenter stated that the Quality Payment Program should focus on performance categories that support quality improvement, such as the improvement activities performance category, rather than on the cost performance category, because quality improvement is so important for patient care.

Response: We agree with commenters that the improvement activities performance category reflects important aspects of quality improvement and performance. However, we do have concerns with redistributing a substantial portion of the performance category weights to the improvement activities performance category due to a lack of variability in performance for this category, and we continue to believe that we should not redistribute weight to the improvement activities performance category. However, we agree with commenters that a weight of 85 percent for the cost performance category is not appropriate for the 2022 MIPS payment year. As noted in section III.K.3.c.(2)(b) of this final rule, opportunities to improve performance in the cost performance category are somewhat dependent on the performance feedback on cost measures we are able to provide. As we have provided detailed feedback on the cost measures for the first time during the 2019 performance period and expect to provide detailed feedback on new and revised cost measures for the first time during the 2020 performance period, we believe that we should not weight the cost performance category so heavily for the 2022 MIPS payment year. We believe that weighting the cost and improvement activities performance categories each at 50 percent would appropriately balance our concerns with redistributing weight to the improvement activities performance category and the concerns raised by commenters with a weight of 85 percent for the cost performance category.

Comment: One commenter stated that our current reweighting policies put undue emphasis on the quality performance category, and suggested that CMS redistribute weight evenly to the quality and improvement activities performance categories, especially for non-patient facing clinicians who may lack applicable measures and are spending valuable time performing quality improvement activities for the improvement activities performance category.

Response: Under our existing policies, we have generally redistributed weight to the quality performance category. The quality performance category is a critical component of value-based care, and therefore, we believe performance

on quality measures is important. In addition, there is variation in performance for the quality performance category, but for the improvement activities we are only assessing whether the MIPS eligible clinician completed activities. Finally, we believe that redistributing weight to the quality performance category would encourage MIPS eligible clinicians to report on quality measures as a zero score for this performance category would have more significant impact. However, over time, we want to redistribute more weight to the cost and Promoting Interoperability performance categories, and less to the quality performance category, to have better alignment between the cost and quality performance categories and due to our focus on interoperability. In general, we want to avoid redistributing weight to the improvement activities performance category because we believe other performance categories can better identify variation in performance.

Comment: One commenter stated that it is appropriate to delay the redistribution of more weight to the Promoting Interoperability performance category while ONC and other stakeholders work to make functional interoperability a reality.

Response: We thank the commenter for sharing their concern, but we continue to believe it is appropriate to increase the amount of weight redistributed to the Promoting Interoperability performance category in order to align with our focus on interoperability.

After consideration of the comments we received, we are finalizing our redistribution policies for the 2022 MIPS payment year at § 414.1380(c)(2)(ii)(D) as proposed with a few modifications. In sections III.K.3.c.(1)(b) and III.K.3.c.(2)(a) of this final rule, we are finalizing different generally applicable weights for the quality and cost performance categories, respectively, than what we proposed. For the 2022 MIPS payment year, we are finalizing a quality performance category weight of 45 percent (instead of 40 percent as proposed) and a cost performance category weight of 15 percent (instead of 20 percent as proposed). Accordingly, we are modifying the numerical amounts of weight that we will redistribute to account for these different weights for quality and cost, as shown in Table 55. In addition, in the scenario when only the improvement activities and cost performance categories are scored, we will provide a weight of 50 percent for each performance category, as shown in Table 55.

TABLE 55: Performance Category Redistribution Policies Finalized for the 2022 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	45%	15%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	70%	15%	15%	0%
-No Quality	0%	15%	15%	70%
-No Improvement Activities	60%	15%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	85%	15%	0%	0%
-No Quality and no Improvement Activities	0%	15%	0%	85%

In the CY 2020 PFS proposed rule, we proposed weights for the cost performance category of 25 and 30 percent for the 2023 and 2024 MIPS payment years, respectively (84 FR 40752 through 84 FR 40753). Because MIPS eligible clinicians will have had more experience being scored on cost measures, we stated that we believe it would be appropriate to begin redistributing even more of the performance category weights to the cost performance category beginning with the 2023 MIPS payment year. While we proposed to redistribute weight to the cost performance category for the 2022 MIPS payment year in scenarios in which only the cost and improvement activities performance categories are scored, we stated that we believe that we should redistribute weight to the cost performance category in other scenarios beginning with the 2023 MIPS payment year. We stated that in general, we would redistribute performance category weights so that the quality and cost performance categories are almost equal. For simplicity, we would redistribute the weight in 5-point increments. If the redistributed weight cannot be equally divided between quality and cost in 5-point increments, we would redistribute slightly more weight to quality than cost. We stated that we believe that redistributing weight equally to quality and cost is consistent with our goal of greater alignment between the quality and cost performance categories (84 FR 40797 through 40798). We stated that we would also continue to redistribute weight to the Promoting Interoperability

performance category, but we would ensure that if the quality and cost performance categories are scored, they would have a higher weight than the Promoting Interoperability performance category. For example, beginning with the 2024 MIPS payment year, if the improvement activities performance category is the only performance category to be reweighted to zero percent, quality and cost would be 40 and 35 percent, respectively, and we would not increase the weight of the Promoting Interoperability performance category (weighted at 25 percent) so that it would not exceed the weight of the quality or cost performance categories. Our proposed redistribution polices for the 2023 and 2024 MIPS payment years, which we proposed to codify at § 414.1380(c)(2)(ii)(E) and (F), are presented in Tables 56 and 57.

TABLE 56: Performance Category Redistribution Policies Proposed for the 2023 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	35%	25%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	50%	35%	15%	0%
-No Quality	0%	40%	15%	45%
-No Improvement Activities	45%	30%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	65%	0%	0%	35%
-No Promoting Interoperability and no Quality	0%	85%	15%	0%
-No Promoting Interoperability and no Improvement Activities	55%	45%	0%	0%
-No Quality and no Improvement Activities	0%	45%	0%	55%

TABLE 57: Performance Category Redistribution Policies Proposed for the 2024 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	30%	30%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	45%	40%	15%	0%
-No Quality	0%	45%	15%	40%
-No Improvement Activities	40%	35%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	60%	0%	0%	40%
-No Promoting Interoperability and no Quality	0%	85%	15%	0%
-No Promoting Interoperability and no Improvement Activities	50%	50%	0%	0%
-No Quality and no Improvement Activities	0%	60%	0%	40%

We received public comments on our proposed redistribution policies for the 2023 and 2024 MIPS payment years. The following is a summary of the comments we received and our responses.

Comment: Several commenters did not support our proposal to begin to redistribute weight to the cost performance category in any scenario. Commenters indicated that, as CMS adds more measures to the cost performance category, more measures will be in their first or second year of use. Furthermore, one commenter expressed concern that cost measures exclude Part D costs. Another commenter believed other performance categories have a stronger focus on care quality because they measure aspects of care improvement rather than resource use. Another commenter believed that MIPS eligible clinicians who receive reweighting for the promoting interoperability performance category are often in small and/or rural practices with limited resources, and increasing the weight of the cost performance category would place them at a greater disadvantage.

Response: As described in sections III.K.3.c.(1)(b) and III.K.3.c.(2)(a) of this final rule, we are not finalizing weights for the cost and quality performance categories for the 2023 and 2024 MIPS payment years. Instead, we have decided to maintain the weight of the cost performance category at 15 percent for the 2022 MIPS payment year and address its weight for the 2023 and 2024 MIPS payment years in future rulemaking. As a result, we have decided not to finalize redistribution policies for the 2023 and 2024 MIPS payment years because we have not established the generally applicable weights for these years. However, we will take these comments into consideration in future rulemaking.

After consideration of public comments, we are no longer finalizing performance category weights for the 2023 and 2024 MIPS payment years. Therefore, we are no longer finalizing weights for the cost and quality performance categories for the 2023 and 2024 MIPS payment years.

e. MIPS Payment Adjustments

(1) Background

For our previously established policies regarding the final score used in MIPS payment adjustment calculations, we refer readers to the CY 2019 PFS final rule (83 FR 59878 through 59894), CY 2018 Quality Payment Program final rule (82 FR 53785 through 53799) and CY 2017 Quality Payment Program final rule (81 FR 77329 through 77343).

In the CY 2020 PFS proposed rule (84 FR 40800 through 40804), we proposed to: (1) Set the performance threshold for the 2022 and 2023 MIPS payment years and (2) set the additional performance threshold for exceptional performance for the 2022 and 2023 MIPS payment years.

(2) Establishing the Performance Threshold

Under section 1848(q)(6)(D)(i) of the Act, for each year of MIPS, the Secretary shall compute a performance threshold with respect to which the final scores of MIPS eligible clinicians are compared for purposes of determining the MIPS payment adjustment factors under section 1848(q)(6)(A) of the Act for a year. The performance threshold for a year must be either the mean or median (as selected by the Secretary, and which may be reassessed every 3 years) of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary.

Section 1848(q)(6)(D)(iii) of the Act includes a special rule for the initial 2 years of MIPS, which requires the Secretary, prior to the performance period for such years, to establish a performance threshold for purposes of determining the MIPS payment adjustment factors under section 1848(q)(6)(A) of the Act and an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors under section 1848(q)(6)(C) of the Act, each of which shall be based on a period prior to the performance period and take into account data available for performance on measures and activities that may be used under the performance categories and other factors determined appropriate by the Secretary. Section 51003(a)(1)(D) of the Bipartisan Budget Act of 2018 amended section 1848(q)(6)(D)(iii) of the Act to extend the special rule to apply for the initial 5 years of MIPS instead of only the initial 2 years of MIPS.

In addition, section 51003(a)(1)(D) of the Bipartisan Budget Act of 2018 added a new clause (iv) to section 1848(q)(6)(D) of the Act, which includes an additional special rule for the third, fourth, and fifth years of MIPS (the 2021 through 2023 MIPS payment years). This additional special rule provides, for purposes of determining the MIPS payment adjustment factors under section 1848(q)(6)(A) of the Act, in addition to the requirements specified in section 1848(q)(6)(D)(iii) of the Act, the Secretary shall increase the performance threshold for each of the third, fourth, and fifth years to ensure a gradual and incremental transition to the performance threshold described in section 1848(q)(6)(D)(i) of the Act (as estimated by the Secretary) with respect to the sixth year (the 2024 MIPS payment year) to which the MIPS applies. The performance thresholds for the first 3 years of MIPS are presented in Table 58.

TABLE 58—PERFORMANCE THRESHOLDS FOR THE 2019 MIPS PAYMENT YEAR, 2020 MIPS PAYMENT YEAR, AND 2021 MIPS PAYMENT YEAR

	2019 MIPS payment year (points)	2020 MIPS payment year (points)	2021 MIPS payment year (points)
Performance Threshold	3	15	30

To determine a performance threshold to propose for the fourth year of MIPS (2020 MIPS performance period/2022 MIPS payment year) and the fifth year of MIPS (2021 MIPS performance period/2023 MIPS payment year), in the CY 2020 PFS proposed rule (84 FR 40801), we again relied upon the special rule in section 1848(q)(6)(D)(iii) of the Act, as amended by 51003(a)(1)(D) of the Bipartisan Budget Act of 2018.

As required by section 1848(q)(6)(D)(iii) of the Act, we considered data available from a prior period with respect to performance on measures and activities that may be used under the MIPS performance categories. In accordance with clause (iv) of section 1848(q)(6)(D) of the Act, we also considered which data could be used to estimate the performance threshold for the 2024 MIPS payment year to ensure a gradual and incremental transition from the performance threshold we would establish for the 2022 MIPS payment year. In accordance with section

1848(q)(6)(D)(i) of the Act, the performance threshold for the 2024 MIPS payment year will be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary.

As noted in the CY 2020 PFS proposed rule (84 FR 40801), to estimate the performance threshold for the 2024 MIPS payment year, we considered the actual MIPS final scores for MIPS eligible clinicians for the 2019 MIPS payment year and the estimated MIPS final scores for the 2020 MIPS payment year and 2021 MIPS payment year. We analyzed the actual final scores for the first year of MIPS (the 2019 MIPS payment year) and found the mean final score was 74.01 points and the median final score was 88.97 points, as described in the CY 2019 PFS final rule (83 FR 59881). In the Regulatory Impact Analysis of the CY 2019 PFS final rule, we used data submitted for the first year of MIPS (2017 MIPS performance period/2019 MIPS payment year) and applied the scoring and eligibility policies for the third year of MIPS (2019 MIPS performance period/2021 MIPS payment year) to estimate the potential final scores for the 2021 MIPS payment year. The estimated mean final score for the 2021 MIPS payment year was 69.53 points and the median final score was 78.72 points (83 FR 60048). We also estimated mean and median final scores for the 2020 MIPS payment year of 80.3 points and 90.91 points, respectively, based on information in the Regulatory Impact Analysis in the CY 2018 Quality Payment Program final rule (82 FR 53926 through 53950). Specifically, we used 2015 and 2016 PQRS data, 2014 and 2015 CAHPS for PQRS data, 2014 and 2015 VM data, 2015 and 2016 Medicare and Medicaid EHR Incentive Program data, the data prepared to support the 2017 performance period initial determination of clinician and special status eligibility, the initial QP determination file for the 2019 MIPS payment year, the 2017 MIPS measure benchmarks, and other available data to model the final scores for clinicians estimated to be MIPS eligible in the 2020 MIPS payment year (82 FR 53930). In the CY 2020 PFS proposed rule, we considered using the actual final scores for the 2020 MIPS payment year; however, the data used to calculate the final scores was submitted through the first quarter of 2019, and final scores for MIPS eligible clinicians were not available in time for us to use in our analyses for purposes of the proposed rule; we stated our intention to include those results in the final rule if available (84 FR 40801). We believed the data points based on actual data from the 2017 MIPS performance period/2019 MIPS payment year were appropriate to use in our analysis in projecting the estimated performance threshold for the 2024 MIPS payment year. However, we also noted that after we analyze the actual final scores for the 2020 MIPS payment year, if we see the mean or median final scores significantly increasing or decreasing, we will consider modifying our estimation of the performance threshold for the 2024 MIPS payment year accordingly. Table 51 of the CY 2020 PFS proposed rule summarized the different estimated performance thresholds for the 2024 MIPS payment year (84 FR 40802).

In the CY 2020 PFS proposed rule, we chose the mean final score of 74.01 points for the 2019 MIPS payment year as our estimate of the performance threshold for the 2024 MIPS payment year because it represents a mean based on actual data; is more representative of clinician performance because all final scores are considered in the calculation; is more achievable for clinicians, particularly for those that are new to MIPS; and is a value that falls generally in the middle of potential values for the performance threshold referenced in Table 51 in the CY 2020 PFS proposed rule (84 FR 40802). In the CY 2019 PFS proposed rule (83 FR 35972), we had requested comment on our approach to estimating the performance threshold for the 2024 MIPS payment year, which was based on the estimated mean final score for the 2019 MIPS payment year, and whether we should use the median instead of the mean. A summary of comments was included in CY 2020 PFS proposed rule (84 FR 40802).

We noted that estimating the performance threshold for the 2024 MIPS payment year based on the mean final score for the 2019 MIPS payment year is only an estimation that we are providing in accordance with section 1848(q)(6)(D)(iv) of the Act. We proposed to use data from the 2019 MIPS payment year because it was the only MIPS final score data available and usable in time for the publication of the CY 2020 PFS proposed rule (84 FR 40802).

We anticipated that the mean and median data points for the 2020 MIPS payment year would be available for consideration prior to publication of the final rule and solicited comment on whether and how we should use this information to update our estimates.

Since the publication of the CY 2020 PFS proposed rule, we now have the actual final score data for the 2020 MIPS payment year with which to estimate the mean and median. We note these values are estimates and that the mean and median may change as we finish the targeted review process for the 2020 MIPS payment year. In addition, we anticipate that the scores of some MIPS eligible clinicians may change as a result of the policy that we are finalizing in section III.K.3.d.(2)(b)(ii)(A) of this final rule to reweight the performance categories for a MIPS eligible clinician due to compromised data. We estimate the mean of the actual final scores for the 2020 MIPS payment year at 86.91 points and the median at 99.63 points although, again, the values may change after the completion of targeted reviews and due to the reweighting policy for data that are inaccurate, unusable, or otherwise compromised. We noted in the CY 2020 PFS proposed rule (84 FR 40802) some policies which could increase final scores. For example, beginning with the 2020 MIPS payment year, we increased the low-volume threshold compared to the 2019 MIPS payment year. We also added incentives for improvement scoring for the quality performance category and bonuses for complex patients and small practices.

We refer readers to Table 59 for potential values for estimating the performance threshold for the 2024 MIPS payment year based on the mean or median final score from prior periods. We have updated this table from the CY 2020 PFS proposed rule (84 FR 40802) to include the actual final score data for the 2020 MIPS payment year. We have also updated this table to include an estimate of the mean and median for the 2022 MIPS payment year from our Regulatory Impact Analysis in section VII.F.10. of this final rule as this estimate incorporates the newly available data for the 2020 MIPS payment year.

TABLE 59—POTENTIAL VALUES FOR ESTIMATED PERFORMANCE THRESHOLD FOR THE 2024 MIPS PAYMENT YEAR BASED ON THE MEAN OR MEDIAN FINAL SCORE FOR THE 2019 MIPS PAYMENT YEAR, 2020 MIPS PAYMENT YEAR, 2021 MIPS PAYMENT YEAR, AND 2022 MIPS PAYMENT YEAR

	2019 MIPS payment year * (points)	2020 MIPS payment year ** (points)	2021 MIPS payment year *** (points)	2022 MIPS payment year *** (points)
Mean Final Score	74.01	86.91	69.53	76.67
Median Final Score	88.97	99.63	78.72	83.57

* Mean and median final scores based on actual final scores for the 2019 MIPS payment year as published in CY 2019 PFS final rule RIA (83 FR 60048).

** Mean and median final scores based on actual final scores for the 2020 MIPS payment year. Mean and median may change after the completion of targeted reviews and due to the reweighting policy for data that are inaccurate, unusable, or otherwise compromised.

*** Mean and median final scores based on estimated final scores for the 2021 MIPS payment year as published in CY 2019 PFS final rule RIA (83 FR 60048) and the 2022 MIPS payment year as estimated in section VII. of this final rule.

We noted in the CY 2020 PFS proposed rule (84 FR 40801 through 40802) that we would analyze the actual final scores for the 2020 MIPS payment year, and because the data is now available and usable, we have updated our analyses. As illustrated in Table 59, we found the mean and median final scores for the 2020 MIPS payment year are higher than the values for the 2019 MIPS payment year and higher than our original estimate from the CY 2020 PFS proposed rule which had an estimated mean of 80.30 and median of 90.91 (84 FR 40802); however, we also estimated the final scores for the 2021 MIPS payment year will be lower than the values for both the 2019 and 2020 MIPS payment years.

In the CY 2020 PFS proposed rule (84 FR 40802), we noted that using final scores from the early years of MIPS has numerous limitations and may not be similar to the distribution of final scores for the 2024 MIPS payment year. Recognizing the limitations of data for the 2019 MIPS payment year and the 2020 MIPS payment year, we requested comments in the CY 2020 PFS proposed rule on whether we should update or modify our estimates (84 FR 40802).

We proposed a performance threshold of 45 points for the 2022 MIPS payment year and a performance threshold of 60 points for the 2023 MIPS payment year to be codified at § 414.1405(b)(7) and (8), respectively. A performance threshold of 45 points for the 2022 MIPS payment year and 60 points for the 2023 MIPS payment year would be an increase that is consistent with the increase in the performance threshold from the 2020 MIPS payment year (15 points) to the 2021 MIPS payment year (30 points), and we believe it would allow for a consistent increase over time that provides a gradual and incremental transition to the performance threshold we will establish for the 2024 MIPS payment year, which we estimated in the CY 2020 PFS proposed rule (84 FR 40802) to be 74.01 points.

In the CY 2020 PFS proposed rule (84 FR 40802), we provided the example that if in future rulemaking we were to set the performance threshold for the 2024 MIPS payment year at 75 points (which is close to the mean final score for the 2019 MIPS payment year), this would represent an increase in the performance threshold of approximately 45 points from the 2021 MIPS payment year (that is, the difference from the Year 3 performance threshold of 30 points to a Year 6 performance threshold of 75 points). We stated that we believe an increase of approximately 15 points each year, from Year 3 through Year 6 of the MIPS program, would provide for a gradual and incremental transition toward a performance threshold that must be set at the mean or median final score for a prior period in Year 6 of the MIPS program (84 FR 40802).

We stated that we also believe this increase of 15 points per year could incentivize higher performance by MIPS eligible clinicians and that a performance threshold of 45 points for the 2022 MIPS payment year, and a performance threshold of 60 points for the 2023 MIPS payment year, represent a meaningful increase compared to 30 points for the 2021 MIPS payment year, while maintaining flexibility for MIPS eligible clinicians in the pathways available to achieve this performance threshold (84 FR 40802). In the CY 2020 PFS proposed rule (84 FR 40807 through 40809), we provided examples of the ways clinicians can meet or exceed the proposed performance threshold for the 2022 MIPS payment year.

We recognized that some MIPS eligible clinicians may not exceed the proposed performance thresholds either due to poor performance or by failing to report on an applicable measure or activity that is required (84 FR 40803). We also recognized the unique challenges for small practices and rural clinicians that could prevent them from meeting or exceeding the proposed performance thresholds and sought feedback in the proposed rule on the participation of small and rural practices in MVPs (84 FR 40740).

We invited public comment on our proposals to set the performance threshold for the 2022 MIPS payment year at 45 points and to set the performance threshold for the 2023 MIPS payment year at 60 points. We also solicited comment on whether we should adopt a different performance threshold in this final rule if we determine that the actual mean or median final scores for the 2020 MIPS payment year are higher or lower than our estimated performance threshold for the 2024 MIPS payment year of 74.01 points. We anticipated the data will change over time and that the distribution of final scores will differ from one year to the next. We also solicited comment on whether the increase should be more gradual for the 2022 MIPS payment year, which would mean a lower performance threshold (for example, 35 instead of 45 points), or whether the increase should be steeper (for example, 50 points). We also solicited comment on alternative numerical values for the performance threshold for the 2022 MIPS payment year. For the 2023 MIPS payment year, we alternatively considered whether the performance threshold should be set at a lower or higher number, for example, 55 points or 65 points, and also solicited comment on alternative numerical values for the performance threshold for the 2023 MIPS payment year.

We received public comments on our proposals to set the performance threshold at 45 points for the 2022 MIPS payment year and at 60 points for the 2023 MIPS payment year. We also received public comments on whether the performance threshold for the 2022

MIPS payment year and the 2023 MIPS payment year should be higher or lower; whether we should adopt alternative numerical values for the performance threshold for the 2022 MIPS payment year and the 2023 MIPS payment year; and whether we should adopt a different performance threshold in this final rule if we determine that the actual mean or median final scores for the 2020 MIPS payment year are higher or lower than the 74.01 points estimated for the 2024 MIPS payment year.

The following is a summary of the comments we received and our responses.

Comment: Many commenters supported the proposed performance thresholds. Several commenters believed that the higher performance thresholds are a reasonable and gradual increase; would encourage participation; motivate clinicians to improve health care quality; hold clinicians accountable for quality and cost; ensure the incentives are conveyed to those clinicians who are attaining the thresholds needed to continually provide high quality health care for all patients; and would benefit clinicians in the transition to value-based payment. One commenter indicated that the proposal should give more genuinely high-quality clinicians meaningful bonuses, which in the past have been small due to MIPS policies and budget neutrality requirements.

Response: We agree that MIPS should incentivize clinicians to perform at a high level and support their transition to value-based care and believe that raising the performance threshold helps accomplish that goal. In addition, as discussed in section III.K.3.e.(3) of this final rule, we are raising the additional performance threshold to recognize and incentivize clinicians that provide high value care.

Comment: A few commenters did not support the proposed performance threshold of 45 points for the 2022 MIPS payment year believing that current policies and clinician participation levels make it impossible for high performing clinicians to achieve the advertised positive adjustment and receive a meaningful incentive for participation in MIPS. One commenter also expressed concerns that MIPS reporting requires investments in technology, staffing, as well as adjustments to workflows to meet quality measure requirements throughout the year and that practices committed to quality care and performing at exceptional levels receive adjustments of less than two percent for reaching the highest levels of MIPS scoring. Another commenter stated that the proposed performance thresholds and the low-volume threshold lead to an unsustainable distribution of scores.

Response: We recognize that, due to statutory requirements of budget neutrality and the application of a scaling factor, high performers may receive payment adjustments that are different than the applicable percent for the year provided in the statute (for example, 9 percent for the 2022 MIPS payment year). While a higher performance threshold may enlarge the estimated decrease in aggregate allowed charges resulting from the application of negative MIPS payment adjustment factors, and therefore, may increase the scaling factor, we believe the proposed performance thresholds of 45 points for the 2022 MIPS payment year and 60 points for the 2023 MIPS payment year would encourage movement toward value-based care with a focus on the delivery of high quality care for Medicare beneficiaries and provide a gradual and incremental transition to the estimated performance threshold for the 2024 MIPS payment year, as required by the statute. We also believe that the additional performance threshold for exceptional performance discussed later in section III.K.3.e.(3) of this final rule provides an additional financial incentive for high performers and will continue to incentivize their exceptional performance.

Comment: A few commenters did not support adopting a different performance threshold than the proposed performance thresholds of 45 points and 60 points, for the 2022 and 2023 MIPS payment years, respectively, if the actual mean or median final scores for the 2020 MIPS payment year are higher than the estimated performance threshold of 74.01 points for the 2024 MIPS payment year. One commenter recommended that the performance threshold should not increase even if the actual scores for the 2018 MIPS performance period are higher than expected. One commenter recommended lowering the performance threshold, or, alternatively, not increasing it and cited concern for small practices.

Response: We thank the commenters for their suggestions. Since the publication of the CY 2020 PFS proposed rule, the actual final score data for the 2020 MIPS payment year have become available and usable. For the 2020 MIPS payment year, the calculated mean and median of the actual final scores are 86.91 points and 99.63 points, respectively (although the mean and median may change after the completion of targeted reviews and due to the reweighting policy for data that are inaccurate, unusable, or otherwise compromised). Those mean and median final scores are higher than our estimates of 80.30 for the mean and 90.91 for the median that we included in Table 51 of the CY 2020 PFS proposed rule (84 FR 40802). We noted in the CY 2020 PFS proposed rule (84 FR 40801) that after we analyze the actual final scores for the 2020 MIPS payment year, if the mean or median final scores are significantly higher or lower, we will consider modifying our estimation of the performance threshold for the 2024 MIPS payment year. In considering whether to modify our estimate of the performance threshold for the 2024 MIPS payment year, we took into account how the actual mean and median final scores for the 2019 and 2020 MIPS payment years align with the projected mean and median final scores for 2021 and 2022 MIPS payment years and considered the differences in the eligibility and scoring policies for the different MIPS payment years.

We note that our original estimates for the 2020 MIPS payment year were lower than the actual values for the 2020 MIPS payment year. The difference in actual versus estimated values for the 2020 MIPS payment year may be partially due to the data sources available for estimates at that time. The estimates for the 2020 MIPS payment year were created using data from legacy programs, such as the Physician Quality Reporting System (PQRS) and the Value Modifier and the models applied participation assumptions (82 FR 53926 through 53948). In contrast, the estimated final scores for the 2021 and 2022 MIPS payment years incorporate data that were submitted for MIPS. These estimates also have limitations and assumptions; however, we believe that using MIPS submission data provides a better approximation of potential MIPS participation and performance. Specifically, for the 2021 MIPS payment year, we estimated final scores using primarily data submitted for MIPS for the 2017 MIPS performance period, including data submitted for the quality, improvement activities, and Promoting Interoperability (which was called advancing care information for the 2017 MIPS performance period) performance categories. For the 2022 MIPS payment year, we updated the analysis to include information submitted for the 2018 MIPS performance period. In addition to using MIPS submission data, we integrated additional data sources: CAHPS for MIPS and CAHPS for ACOs, the total per capita cost measure, Medicare

Spending Per Beneficiary (MSPB) clinician measure, the episode-based measures and other data sets. For a complete description of the data sources and our methodology to estimate the 2021 MIPS payment year final scores, please refer to the Regulatory Impact Analysis in the CY 2019 PFS final rule (83 FR 60046 through 83 FR 60059). For a complete description of the data sources and methodology for the projected 2022 MIPS payment year final scores, please refer to the Regulatory Impact Analysis in section VII. of this final rule.

When we compare the actual mean and median scores from the 2019 and 2020 MIPS payment years to the projected mean and median scores for the 2021 and 2022 MIPS payment years (see Table 59), we see that the 2020 MIPS payment year mean final score of 86.91 is higher than the projected mean final scores for the 2021 and 2022 MIPS payment years (69.53 and 76.67, respectively). In contrast, the mean result for the 2019 MIPS payment year (74.01) falls between the projected means for the 2021 and 2022 MIPS payment years (69.53 and 76.67, respectively). The median actual values for both the 2019 and 2020 MIPS payment years are higher than the projected median values for the 2021 and 2022 MIPS payment years.

In addition to comparing the actual and estimated mean and median final scores across different payment years, we also considered the policy differences across the different MIPS payment years. We stated in the CY 2020 PFS proposed rule (84 FR 40802) that we understood using final scores from the early years of MIPS had numerous limitations. We also noted that the distribution of final scores for the 2024 MIPS year may be different from the early years due to eligibility and scoring policy changes. For example, beginning with the 2020 MIPS payment year, we increased the low-volume threshold compared to the 2019 MIPS payment year. We also added incentives for improvement scoring for the quality performance category and bonuses for complex patients and small practices, which could increase scores. Starting with the 2021 MIPS payment year, we modified our eligibility to include new clinician types and an opt-in policy, revised the small practice bonus, significantly revised the Promoting Interoperability performance category scoring methodology, and added a topped-out cap for certain topped out quality measures. In addition, the performance category weights changed each payment year which limits the comparability of the actual mean or median final scores from either the 2019 or 2020 MIPS payment year to future payment year performance.

Given these concerns, and based on feedback from commenters, we have decided to take a conservative approach for estimating the 2024 MIPS payment year performance threshold. We believe the policy changes across MIPS payment years, in conjunction with the projected decrease in mean and median final scores from the 2020 MIPS payment year, justifies using the mean from the 2019 MIPS payment year (74.01 points) as the estimated performance threshold for the 2024 MIPS payment year. Despite differences in policies for the 2019 MIPS payment year compared to later MIPS payment years, this value is the lowest of all the actual mean final scores and falls between the projected mean final scores for the 2021 and 2022 MIPS payment year. If we increase our estimated performance threshold for the 2024 MIPS payment year based on the actual scores for the 2020 MIPS payment year (and accordingly increase the performance threshold for 2022 and 2023 MIPS payment years), then we may be forcing a transition that may not be gradual and incremental. As discussed further in our responses to comments, we are finalizing the performance thresholds for the 2022 and 2023 MIPS payment years as proposed, but we may revisit the performance threshold for the 2023 MIPS payment year in future rulemaking if we receive additional data that changes our estimate of the performance threshold for the 2024 MIPS payment year.

Comment: A few commenters expressed concerns with the use of data from the 2017 MIPS performance period and 2019 MIPS payment year to set the performance threshold at 45 points stating that data from the 2017 MIPS performance period is not an accurate representation of current actual performance because of policy changes to the MIPS program; is based on one year of data that is not indicative of performance in the future; and that the threshold is too high for small practices. Commenters recommended that CMS instead focus on ensuring stability and participation in MIPS.

Response: We appreciate the need to ensure relevant data are used to develop performance thresholds. As discussed in the previous response, we also agree that there are limitations with using final scores from the early years of MIPS (including the 2017 MIPS performance period which is associated with the 2019 MIPS payment year). We have considered all available data and found that the mean of 74.01 points for the 2019 MIPS payment year is the lowest of the two actual mean scores available and is close to our projections for mean final scores for the 2021 and 2022 MIPS payment years illustrated in Table 59. Therefore, we believe that 74.01 points is an appropriate estimate for a performance threshold for the 2024 MIPS payment year. We also believe the proposed performance thresholds of 45 points and 60 points for the 2022 and 2023 MIPS payment years, respectively, are appropriate because they would represent a gradual and incremental transition to the estimated performance threshold for the 2024 MIPS payment year, as required by the statute. We may revisit the performance threshold for the 2023 MIPS payment year in future rulemaking if we determine there is additional data to suggest our estimate should be modified.

We acknowledge the concerns regarding the potential burden on small practices. There are special policies available for small practices such as the small practice bonus and special scoring for the improvement activities performance category, and the availability of customized technical assistance through the Small, Underserved, and Rural Support Initiative to assist clinicians in small practices. Finally, we note that we expect a majority of clinicians in all practice sizes will receive a positive payment adjustment if they participate in MIPS. As shown in Table 123 within the Quality Payment Program section of the Regulatory Impact Analysis in section VII. of this final rule, 92.5 percent of clinicians who participate in MIPS receive a neutral or positive payment adjustment.

Comment: A few commenters suggested that the performance threshold remain at 30 points to allow clinicians to adjust to changes with program requirements. Some commenters recommended that CMS rework incentives for participation instead of increasing the performance threshold and the possibility of a negative payment adjustment. Several commenters recommended a smaller increase in the performance threshold for the 2022 MIPS payment year. One commenter suggested an increase from 30 points to 35 points because this increase would be consistent with the size of the proposed increase in the additional performance threshold for exceptional performance. One commenter stated a lower performance threshold of score of 35 points would reduce the magnitude of payment adjustments and the consequences of penalties or bonuses. One commenter

recommended that the performance threshold for the 2022 MIPS payment year should increase to 40 points and that the increase for the 2023 MIPS payment year should be delayed, but did not provide reasons for that recommendation.

Response: We thank the commenters for their suggestions. However, we do not believe that keeping the performance threshold at 30 points or increasing the performance threshold by 5 or 10 points would as effectively incentivize the delivery of high quality care for the 2022 MIPS payment year. We also do not believe it would provide as much of a gradual and incremental transition to the estimated performance threshold for the 2024 MIPS payment year, which we have estimated in the proposed rule at 74.01 points and still believe is an appropriate estimate after consideration of available data referenced in Table 59. We note that 74.01 points is the lowest of the two actual mean scores available and is close to our projections for mean final scores for the 2021 and 2022 MIPS payment years. We believe our proposal is an appropriate increase of 15 points from the performance threshold of 30 points for the 2021 MIPS payment year that would encourage an increased focus on the delivery of high-quality care to be successful in MIPS and receive a neutral or positive payment adjustment. In addition, we note that the gap from 30 points to approximately 75 points is much larger than any potential increase to the additional performance threshold. We also believe that delaying an increase for the 2023 MIPS payment year does not support our efforts to help eligible clinicians plan for future performance requirements under MIPS. We also believe that it is beneficial for planning purposes that we finalize the performance threshold for the 2023 MIPS payment year; however, we may revisit the performance threshold for the 2023 MIPS payment year in future rulemaking if we receive additional data that would cause us to reconsider our estimate of the performance threshold for the 2024 MIPS payment year.

Comment: One commenter stated the performance threshold should increase to 50 points for the 2022 MIPS payment year based on the increased mean score for the 2020 MIPS payment year which was mentioned in a webinar.

Response: We believe that an increase of 15 points from the performance threshold of 30 points for the 2021 MIPS payment year is an appropriate increase to incentivize high clinician performance. As discussed earlier, we believe a conservative approach is warranted for estimating the performance threshold for the 2024 MIPS payment year. Even though the actual mean score for the 2020 MIPS payment year is higher than we estimated, we do not believe that a higher actual mean score for the 2020 MIPS payment year warrants an increase to our proposed performance threshold for the 2022 MIPS payment year because we project the mean final scores for the 2021 MIPS payment year and the 2022 MIPS payment year to be lower than the mean final score for the 2020 MIPS payment. We also believe an increase to 50 points is too steep and that a performance threshold at 45 points for the 2022 MIPS payment year allows for a gradual and incremental transition to our estimated performance threshold for the 2024 MIPS payment year of 74.01 points.

Comment: Several commenters did not support our proposal of 45 points for the performance threshold for the 2022 MIPS payment year and stated that small and rural practices would be at a disadvantage to participate in MIPS compared to the larger groups. Some commenters recommended more bonus opportunities and developing a separate performance threshold for small and rural practices. One commenter stated that the increase in the performance threshold might lead to practice consolidation for small practices.

Response: We acknowledge the concerns of commenters regarding the potential impact on small practices. As discussed in a prior response, we have established special policies available for small practices to support their efforts to be successful in MIPS.

We also believe that different performance criteria for certain types of clinicians or practices may create more confusion and burden than a cohesive set of criteria; moreover, we are statutorily required to establish a single performance threshold for all MIPS eligible clinicians. We do not have data that would support the theory that increasing the performance threshold leads to the consolidation of small practices.

Comment: A few commenters did not support the increase in the performance threshold for the 2022 and 2023 MIPS payment years and stated it would have a negative impact on specialists. Some commenters noted this increase would make it difficult for pathologists, audiologists, physical therapists, ambulatory surgical center (ASC)-based and hospital-based MIPS eligible clinicians to meet the threshold due to a lack of quality measures for these practices. One commenter stated audiologists should be exempt from negative payment adjustments. One commenter expressed concern that quality measurement reporting requirements could result in lower scores for some specialties. One commenter recommended an analysis of the distribution of overall scores by specialty and sub-specialty is needed to help address disadvantages and possible upcoming negative adjustments.

Response: We appreciate the unique challenges faced by MIPS eligible clinicians that are in specialty practices, including pathologists, audiologists, physical therapists, and ASC-based and hospital-based MIPS clinicians. We believe that there are multiple pathways for clinicians, including specialty practices, to meet or exceed the performance threshold and be successful in MIPS and refer to the examples discussed at section III.K.3.e.(4) of this final rule. We also note that there are policies that adjust the quality performance category scores to account for the number of available quality measures, such as data validation process discussed in the CY 2017 Quality Payment Program final rule (81 FR 77290 through 77291) and the CY 2019 PFS final rule (83 FR 35950), and to assess if clinicians have fewer than 6 measures available and applicable for the quality performance category.

Comment: Several commenters expressed concerns with increasing the proposed thresholds while proposing significant changes to the cost and Promoting Interoperability performance categories believing that clinicians would not have enough time to adjust to the changes and this could result in lower scores.

Response: We acknowledge the concerns submitted by the commenters. We recognize that some requirements and scoring policies in the MIPS program have changed from year to year, including from the 2021 MIPS payment year to the 2022 MIPS payment year, but we believe the proposed performance threshold of 45 points for the 2022 MIPS payment year and 60 points for the 2023 MIPS payment year are appropriate increases that encourage increased participation and engagement in the MIPS program and that incentivize clinicians to transition to value-based care. We also note that we have modified the weight of the cost performance category in response to comments; specifically, we maintain the weight of the cost performance category at 15 percent for 2022 MIPS payment year to allow clinicians to become more familiar with the performance feedback process and allow us to continue to improve feedback reports. We do not

believe the policy changes to the Promoting Interoperability performance category referenced in section III.K.3.c.(4) of this final rule would require additional time for clinicians to adjust in order to avoid a negative payment adjustment. We also believe there are multiple pathways to meeting or exceeding a performance threshold of 45 points and refer readers to examples discussed at section III.K.3.e.(4) of this final rule.

After consideration of public comments, we are finalizing our proposal to set the performance threshold at 45 points for the 2022 MIPS payment year and at 60 points for the 2023 MIPS payment year. We are codifying the performance threshold for the 2022 MIPS payment year at § 414.1405(b)(7) and codifying the performance threshold for the 2023 MIPS payment year at § 414.1405(b)(8).

(3) Additional Performance Threshold for Exceptional Performance

Section 1848(q)(6)(D)(ii) of the Act requires the Secretary to compute, for each year of the MIPS, an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors for exceptional performance under section 1848(q)(6)(C) of the Act. For each such year, the Secretary shall apply either of the following methods for computing the additional performance threshold: (1) The threshold shall be the score that is equal to the 25th percentile of the range of possible final scores above the performance threshold determined under section 1848(q)(6)(D)(i) of the Act; or (2) the threshold shall be the score that is equal to the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold for the prior period described in section 1848(q)(6)(D)(i) of the Act. Under section 1848(q)(6)(C) of the Act, a MIPS eligible clinician with a final score at or above the additional performance threshold will receive an additional MIPS payment adjustment factor and may share in the $500 million of funding available for the year under section 1848(q)(6)(F)(iv) of the Act.

As we discussed in the CY 2020 PFS proposed rule (84 FR 40800 through 40803), we relied on the special rule under section 1848(q)(6)(D)(iii) of the Act to propose a performance threshold of 45 points for the 2022 MIPS payment year and to propose a performance threshold of 60 points for the 2023 MIPS payment year. The special rule under section 1848(q)(6)(D)(iii) of the Act also applies for purposes of establishing an additional performance threshold for a year, for the initial 5 years of MIPS. For the 2022 MIPS payment year and the 2023 MIPS payment year, we proposed again to rely on the discretion afforded by the special rule and to decouple the additional performance threshold from the performance threshold.

For illustrative purposes, we considered what the numerical values would be for the additional performance threshold under one of the methods described in section 1848(q)(6)(D)(ii) of the Act: The 25th percentile of the range of possible final scores above the performance threshold. With a proposed performance threshold of 45 points, the range of total possible points above the performance threshold is 45.01 to 100 points and the 25th percentile of that range is 58.75, which is just more than one-half of the possible 100 points in the MIPS final score. We stated that we do not believe it would be appropriate to lower the additional performance threshold to 58.75 points because it is below the mean and median final scores for each of the prior performance periods that are referenced in Table 51 of the CY 2020 PFS proposed rule (84 FR 40802). Similarly, with a proposed performance threshold for the 2023 MIPS payment year of 60 points, the range of possible points above the performance threshold is 60.01 to 100 points and the 25th percentile of that range is 69.99 points. We stated that we do not believe it would be appropriate to lower the additional performance threshold to 69.99 points because it is below or close to the mean and median final scores for each of the prior performance periods that are referenced in Table 51 of the CY 2020 PFS proposed rule (84 FR 40802).

We relied on the special rule under section 1848(q)(6)(D)(iii) of the Act and proposed at § 414.1405(d)(6) to set the additional performance threshold for the 2022 MIPS payment year at 80 points and proposed at § 414.1405(d)(7) to set the additional performance threshold for the 2023 MIPS payment year at 85 points. These values are higher than the 25th percentile of the range of the possible final scores above the proposed performance threshold for the 2022 and 2023 MIPS payment years.

We originally proposed 80 points for the additional performance threshold for the 2021 MIPS payment year in the CY 2019 PFS proposed rule (83 FR 35973) although we finalized 75 points in the CY 2019 PFS final rule (83 FR 59886). In the CY 2019 PFS final rule, we noted the impact that policy changes for the 2021 MIPS payment year could have on final scores as clinicians are becoming familiar with these changes and noted our belief that 75 points was appropriate for Year 3 of MIPS (83 FR 59883 through 59886). We also signaled our intent to increase the additional performance threshold in future rulemaking (83 FR 59886).

We stated that we believe that 80 points and 85 points are minimal and incremental increases over the additional performance threshold of 75 points for the 2021 MIPS payment year (84 FR 40803). We stated that we also believe it is appropriate to raise the bar on what is rewarded as exceptional performance for the 2022 and 2023 MIPS payment years and that increasing the additional performance threshold each year will encourage clinicians to increase their focus on value-based care and enhance the delivery of high quality care for Medicare beneficiaries (84 FR 40803).

An additional performance threshold of 80 points and 85 points would each require a MIPS eligible clinician to participate and perform well in multiple performance categories. Generally, under the performance category weights for the 2022 MIPS payment year proposed in the CY 2020 PFS proposed rule (84 FR 40795), a MIPS eligible clinician who is scored on all four performance categories could receive a maximum of 40 points towards the final score for the quality performance category or a maximum score of 65 points for participating in the quality performance category and Promoting Interoperability performance category, which are both below the proposed 80-point and 85-point additional performance thresholds. In addition, 80 points and 85 points are at a high enough level that MIPS eligible clinicians must submit data for the quality performance category to achieve this target. We stated that we believe setting the additional performance threshold at 80 points and 85 points could increase the incentive for exceptional performance while keeping the focus on quality performance (84 FR 40802).

We noted that under section 1848(q)(6)(F)(iv) of the Act, funding is available for additional MIPS payment adjustment factors under section 1848(q)(6)(C) of the Act only through the 2024 MIPS payment year, which is the sixth year of the MIPS program (84 FR 40804). We stated that we believe it is appropriate to further incentivize clinicians whose performance meets or exceeds the additional performance threshold for the fourth and fifth years of the MIPS program (84 FR 40804). We recognized that setting a higher additional performance threshold may result in fewer clinicians receiving additional MIPS payment adjustments

(84 FR 40804). We also noted that a higher additional performance threshold could increase the maximum additional MIPS payment adjustment that a MIPS eligible clinician potentially receives if the funds available (up to $500 million for each year) are distributed over fewer clinicians that have final scores at or above the higher additional performance threshold (84 FR 40804).

We invited public comment on our proposals to set the additional performance threshold at 80 points for the 2022 MIPS payment year and at 85 points for the 2023 MIPS payment year. Alternatively, for the 2022 MIPS payment year, we considered whether the additional performance threshold should remain at 75 points or be set at a higher number, for example, 85 points, and also solicited comment on alternative numerical values for the additional performance threshold for the 2022 MIPS payment year. We referred readers to the RIA in the CY 2020 PFS proposed rule (84 FR 40911) for the estimated maximum payment adjustments when the additional performance threshold is set at 80 points and at 85 points, respectively, for the 2022 MIPS payment year.

Alternatively, for the 2023 MIPS payment year, we also considered whether the additional performance threshold should remain at 80 points as proposed for the 2022 MIPS payment year or whether a different numerical value should be adopted for the 2023 MIPS payment year, and also solicited comment on alternative numerical values for the additional performance threshold for the 2023 MIPS payment year. Additionally, in the event that we adopt different numerical values for the performance threshold in the final rule than proposed in the CY 2020 PFS proposed rule (84 FR 40800 through 40803), we solicited comment on whether we should adopt different numerical values for the additional performance threshold and how we should set those values. We also solicited comment on how the distribution of the additional MIPS payment adjustments across MIPS eligible clinicians may impact exceptional performance by clinicians participating in MIPS. For example, the distribution of the additional MIPS payment adjustments could result in a higher additional MIPS payment adjustment available to fewer clinicians or could result in a lower additional MIPS payment adjustment available to a larger number of clinicians. We also reminded readers that we anticipate the data will change over time and that the distribution of final scores will differ from one year to the next.

We received public comments on our proposals to set the additional performance threshold at 80 points for the 2022 MIPS payment year and at 85 points for the 2023 MIPS payment year. We also received public comments on alternative numerical values for the additional performance threshold for the 2022 MIPS payment year

We also received public comments on alternative numerical values for the additional performance threshold for the 2023 MIPS payment year, whether we should adopt different numerical values for the additional performance threshold and how we should set those values, and how the distribution of the additional MIPS payment adjustments across MIPS eligible clinicians may impact exceptional performance by clinicians participating in MIPS.

The following is a summary of the comments we received and our responses.

Comment: One commenter did not support the proposed additional performance threshold for the 2022 MIPS payment year and stated the additional performance threshold should be 85 points based on the increased mean score for 2020 MIPS payment year. Another commenter expressed concerns that clinicians who have invested in their practices to meet quality measure requirements and are performing at exceptional levels receive low payment adjustments of less than 2 percent for reaching the highest levels of MIPS scoring.

Response: We appreciate the investments made by clinicians to make improvements in their clinical practice and their efforts to transition to value-based care in the Medicare program. We note that a higher additional performance threshold could increase the maximum additional payment adjustment that a MIPS eligible clinician could potentially receive if the funds available (up to $500 million for the year) are distributed over fewer clinicians that score at or above the higher additional performance threshold. We appreciate the commenter's suggestion of 85 points for the additional performance threshold for the 2022 MIPS payment year.

We believe it is important to incentivize exceptional performance in MIPS and will increase the additional performance threshold from our proposal for the 2022 MIPS payment year of 80 points to 85 points. This adjustment would raise the bar on exceptional performance and provide an appropriate financial incentive for high performers.

As discussed in section VII.F.10 of the Regulatory Impact Analysis in this final rule, we estimate that the number of MIPS eligible clinicians receiving an additional payment adjustment with the additional performance threshold at 80 points and 85 points is 533,069 and 390,354 MIPS eligible clinicians, respectively. We found that increasing the additional performance threshold to 85 points rather than 80 points leads to a decrease in the number of MIPS eligible clinicians that would receive an additional payment adjustment by 142,715 clinicians. The estimated 390,354 MIPS eligible clinicians expected to receive the additional payment adjustment when the additional performance threshold is set at 85 points is about 44 percent of the MIPS eligible population compared to 61 percent of the MIPS eligible population when the additional performance threshold is set at 80 points. We also estimate that the maximum payment adjustment (for a MIPS eligible clinician with a final score of 100 points) would increase from 4.5 to 6.2 percent. However, this projection is only an estimate and may change based on the distribution of actual final scores for clinicians with final scores at or higher than the additional performance threshold and the associated Medicare payments. Given this analysis, we believe that increasing the additional performance threshold to 85 points for the 2022 MIPS payment year would provide an appropriate incentive for exceptional clinician performance.

We also note that the funding for the additional payment adjustment ends with the 2024 MIPS payment year and believe the additional performance threshold should be set at a number that encourages the transition to value-based care.

For the reasons discussed above, we believe 85 points is appropriate for the additional performance threshold for the 2022 MIPS payment year; therefore, we will finalize 85 points for the additional performance threshold for exceptional performance for both the 2022 and 2023 MIPS payment years.

Comment: A few commenters supported the proposed additional performance threshold for exceptional performance because they would reasonably raise the bar on what is rewarded as exceptional performance; ensure that clinicians continue to be held accountable for quality and cost; incentivize individuals and groups to continuously improve performance; and motivate health care providers to continually provide high quality health care for all patients. A few commenters supported our proposals believing that high-quality clinicians should receive

larger bonuses for meeting the additional performance threshold.

Response: We agree with commenters that increasing the additional performance threshold incentivizes individuals and groups to continuously improve performance and motivates health care providers to continually provide high quality health care for all patients. However, we also note that we received comments expressing concern that the MIPS payment adjustments would not provide for appropriate financial incentives for exceptional performers in MIPS.

We have considered the totality of the comments and more recent data discussed in the Regulatory Impact Analysis at section VII. of this final rule estimating the number of eligible clinicians receiving an additional payment adjustment and the potential increase in the additional payment adjustment with the additional performance threshold set at 80 points and 85 points and we believe it is appropriate to finalize a higher additional performance threshold for the 2022 MIPS payment year that further incentivizes continued care improvement by high performing clinicians that have invested in quality care and are exceptional performers in MIPS. Given this, we believe that an increase of 10 points from the additional performance threshold of 75 points for the 2021 MIPS payment year is a reasonable increase for the 2022 MIPS payment year and would provide an appropriate financial incentive for clinicians to deliver exceptional performance in MIPS.

Comment: Several commenters did not support the proposal to set the additional performance threshold at 80 points for the 2022 MIPS payment year. A few commenters stated it should remain at 75 points for the 2022 MIPS payment year and to 80 points for the 2023 MIPS payment year believing that clinicians should have more time to implement quality improvement projects. A few commenters stated the additional performance threshold should not exceed the 75-point threshold until more insight is gained by practice size. One commenter indicated that the proposed additional performance thresholds are too high and would have a negative impact on small practices. A few commenters did not support the proposals for the additional performance threshold and noted changes to the improvement activities and Promoting Interoperability performance categories would impede the ability to achieve high scores. One commenter recommended the additional performance threshold remain at 75 points for the 2022 MIPS payment year should the proposal to increase the percentage of clinicians who must perform an improvement activity for the group to receive credit for the improvement activities performance category be finalized.

Response: We believe that an increase for the additional performance threshold is appropriate for the 2022 MIPS payment year and the 2023 MIPS payment year to encourage high performance across all clinician practices and to support their transition to value-based care. We believe that keeping the additional performance threshold at 75 points for the 2022 MIPS payment year and increasing it to 80 points for the 2023 MIPS payment year does not appropriately raise the bar on exceptional performance. We also note that clinicians could still meet or exceed the performance threshold and receive a neutral or positive payment adjustment to be successful in the MIPS program. We recognize the unique challenges for eligible clinicians in small practices participating in MIPS and believe that special policies provide some relief for small practices seeking to perform well as referenced in earlier in this section of the final rule. We also believe that increasing the additional performance threshold aligns with policy changes for the 2022 MIPS payment year for the Promoting Interoperability performance category discussed at section III.K.3.c.(4) of this final rule and the changes to the group submission requirement for the improvement activities performance category discussed at section III.K.3.c.(3)(d) of this final rule that appropriately raise the bar on clinician performance for 2022 MIPS payment year and further support the transition toward value-based care.

Comment: A few commenters did not support the increase in the additional performance threshold for the 2022 and 2023 MIPS payment years believing it would have a negative impact on specialists. A few commenters stated achieving a score above 80 points would be difficult for some specialties and sub-specialties with a low number of quality measures, such as pathology. One commenter stated it is increasingly difficult for some specialties to meet some of the metrics, such as the Promoting Interoperability measures, and that exceptional performance should not imply a competition across specialties but be based on truly meaningful measures. One commenter stated an increase would make it difficult for hospital-based MIPS clinicians to meet the threshold due to a lack of quality measures. One commenter recommended an analysis of the distribution of overall scores by specialty and sub-specialty to address disadvantages and possible negative adjustments.

Response: We acknowledge that the number of quality measures available to clinicians can vary by specialty and practice, including pathology and for hospital-based clinicians. We believe our quality performance category scoring validation policy accounts for certain instances where clinicians have fewer than 6 measures available. We also believe these adjustments allow us to develop a fair comparison across different MIPS eligible clinicians and would not preclude clinicians in specialty practices from reaching the additional performance threshold. We agree that performance measurement should be based on meaningful measures and that our policies account for when measures are not available or applicable. We are also looking at ways to implement MVPs in a way to make the program more meaningful for clinicians.

Comment: Some commenters stated the additional performance threshold should increase based on performance results from the previous year rather than an arbitrary change.

Response: We disagree with the characterization that the additional performance threshold is set arbitrarily. In the proposed rule (84 FR 40803), for illustrative purposes, we considered what the numerical values would be for the additional performance threshold under one of the methods described in section 1848(q)(6)(D)(ii) of the Act: the 25th percentile of the range of possible final scores above the performance threshold. With a proposed performance threshold of 45 points, the range of total possible points above the performance threshold is 45.01 to 100 points and the 25th percentile of that range is 58.75, which is just more than one-half of the possible 100 points in the MIPS final score. Similarly, with a proposed performance threshold for the 2023 MIPS payment year of 60 points, the range of possible points above the performance threshold is 60.01 to 100 points and the 25th percentile of that range is 69.99 points. We still do not believe it would be appropriate to lower the additional performance threshold to 69.99 points or 58.75 points because these numbers are below or close to the mean and median final scores for each of the prior performance periods that are referenced in Table 59.

After consideration of public comments, we are not finalizing our proposal to set the additional performance threshold at 80 points for the 2022 MIPS payment year, and

instead, are finalizing the additional performance threshold at 85 points for the 2022 MIPS payment year. We are finalizing the additional performance threshold at 85 points for the 2023 MIPS payment year as proposed. We are codifying the additional performance threshold for the 2022 MIPS payment year and for the 2023 MIPS payment year at § 414.1405(d)(6).

(4) Example of Adjustment Factors

In the CY 2020 PFS proposed rule (84 FR 40804 through 40809),we provided a figure and several tables as illustrative examples of how various final scores would be converted to a MIPS payment adjustment factor, and potentially an additional MIPS payment adjustment factor, using the statutory formula and based on our proposed policies for the 2022 MIPS payment year. We are updating the figure and tables based on our finalized policies in this final rule.

Figure 1 provides an example of how various final scores will be converted to a MIPS payment adjustment factor, and potentially an additional MIPS payment adjustment factor, using the statutory formula and based on the policies for the 2022 MIPS payment year in this final rule. In Figure 1, the performance threshold is 45 points. The applicable percentage is 9 percent for the 2022 MIPS payment year. The MIPS payment adjustment factor is determined on a linear sliding scale from zero to 100, with zero being the lowest possible score which receives the negative applicable percentage (negative 9 percent for the 2022 MIPS payment year) and results in the lowest payment adjustment, and 100 being the highest possible score which receives the highest positive applicable percentage and results in the highest payment adjustment. However, there are two modifications to this linear sliding scale. First, there is an exception for a final score between zero and one-fourth of the performance threshold (zero and 11.25 points based on the performance threshold of 45 points for the 2022 MIPS payment year). All MIPS eligible clinicians with a final score in this range will receive the lowest negative applicable percentage (negative 9 percent for the 2022 MIPS payment year). Second, the linear sliding scale line for the positive MIPS payment adjustment factor is adjusted by the scaling factor, which cannot be higher than 3.0.

If the scaling factor is greater than zero and less than or equal to 1.0, then the MIPS payment adjustment factor for a final score of 100 will be less than or equal to 9 percent. If the scaling factor is above 1.0, but less than or equal to 3.0, then the MIPS payment adjustment factor for a final score of 100 will be higher than 9 percent.

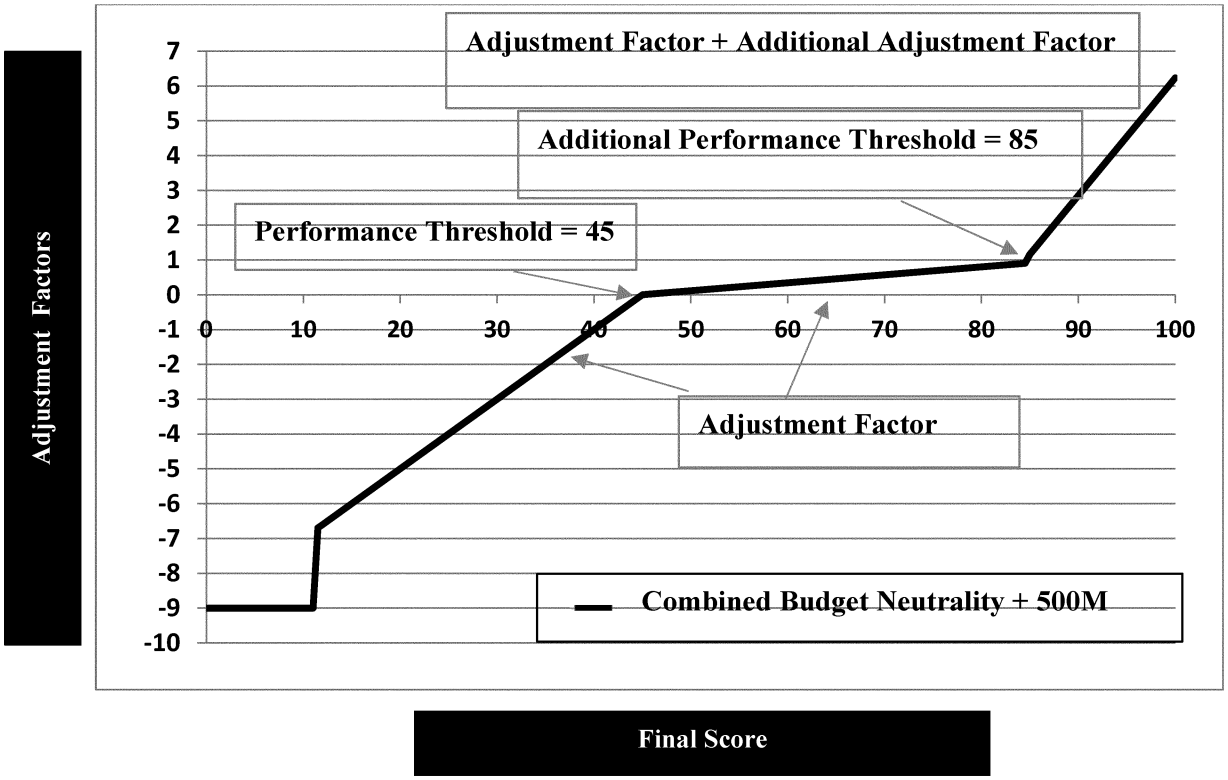
Only those MIPS eligible clinicians with a final score equal to 45 points (which is the performance threshold in this example) will receive a neutral MIPS payment adjustment. Because the performance threshold is 45 points, we anticipate that more clinicians will receive a positive adjustment than a negative adjustment and that the scaling factor will be less than 1 and the MIPS payment adjustment factor for each MIPS eligible clinician with a final score of 100 points will be less than 9 percent.

Figure 1 illustrates an example of the slope of the line for the linear adjustments for the 2022 MIPS payment year, but it can change considerably as new information becomes available. In this example, the scaling factor for the MIPS payment adjustment factor is 0.1401. In this example, MIPS eligible clinicians with a final score equal to 100 will have a MIPS payment adjustment factor of 1.261 percent (9 percent × 0.1401). (Note that this is prior to adding the additional payment adjustment for exceptional performance, which is explained below.)

The additional performance threshold for the 2022 MIPS payment year is 85 points. An additional MIPS payment adjustment factor of 0.5 percent starts at the additional performance threshold and increases on a linear sliding scale up to 10 percent. This linear sliding scale line is also multiplied by a scaling factor that is greater than zero and less than or equal to 1.0. The scaling factor will be determined so that the estimated aggregate increase in payments associated with the application of the additional MIPS payment adjustment factors is equal to $500 million. In Figure 1, the example scaling factor for the additional MIPS payment adjustment factor is 0.499. Therefore, MIPS eligible clinicians with a final score of 100 will have an additional MIPS payment adjustment factor of 4.99 percent (10 percent × 0.499). The total adjustment for a MIPS eligible clinician with a final score equal to 100 would be 1 + 0.0126 + 0.0499 = 1.0625, for a total positive MIPS payment adjustment of 6.25 percent.

BILLING CODE 4120–01–P

FIGURE 1: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2022 MIPS Payment Year



Note: The adjustment factor for final score values above the performance threshold is illustrative. For MIPS eligible clinicians with a final score of 100, the adjustment factor would be 9 percent times a scaling factor greater than zero and less than or equal to 3.0. The scaling factor is intended to ensure budget neutrality, but cannot be higher than 3.0. MIPS eligible clinicians with a final score of at least 85 points would also receive an additional adjustment factor for exceptional performance. The additional adjustment factor is also illustrative. The additional adjustment factor starts at 0.5 percent and cannot exceed 10 percent and is also multiplied by a scaling factor that is greater than zero and less than or equal to 1. MIPS eligible clinicians at or above the additional performance threshold will receive the amount of the adjustment factor plus the additional adjustment factor. This example is illustrative as the actual payment adjustments may vary based on the distribution of final scores for MIPS eligible clinicians.

The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians above the performance threshold means the scaling factors will decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment factor. More MIPS eligible clinicians below the performance threshold means the scaling factors will increase because more MIPS eligible clinicians will receive a negative MIPS payment adjustment factor and relatively fewer MIPS eligible clinicians will receive a positive MIPS payment adjustment factor.

Table 60 illustrates the changes in payment adjustments based on the final policies for the 2020 and 2021 MIPS payment years, and the policies for the 2022 and 2023 MIPS payment years discussed in this final rule, as well as the statutorily-required increase in the applicable percent as required by section 1848(q)(6)(B) of the Act.

TABLE 60: Illustration of Point System and Associated Adjustments Comparison between the 2020 MIPS Payment Year, the 2021 MIPS Payment Year, and the Policies for the 2022 MIPS Payment Year and the 2023 MIPS Payment Year

2020 MIPS payment year		2021 MIPS payment year		2022 MIPS payment year		2023 MIPS payment year	
Final Score Points	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**
0.0-3.75	Negative 5%	0.0-7.5	Negative 7%	0.0-11.25	Negative 9%	0.0-15.0	Negative 9%
3.76-14.99	Negative MIPS payment adjustment greater than negative 5% and less than 0% on a linear sliding scale	7.51-29.99	Negative MIPS payment adjustment greater than negative 7% and less than 0% on a linear sliding scale	11.26-44.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale	15.01-59.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
15.0	0% adjustment	30.0	0% adjustment	45.0	0% adjustment	60.0	0% adjustment
15.01-69.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 5% for scores from 15.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	30.01-74.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 7% for scores from 30.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	45.01-84.99.	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 45.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	60.01-84.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 60.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality
70.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 5% for final scores from 15.00 to 100.00. This sliding scale is multiplied by a	75.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 7% for final scores from 30.00 to 100.00. This sliding scale is multiplied by a	85.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for final	85.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges

2020 MIPS payment year		2021 MIPS payment year		2022 MIPS payment year		2023 MIPS payment year	
Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment
	scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. PLUS An additional MIPS payment adjustment for exceptional performance. The additional MIPS payment adjustment starts at 0.5% and increases on a linear sliding scale. The linear sliding scale ranges from 0.5 to 10% for scores from 70.00 to 100.00. This sliding scale is multiplied by a scaling factor not greater than 1.0 in order to proportionately distribute the available funds for exceptional performance.		scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. PLUS An additional MIPS payment adjustment for exceptional performance. The additional MIPS payment adjustment starts at 0.5% and increases on a linear sliding scale. The linear sliding scale ranges from 0.5 to 10% for scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor not greater than 1.0 in order to proportionately distribute the available funds for exceptional performance.		scores from 45.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. PLUS An additional MIPS payment adjustment for exceptional performance. The additional MIPS payment adjustment starts at 0.5% and increases on a linear sliding scale. The linear sliding scale ranges from 0.5 to 10% for scores from 85.00 to 100.00. This sliding scale is multiplied by a scaling factor not greater than 1.0 in order to proportionately distribute the available funds for exceptional performance.		from 0 to 9% for final scores from 60.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. PLUS An additional MIPS payment adjustment for exceptional performance. The additional MIPS payment adjustment starts at 0.5% and increases on a linear sliding scale. The linear sliding scale ranges from 0.5 to 10% for scores from 85.00 to 100.00. This sliding scale is multiplied by a scaling factor not greater than 1.0 in order to proportionatel y distribute the available funds for exceptional performance

We have provided updated examples below with the policies finalized for the 2022 MIPS payment year to demonstrate scenarios in which MIPS eligible clinicians can achieve a final score above the proposed performance threshold of 45 points based on our final policies.

Example 1: MIPS Eligible Clinician in Small Practice Submits 5 Quality Measures and 1 Improvement Activity

In the example illustrated in Table 61, a MIPS eligible clinician in a small practice reporting individually exceeds the performance threshold by performing at the median level for 5 quality measures via Part B claims collection type and one medium-weight improvement activity. The practice does not submit data for the Promoting Interoperability performance category, but does submit a significant hardship exception application which is approved; therefore, the weight for the Promoting Interoperability performance

category is redistributed to the quality performance category under the proposed reweighting policies finalized in section III.K.3.d.(2)(b)(iii) of this proposed rule. We also assumed the small practice has a cost performance category percent score of 50 percent. Finally, we assumed a complex patient bonus of 3 points which represents the average HCC risk score for the beneficiaries seen by the MIPS eligible clinician, as well as the proportion of Medicare beneficiaries that are dual eligible. There are special scoring rules for the improvement activities performance category which affect MIPS eligible clinicians in a small practice.

- Six measure achievement points for each of the 5 quality measures submitted at the median level of performance. We refer readers to § 414.1380(b)(1)(i) for further discussion of the quality performance category scoring policy. Because the measures are submitted via Part B claims, they do not qualify for the end-to-end electronic reporting bonus, nor do the measures submitted qualify for the high-priority bonus. The small practice bonus of 6 measure bonus points apply because at least 1 measure was submitted. Because the MIPS eligible clinician does not meet full participation requirements, the MIPS eligible clinician does not qualify for improvement scoring. We refer readers to § 414.1380(b)(1)(vi) for the full participation requirements for improvement scoring. Therefore, the quality performance category is (30 measure achievement points + 6 measure bonus points)/60 total available measure points + zero improvement percent score which is 60 percent.
- The Promoting Interoperability performance category weight is redistributed to the quality performance category so that the quality performance category score is worth 70 percent of the final score. We refer readers to section III.K.3.d.(2)(b)(iii) of this final rule for a discussion of this policy.
- MIPS eligible clinicians in small practices qualify for special scoring for improvement activities so a medium weighted activity is worth 20 points out of a total 40 possible points for the improvement activities performance category. We refer readers to § 414.1380(b)(3) for further detail on scoring policies for small practices for the improvement activities performance category.
- This MIPS eligible clinician exceeds the performance threshold of 45 points (but does not exceed the additional performance threshold). This score is summarized in Table 61.

TABLE 61: Scoring Example 1, MIPS Eligible Clinician in a Small Practice

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	60%	70%	42
Cost	50%	15%	7.5
Improvement Activities	20 out of 40 points - 50%	15%	7.5
Promoting Interoperability	N/A	0% (redistributed to quality)	0
Subtotal (Before Bonuses)			57
Complex Patient Bonus			3
Final Score (not to exceed 100)			**60**

Example 2: Group Submission Not in a Small Practice

In the example illustrated in Table 62, a MIPS eligible clinician in a medium size practice participating in MIPS as a group receives performance category scores of 80 percent for the quality performance category, 60 percent for the cost performance category, 90 percent for the Promoting Interoperability performance category, and 100 percent for improvement activities performance category. There are many paths for a practice to receive an 80 percent score in the quality performance category, so for simplicity we are assuming the score has been calculated at this amount. Again, for simplicity, we assume a complex patient bonus of 3 points. The final score is calculated to be 85.5 points, and both the performance threshold of 45 points and the additional performance threshold of 85 points are exceeded. In this example, the group practice exceeds the additional performance threshold and will receive the additional MIPS payment adjustment.

TABLE 62: Scoring Example 2, MIPS Eligible Clinician in a Medium Practice

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	80%	45%	36
Cost	60%	15%	9
Improvement Activities	40 out of 40 points - 100%	15%	15
Promoting Interoperability	90%	25%	22.5
Subtotal (Before Bonuses)			82.5
Complex Patient Bonus			3
Final Score (not to exceed 100)			**85.5**

Example 3: Non-Patient Facing MIPS Eligible Clinician

In the example illustrated in Table 63, an individual MIPS eligible clinician that is non-patient facing and not in a small practice receives performance category scores of 50 percent for the quality performance category, 50 percent for the cost performance category, and 50 percent for 1 medium-weighted improvement activity. Again, there are many paths for a practice to receive a 50 percent score in the quality performance category, so for simplicity we are assuming the score has been calculated. Because the MIPS eligible clinician is non-patient facing, they qualify for special scoring for improvement activities and receive 20 points (out of 40 possible points) for the medium weighted activity. Also, this individual did not submit Promoting Interoperability measures and qualifies for the automatic redistribution of the Promoting Interoperability performance category weight to the quality performance category. Again, for simplicity, we assume a complex patient bonus of 3 points.

In this example, the final score is 53 points and the performance threshold of 45 points is exceeded while the additional performance threshold of 85 points is not.

TABLE 63: Scoring Example 3, Non-Patient Facing MIPS Eligible Clinician

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	50%	70%	35
Cost	50%	15%	7.5
Improvement Activities	20 out of 40 points for 1 medium weight activity - 50%	15%	7.5
Promoting Interoperability	0%	0% (redistributed to quality)	0
Subtotal (Before Bonuses)			50
Complex Patient Bonus			3
Final Score (not to exceed 100)			**53**

BILLING CODE 4120–01–C

We note that these examples are not intended to be exhaustive of the types of participants in MIPS nor the opportunities for reaching and exceeding the performance threshold.

f. Targeted Review and Data Validation and Auditing

For previous discussions of our policies for targeted review, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77353 through 77358).

In the CY 2020 PFS proposed rule (84 FR 40809 through 40810), we proposed to: (1) Identify who is eligible to request a targeted review; (2) revise the timeline for submitting a targeted review request; (3) add criteria for denial of a targeted review request; (4) update requirements for requesting additional information; (5) state who will be notified of targeted review decisions and require retention of documentation submitted; and (6) codify the policy on scoring recalculations. These proposals are discussed in more detail in this section of the final rule.

(1) Targeted Review

(a) Who Is Eligible To Request Targeted Review

In the CY 2017 Quality Payment Program final rule, we established at § 414.1385(a) that MIPS eligible clinicians and groups may submit a targeted review request and that these submissions could be with or without the assistance of a third party intermediary (81 FR 77353). As we stated in the CY 2020 PFS proposed rule (84 FR 40809), in our efforts to minimize burden on MIPS eligible

clinicians and groups, we believe it is important to allow designated support staff and third party intermediaries to submit targeted review requests on their behalf. To expressly acknowledge the role of designated support staff and third party intermediaries in the targeted review process, we proposed to revise § 414.1385(a)(1) to state that a MIPS eligible clinician or group (including their designated support staff), or a third party intermediary as defined at § 414.1305, may submit a request for a targeted review. MIPS eligible clinicians and groups (including their designated support staff) can request a targeted review by logging into the Quality Payment Program website at *qpp.cms.gov,* and after reviewing their performance feedback for the relevant performance period and MIPS payment year, they can submit a request for targeted review. An authorized third party intermediary as defined at § 414.1305, such as a qualified registry, health IT vendor, or QCDR, that does not have access to their clients' performance feedback still would be able to request a targeted review on behalf of their clients. Third party intermediaries do not have access to the performance feedback of MIPS eligible clinicians and groups; therefore, we will share an URL link to the Targeted Review Request Form with these designated entities. In the CY 2017 Quality Payment Program final rule, we established at § 414.1385(a)(2) that we will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted (81 FR 77353). We proposed to redesignate this provision as § 414.1385(a)(4).

The following is a summary of the comments we received on the proposals regarding who is eligible to request targeted review and our responses.

Comment: Several commenters supported the proposal for a MIPS eligible clinician, group (including their designated support staff), or a third-party intermediary to have the ability to submit a request for a targeted review because of the belief that the policy takes into account resources of small and mid-sized groups and reduces administrative burden on physician practices. Commenters also supported the proposal because they believed third party intermediaries may potentially have more of a working knowledge of measure scoring and streamlining review requests, which may expedite review and approval of a targeted review request.

Response: We agree that the proposal allowing for a MIPS eligible clinician, group (including their designated support staff), or a third-party intermediary to submit a request for a targeted review takes into account the resources of small and mid-sized groups. We recognize the benefit of allowing those working with clinicians, such as support staff and third party intermediaries, to submit a targeted review request therefore reducing burden for MIPS eligible clinicians and groups and improving the efficiency of the targeted review process.

After consideration of the public comments received, we are finalizing our proposal, as proposed, to revise § 414.1385(a)(1) to state that a MIPS eligible clinician or group (including their designated support staff), or a third party intermediary as defined at § 414.1305, may submit a request for a targeted review. We received no comments on our proposal to redesignate as § 414.1385(a)(4) the provision previously designated as § 414.1385(a)(2), which states that we will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted and are finalizing the redesignation as proposed.

(b) Timeline for Targeted Review Requests

In the CY 2017 Quality Payment Program final rule (81 FR 77358), we finalized at § 414.1385(a)(1) that MIPS eligible clinicians and groups have a 60-day period to submit a request for targeted review, which begins on the day we make available the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor (collectively referred to as the MIPS payment adjustment factors), for the MIPS payment year and ends on September 30 of the year prior to the MIPS payment year or a later date specified by CMS. During the first year of targeted review for MIPS, we allowed MIPS eligible clinicians and groups 90 days, with an additional 14-day extension, to submit a targeted review request. In response to user feedback, in December 2018, we made available revised performance feedback to MIPS eligible clinicians and groups who had filed a targeted review request. As we stated in the CY 2020 PFS proposed rule (84 FR 40809), we believe it is important to ensure MIPS eligible clinicians and groups have an opportunity to review their revised performance feedback prior to the application of the MIPS payment adjustment factors. We stated that we anticipate that by limiting the targeted review period to 60 days, we would be able to make available the revised performance feedback during October of the year prior to the MIPS payment year, which would be approximately 2 months earlier than what we were able to do for the first year of targeted review. Therefore, we proposed to revise § 414.1385(a)(2) to state that all requests for targeted review must be submitted during the targeted review request submission period, which is a 60-day period that begins on the day CMS makes available the MIPS payment adjustment factors for the MIPS payment year, and to state that the targeted review request submission period may be extended as specified by CMS. We proposed this change would apply beginning with the 2019 performance period.

The following is a summary of the comments we received on the proposals regarding the timeline for targeted review requests and our responses.

Comment: A few commenters supported the proposal to change the timeline for submitting a targeted review request to 60 days because of their belief that it is a reasonable amount of time, may allow for a consistent period of time to submit questions, and may give CMS flexibility if feedback reports are delayed.

Response: We agree that the proposal to limit the period for submitting a targeted review request to 60 days is reasonable and adequate.

Comment: A few commenters expressed concern with the proposal to change the timeline for submitting a targeted review request to 60 days because they indicated it may limit an eligible clinician's time to review their performance feedback report, particularly eligible clinicians who may have been assessed inaccurately. One commenter expressed concern and recommended increased transparency related to the timeline for targeted review requests for eligible clinicians, groups (and their support staff), and third-party intermediaries. One commenter expressed concern over the proposal and recommended adding a targeted review category specific to vendor issues that would apply to eligible clinicians who experienced a data submission issue caused by a third-party intermediary. One commenter expressed concern and recommended adding an exception to the targeted review timeline for eligible clinicians and groups who have received an automatic extreme and uncontrollable circumstances exception.

Response: We believe that a 60-day submission period for targeted review requests is sufficient, as we have seen that eligible clinicians or groups who have identified errors typically submit targeted review requests at the start of the targeted review request submission

period, with a significant decrease in targeted review requests towards the end of the period. The release of the MIPS payment adjustment factors and performance feedback reports at the start of the targeted review request submission period would allow ample time for eligible clinicians, groups (and their support staff), and third-party intermediaries to properly submit an informed targeted review request. We believe that our proposal to limit the targeted review request submission period to 60 days would provide transparency related to the timeline for targeted review requests. We appreciate the recommendation of adding a targeted review category specific to third party intermediary issues. However, we continue to believe that MIPS eligible clinicians and groups are ultimately responsible for the data that is submitted by their third party intermediary and should hold their third party intermediary accountable for accurate reporting. In addition, in section III.K.3.d.(2)(b)(ii)(A) of this final rule, we are establishing a policy to reweight the performance categories for a MIPS eligible clinician who we determine has data that are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician or its agents, which could address some of the commenter's concerns about vendor issues. We appreciate the feedback concerning extreme and uncontrollable circumstances. We will continue to reweight the performance categories for MIPS eligible clinicians who qualify for the automatic extreme and uncontrollable circumstances policy, without the submission of a targeted review request, and we do not believe an exception to the targeted review timeline is warranted.

Comment: One commenter recommended aligning the MIPS and APM timelines in order for MIPS targeted reviews to be completed prior to the release of the APM results because they believe it may allow for corrections to reflect the final ACO Quality Scores and Shared Savings rates.

Response: We currently send unofficial reports to eligible clinicians that do reflect a change in ACOs, as a result of a targeted review or other changes. Due to ACO scoring update parameters, unfortunately, the APM and MIPS programmatic timing of report releases and the end of targeted review cannot be aligned.

After consideration of the public comments received, we are finalizing our proposal, as proposed, to revise § 414.1385(a)(2) to state that all requests for targeted review must be submitted during the targeted review request submission period, which is a 60-day period that begins on the day we make available the MIPS payment adjustment factors for the MIPS payment year, and to state that the targeted review request submission period may be extended as specified by CMS. We are finalizing our proposal, as proposed, that this change will apply beginning with the 2019 performance period.

(c) Denial of Targeted Review Requests

Each targeted review request is carefully reviewed based upon the information provided at the time the request is submitted. During the first year of targeted review, CMS received many targeted review requests that were duplicative. We continue to seek opportunities to limit burden and improve the efficiency of our processes. Therefore, we proposed (84 FR 40810) to revise § 414.1385(a)(3) to state that a request for a targeted review may be denied if: The request is duplicative of another request for targeted review; the request is not submitted during the targeted review request submission period; or the request is outside of the scope of targeted review, which is limited to the calculation of the MIPS payment adjustment factors applicable to the MIPS eligible clinician or group for a year. We stated that notification would be provided to the individual or entity that submitted the targeted review request as follows:

- If the targeted review request is denied; in this case, there will be no change to the MIPS final score or associated MIPS payment adjustment factors for the MIPS eligible clinician or group.
- If the targeted review request is approved; in this case, the MIPS final score and associated MIPS payment adjustment factors may be revised, if applicable, for the MIPS eligible clinician or group.

The following is a summary of the comments we received on the proposals regarding the denial of targeted review requests and our responses.

Comment: One commenter suggested that CMS should not deny both requests for targeted review if duplicate requests are received because they indicated it may be punitive to eligible clinicians who are attempting to fix issues in their performance feedback, MIPS final scores, and/or payment adjustment determination.

Response: We agree and will only deny the duplicate request for a targeted review, not the initial request. If there is a change to an eligible clinician or groups performance feedback, MIPS final scores, and/or payment adjustment determination, that targeted review would not be considered a duplicate but viewed as additional information around that initial targeted review request.

Comment: One commenter expressed concern with the proposal to add criteria for denial of a targeted review request and recommended instituting a process for reviewing targeted review requests that have been denied because of their belief that such a review process may promote integrity within MIPS.

Response: We believe that establishing the reasons for which a targeted review request may be denied creates transparency with the targeted review process and MIPS, and improves the efficiency of our processes. However, we believe that further review of requests that have been denied may be counterproductive to the efficiency of our processes. We note that section 1848(q)(13)(A) of the Act describes the review process as ''targeted'' and ''informal,'' and on that basis, we do not believe that further review of requests that have been denied is warranted (81 FR 77353).

After consideration of the public comments received, we are finalizing our proposal, as proposed, to revise § 414.1385(a)(3) to state that a request for a targeted review may be denied if: The request is duplicative of another request for targeted review; the request is not submitted during the targeted review request submission period; or the request is outside of the scope of targeted review, which is limited to the calculation of the MIPS payment adjustment factors applicable to the MIPS eligible clinician or group for a year.

(d) Request for Additional Information

In the CY 2017 Quality Payment Program final rule (81 FR 77358), we finalized at § 414.1385(a)(3) that the MIPS eligible clinician or group may include additional information in support of their request for targeted review at the time the request is submitted, and if CMS requests additional information from the MIPS eligible clinician or group, it must be provided and received by CMS within 30 days of the request, and that non-responsiveness to the request for additional information may result in the closure of the targeted review request, although the MIPS eligible clinician or group may submit another request for targeted review before the deadline. Supporting documentation is a critical component of evaluating and processing a targeted review request. We may need to request supporting documentation, as

each targeted review request is reviewed individually and by category. Therefore, we proposed (84 FR 40810) to add § 414.1385(a)(5) to state that a request for a targeted review may include additional information in support of the request at the time it is submitted. If CMS requests additional information from the MIPS eligible clinician or group that is the subject of a request for a targeted review, it must be provided and received by CMS within 30 days of CMS' request. Non-responsiveness to CMS' request for additional information may result in a final decision based on the information available, although another request for a targeted review may be submitted before the end of the targeted review request submission period. Documentation can include, but is not limited to:

- Supporting extracts from the MIPS eligible clinician or group's EHR.
- Copies of performance data provided to a third party intermediary by the MIPS eligible clinician or group.
- Copies of performance data submitted to CMS.
- Quality Payment Program Service Center ticket numbers.
- Signed contracts or agreements between a MIPS eligible clinician/group and a third party intermediary.

The following is a summary of the comments we received on the proposals regarding requests for additional information and our responses.

Comment: Commenters expressed concern regarding the proposal to update requirements for requesting additional information as part of targeted review, specifically recommending a one-time extension of the 30-day timeframe for eligible clinicians and groups to submit additional information. A commenter shared their belief that quality data held by a third party intermediary may not be accessible within the 30-day timeframe.

Response: We agree that in certain circumstances, an extension to the 30-day timeframe may be warranted. We will consider granting an extension on a case-by-case basis, but the request for an extension should be submitted before the end of the 30-day period.

After consideration of the public comments received, we are finalizing our proposal, with modification, to add § 414.1385(a)(5) to state that a request for a targeted review may include additional information in support of the request at the time it is submitted. If we request additional information from the MIPS eligible clinician or group that is the subject of a request for a targeted review, it must be provided and received by CMS within 30 days of CMS' request. Non-responsiveness to our request for additional information may result in a final decision based on the information available, although another non-duplicative request for a targeted review may be submitted before the end of the targeted review request submission period. The modification to the regulation text is intended to clarify that if another request for targeted review is submitted, it cannot be duplicative of a prior request.

(e) Notification of Targeted Review Decisions

In the CY 2017 Quality Payment Program final rule (81 FR 77358), we finalized at § 414.1385(a)(4) that decisions based on the targeted review are final, and there is no further review or appeal. We proposed (84 FR 40810) to renumber this paragraph as § 414.1385(a)(7) and to add text to § 414.1385(a)(7) to state that CMS will notify the individual or entity that submitted the request for a targeted review of the final decision. To align with policies finalized at § 414.1400(g) regarding the auditing of entities submitting MIPS data, we also proposed to add § 414.1385(a)(8) to state that documentation submitted for a targeted review must be retained by the submitter for 6 years from the end of the MIPS performance period.

The following is a summary of the comments we received on the proposals regarding the notification of targeted review decisions and our responses.

Comment: One commenter did not support our existing policy that targeted review decisions are final and no appeal or further review may be requested. They recommended that the targeted review process should expand beyond a one-level process, allow for live technical assistance, and include detailed feedback on the results, particularly on why eligible clinicians or groups may have a particular score. They noted that these changes to the process may help identify areas for improvement and may decrease errors over time.

Response: As mentioned in a prior response, we believe that further review of targeted review decisions may be counterproductive to the efficiency of our processes. We again note that section 1848(q)(13)(A) of the Act describes the review process as ''targeted'' and ''informal,'' and on that basis, we do not believe that a second level of review process is warranted. At this time, we cannot operationalize live technical assistance on performance feedback or scores due to time required for researching individual data, program limitations and the volume of targeted review requests received. We currently hold webinars for stakeholder engagement and that may highlight areas of improvement and possibly decrease errors over time.

Comment: One commenter supported the proposal to require retention of documentation submitted for targeted review for 6 years because they believed that it may ensure accuracy of targeted reviews.

Response: We agree that the proposal to require retention of documentation submitted for targeted review for 6 years is beneficial and maintains integrity within the targeted review process.

After consideration of the public comments received, we are finalizing our proposal, as proposed, to add § 414.1385(a)(8) to state that documentation submitted for a targeted review must be retained by the submitter for 6 years from the end of the MIPS performance period. We did not receive comments on our proposal to renumber as § 414.1385(a)(7), the provision at § 414.1385(a)(4), which states that decisions based on the targeted review are final, and there is no further review or appeal and we are finalizing this renumbering as proposed.

(f) Scoring Recalculations

In the CY 2017 Quality Payment Program final rule (81 FR 77353), we stated that if a request for targeted review is approved, the outcome of such review may vary. We stated, for example, we may determine that the clinician should have been excluded from MIPS, re-distribute the weights of certain performance categories within the final score (for example, if a performance category should have been weighted at zero), or recalculate a performance category score in accordance with the scoring methodology for the affected category, if technically feasible (81 FR 77353). Therefore, we proposed (84 FR 40810) to add § 414.1385(a)(6) to state that if a request for a targeted review is approved, CMS may recalculate, to the extent feasible and applicable, the scores of a MIPS eligible clinician or group with regard to the measures, activities, performance categories, and final score, as well as the MIPS payment adjustment factors.

The following is a summary of the comments we received on the proposals regarding scoring recalculations and our responses.

Comment: A commenter recommended that once a targeted review is approved and if the score of an eligible clinician or group with regard to measures, activities, performance categories, and final score, as well as payment adjustment is

changed, a written alert should be issued to the eligible clinician or group that provides additional details explaining the change.

Response: After we notify the submitter of a targeted review request of our final decision, the MIPS eligible clinician or group that is the subject of the request should review their performance feedback regarding updated performance category or final score results. We will consider an automated notification of performance feedback changes with basic explanation in future years.

We are finalizing our proposal, as proposed, to add § 414.1385(a)(6) to state that if a request for a targeted review is approved, we may recalculate, to the extent feasible and applicable, the scores of a MIPS eligible clinician or group with regard to the measures, activities, performance categories, and final score, as well as the MIPS payment adjustment factors.

(2) Data Validation and Auditing

For previous discussions of our policies for data validation and auditing at § 414.1390, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77358 through 77362). Among other requirements, § 414.1390(b) establishes that all MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must certify to the best of their knowledge that the data submitted is true, accurate and complete. MIPS data that are inaccurate, incomplete, unusable or otherwise compromised can result in improper payment. Despite these existing obligations, we have received inquiries regarding perceived opportunities to selectively submit data that are unrepresentative of the MIPS performance of the clinician or group. Using data selection criteria to misrepresent a clinician or group's performance for an applicable performance period, commonly referred to as ''cherry-picking,'' results in data submissions that are not true, accurate or complete. A clinician or group cannot certify that data submitted to CMS are true, accurate and complete to the best of its knowledge if they know the data submitted is not representative of the clinician's or group's overall performance for a performance period. Accordingly, a clinician or group that submits a certification under § 414.1390(b) in connection with the submission of data they know is cherry-picked has submitted a false certification in violation of existing regulatory requirements. If we believe cherry-picking of data may be occurring, we may subject the MIPS eligible clinician or group to auditing in accordance with § 414.1390(a) and in the case of improper payment a reopening and revision of the MIPS payment adjustment in accordance with § 414.1390(c).

The following is a summary of the comments we received on data validation and auditing and our responses.

Comment: One commenter recommended that CMS publish aggregate findings of previous audits with regard to suspected instances of cherry-picked data.

Response: We appreciate the feedback and will consider publishing the aggregate findings of previous audits surrounding cherry-picked data in connection with future educational efforts.

Comment: A commenter requested clarification that if a clinician who submits data on a single patient in order to receive the minimum point threshold for a quality measure, CMS would not conclude the clinician was cherry-picking data.

Response: We are clarifying that existing policy takes into consideration that MIPS eligible clinicians may submit data in accordance with CMS data submission requirements on a single measure. We believe that even in the context of submitting data on a single patient in order to receive the minimum point threshold, the patient selected should be representative. In other instances where cherry-picking is suspected, we will determine whether a clinician is using selection criteria inappropriately to create an unrepresentative submission for MIPS performance on a case-by-case basis. For additional policies on MIPS final score methodologies, we refer readers to section III.K.3.d of this final rule.

Comment: A few commenters supported the statement that if CMS believes the cherry-picking of data may be occurring, a MIPS eligible clinicians or group may be audited and in the case of improper payment, MIPS payment adjustment may be reopened and revised.

Response: We appreciate the commenters support and agree that if the cherry-picking of data is suspected that a MIPS eligible clinician or group may be audited and in the case of improper payment, a MIPS payment adjustment may be reopened and revised.

g. Third Party Intermediaries

We refer readers to §§ 414.1305 and 414.1400, the CY 2017 Quality Payment Program final rule (81 FR 77362 through 77390), the CY 2018 Quality Payment Program final rule (82 FR 53806 through 53819), and the CY 2019 PFS final rule (83 FR 59894 through 59910) for our previously established policies regarding third party intermediaries.

In the CY 2020 PFS proposed rule (84 FR 40811 through 40821), we proposed to make several changes. We proposed to establish new requirements for MIPS performance categories that must be supported by QCDRs, qualified registries, and Health IT vendors. We proposed to modify the criteria for approval as a third party intermediary, and establish new requirements to promote continuity of service to clinicians and groups that use third party intermediaries for their MIPS submissions. With respect to QCDRs, we also proposed requirements to: Engage in activities that will foster improvement in the quality of care; and enhance performance feedback requirements. These QCDR proposals would also affect the self-nomination process. We also proposed to update considerations for QCDR measures. With respect to qualified registries, we also proposed to require enhanced performance feedback requirements. Finally, we clarified the remedial action and termination provisions applicable to all third party intermediaries.

Because we believe that third party intermediaries, such as QCDRs, represent a useful path to fulfilling MIPS requirements while reducing the reporting burden for clinicians, we believe the policies discussed in this section justify the Collection of Information and Regulatory Impact Analysis burden estimates discussed in sections VI. and VII. of this final rule, respectively, for additional information on the costs and benefits.

(1) Requirements for MIPS Performance Categories That Must Be Supported by Third Party Intermediaries

We refer readers to § 414.1400(a)(2) and the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at § 414.1400(a)(2) (83 FR 60088) for our current policy regarding the types of MIPS data third-party intermediaries may submit. In summary, the current policy is that QCDRs, qualified registries, and health IT vendors may submit data for any of the following MIPS performance categories: Quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability. Through education and outreach, we have become aware of stakeholders' desires to have a more cohesive participation experience across

all performance categories under MIPS. Specifically, we have heard of instances where clinicians would like to use their QCDR or qualified registry for reporting the improvement activities and promoting interoperability performance categories, but their particular third party intermediary does not support all categories, only quality. Based on this feedback and additional data regarding QCDRs and qualified registries respectively, which are discussed further below, we believe it is reasonable to strengthen our policies at § 414.1400(a)(2), and require QCDRs and qualified registries to support three performance categories: Quality; improvement activities; and Promoting Interoperability. Accordingly, we proposed to amend § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year (2021 performance period) and for all future years, for the MIPS performance categories identified in the regulation, QCDRs and qualified registries must be able to submit data for each category, and Health IT vendors must be able to submit data for at least one category (84 FR 40811). We solicited feedback on the benefits and burdens of this proposal, including whether the requirement to support all three identified categories of MIPS performance data should extend to health IT vendors.

As discussed in the CY 2020 PFS proposed rule, however, we recognized the need to create an exception such that third party intermediaries would not be required to submit data for the Promoting Interoperability performance category if it only represents MIPS eligible clinicians, groups and virtual groups that are eligible for reweighting under the Promoting Interoperability performance category. For example, as discussed in the CY 2019 PFS final rule (83 FR 59819 through 59820), physical therapists generally are eligible for reweighting of the Promoting Interoperability performance category to zero percent of the final score; therefore, under this exception, a QCDR or qualified registry that represents only physical therapists that reweighted the Promoting Interoperability performance category to zero percent of the final score, would not be required to support the Promoting Interoperability performance category. Therefore, we proposed to revise § 414.1400(a)(2)(iii) to state that for the Promoting Interoperability performance category, the requirement applies if the eligible clinician, group, or virtual group is using CEHRT; however, a third party could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(1)–(7) or § 414.1380(c)(2)(i)(C)(*9*) (84 FR 40811). We refer readers to section III.K.3.c.(4) of this final rule for additional information on the clinician types that are eligible for reweighting the Promoting Interoperability performance category. We noted that we anticipate using the self-nomination vetting process to assess whether the QCDR or qualified registry is subject to our requirement to support reporting the Promoting Interoperability performance category. We solicited comments on this proposal, including the scope of the exception from the Promoting Interoperability reporting requirement for certain types of QCDRs and qualified registries. Specifically, we solicited comment on whether we should more narrowly tailor, or conversely broaden, the proposed exceptions for when QCDRS and qualified registries must support the Promoting Interoperability performance category.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Many commenters expressed their agreement with the proposal to require QCDRs and qualified registries to support the reporting of data for the quality, Promoting Interoperability, and the improvement activities performance categories, as well as the exemption for third party intermediaries who only serve specialties that are exempt from the Promoting Interoperability performance category.

Response: We thank commenters for their support. We direct readers to the QCDR and qualified registry sections below III.K.3.g.(3) and III.K.3.g.(4) for detailed comment and responses regarding these proposals.

Comment: Several commenters expressed their belief that the scope of proposals in the proposed rule negatively impacts QCDRs and Qualified Registries in general to the point where some third-party intermediaries may end their participation in MIPS. They believe the proposals shift costs and burden of administering the MIPS program onto physicians via their specialty societies that create measures and have QCDRs and require QCDRs to perform services that were not part of the original quality program.

Response: The intent of our proposals is to ensure that the QCDRs and qualified registries that are approved in the program are of the highest quality, and can be used as reliable resources to support quality reporting on behalf of eligible clinicians and groups. We understand that an increase in requirements may cause increased burden to QCDRs and qualified registries, but believe that high-performing third party intermediaries are capable of meeting these requirements. Through the legacy PQRS program and the first few years of MIPS, we have witnessed instances of third party intermediaries, specifically QCDRs and qualified registries leaving the program mid-performance period, creating additional burden to the clinicians who were depending on them for reporting purposes. There have also been instances where QCDRs and qualified registries were unable to support measures, after indicating they could, or having errors related to data submissions. We believe these type of issues also contribute to clinician burden and are addressed through our additional policies as described in this section of the final rule. We refer readers to the Collection of Information and Regulatory Impact Analysis burden estimates discussed in sections VI. and VII. of this final rule, respectively, for additional information on the costs and benefits related to our finalized policies.

Comment: Many commenters opposed the proposal to require QCDRs to support the reporting of data for the quality, Promoting Interoperability, and improvement activities performance categories, specifically citing the requirements to audit and validate Promoting Interoperability data and improvement activities. Several of the commenters stated their opinion that this would represent a significant additional burden, in part due to what they believe to be large increase in the data that would need to be collected without adding any distinct benefit to MIPS eligible clinicians and groups who already have other methods available for reporting MIPS data, and that some QCDRs may incur additional costs from EHR vendors who may charge fees for providing additional necessary reports. One commenter also cited their belief that the QCDRs/registries currently supporting the Promoting Interoperability performance category use a health information exchange (*https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie*) and that vendors operating in areas that do not have a health information exchange would not be able to report on these measures. A few commenters cited their opinion that if the proposal is finalized, the resulting burden may result in many QCDRs electing to reevaluate their decisions to

seek approval to submit MIPS data. A few commenters also stated their opinion that if the proposal is finalized, they would need CMS to provide additional guidance and descriptions of what data would be necessary to validate that an individual MIPS eligible clinician or group could appropriately attest to a specific improvement activity.

Response: We thank the commenters for their suggestions. However, in this case, a majority of existing qualified registries and QCDRs already support all three performance categories which require data submission. We do acknowledge that a small minority of qualified registries and QCDRs may not be able to comply with this requirement, and as a result may elect not to continue in the Quality Payment Program. While we do not yet have data to share for how clinicians participated in 2019 (year 3), we do want to indicate that we have observed from 2017 (year 1) to 2018 (year 2) approximately 24 percent increasing to 36 percent of clinicians have used their QCDR/qualified registry for submitting for all 3 performance categories. We believe when this policy becomes finalized, more MIPS eligible clinicians may want to use this method as a burden reduction on data submission. We also believe the added benefit this policy provides to clinicians who want to use a qualified registry or QCDR to support data submission for the three performance categories outweighs the small number of qualified registries and QCDRs that are not able to comply, and that is why we are taking this step to finalize this policy.

As described in the CY 2017 Quality Payment Program final rule (81 FR 77366 and 81 FR 77384), QCDRs and qualified registries must audit a subset of data prior to submission for all performance categories that the QCDR or qualified registry is submitting data on, that is, quality, improvement activities, and promoting interoperability (previously known as advancing care information). We understand that this policy will require the minority of existing QCDRs and qualified registries who do not support all three performance categories to take on additional efforts and resources to support the remaining performance categories in order to retain their approval. Although some EHR vendors may charge for reports, we believe that the costs will be minimal because CEHRT includes the capability to calculate the Promoting Interoperability measures and the reports that must be generated. In addition, the use of health information exchanges (*https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie*) is an option for transmitting data; their use is not a requirement.

However, we believe that this policy allows for QCDRs and qualified registries to become one-stop-shops for reporting, and will thereby reduce reporting burden for eligible clinicians and groups. Under our current data validation processes, as described in the CY 2017 Quality Payment Program final rule (81 FR 77368 through 77369) and (81 FR 77384 through 77385), QCDRs and qualified registries are required to provide information on their sampling methodology. For example, it is encouraged that 3 percent of TIN/NPIs submitted be sampled with a minimum sample of 10 TIN/NPIs or a maximum sample of 50 TIN/NPIs. For each TIN/NPI sampled, it is encouraged that 25 percent of the TIN/NPI's patients (with a minimum sample of 5 patients (with a maximum sample of 50 patients). We would expect that this review of patient medical records would be done to validate that the pertinent quality actions were done for measures and activities done by the clinician and group. In addition, validation guidance clarifications can be found within the improvement activities validation document at the *MIPS Data Validation Document* link.

Comment: A few commenters asserted that CMS should remunerate QCDRs for the associated cost of performing pre-submission audits of the 3 performance categories.

Response: We disagree that we should have to remunerate QCDRs for the cost associated with validating QCDR data prior to submission for the three performance categories, as we believe validation is a part of the duties of a QCDR.

Comment: A few commenters stated that if the proposal is finalized, it should not be finalized for the 2020 self-nomination process as it does not give QCDRs or clinicians enough time to incorporate it into their processes and workflows.

Response: We clarify that this policy will not be required by QCDRs or qualified registries for the 2020 self-nomination process. As stated in the CY 2020 PFS proposed rule (84 FR 40811), we proposed that beginning with the 2021 performance period and for future years, to require QCDRs to support three performance categories: Quality, improvement activities; and Promoting Interoperability. This policy would take effect beginning with the 2023 MIPS payment year or the 2021 performance period. Specifically, the 2021 self-nomination period which begins on July 1, 2020 and ends on September 1, 2020, which gives QCDRs sufficient time to incorporate this reporting into their workflows. As mentioned above, based on our review, a majority of QCDRs and qualified registries already support all three performance categories, and therefore, they should already have it incorporated into their processes and workflows. To clarify, this policy requires that QCDRs and qualified registries support all three performance categories, but does not require that an eligible clinician or group to report all three performance categories through a QCDR or qualified registry. We note in this final rule that the 2021 performance period corresponds to the 2023 MIPS payment years and are updating our policies to reflect this terminology for consistency.

Comment: One commenter stated that the proposals to require QCDRs and qualified registries to support the reporting of the quality, Promoting Interoperability, and improvement activities performance categories does not appropriately account for use cases in which a health IT vendor acts as both an EHR and a QCDR/qualified registry. The commenter asked CMS to exempt organizations that are EHRs that also have met the requirements to be considered a QCDRs/Qualified Registries from the requirement for QCDRs/Qualified Registries to support all three performance categories if the vendor offers the ability to support the reporting of the remaining performance categories through their EHR. The commenter further believed that a health IT vendor who supports all performance categories, regardless of whether it is accomplished via EHR or qualified registry/QCDR, will suffice in terms of supporting clinicians who participate in MIPS. One commenter expressed the belief that health IT vendors should be held to the same standards as QCDRs and qualified registries, particularly considering that EHRs contain much of the data needed to report on any of the three categories, and as such, CEHRT should be able to support and report on all three performance categories.

Response: We believe that a qualified registry or QCDR should support all three performance categories, regardless of the other types of services they may provide. Health IT vendors and other organizations who act as an EHR in addition to being a QCDR or qualified registry would not be exempt from this requirement. The intent of requiring QCDRs and qualified registries to support all three performance categories is to reduce reporting burden on behalf of the clinician who may have previously been forced to use multiple submission types to report to CMS for

purposes of MIPS. In addition, we appreciate the commenter's feedback that health IT vendors should be held to the same standards as QCDRs and qualified registries, and may consider this feedback in future rulemaking. We also believe it is important for all approved QCDRs and qualified registries to be able to submit MIPS data in all MIPS performance categories as needed by their MIPS eligible clinicians, groups, and virtual groups. Our policy goal is to reduce burden on clinicians and groups by ensuring they can use a single third party intermediary to submit all data on quality, improvement activities, and promoting interoperability. Creating an exception if multiple intermediaries are owned by the same organization would be inconsistent with this goal. For example, some organizations could require an eligible clinician or group to pay two separate fees, one to use its QCDR or qualified registry, and another to use its EHR. We would like to streamline services in order to give eligible clinicians and groups a less burdensome reporting experience. We note that we will be monitoring changes in this space.

Comment: A few commenters stated that the proposed exemption for qualified registries and QCDRs whose participants receive an exemption under the special status categories for the Promoting Interoperability performance category is unclear. Specifically, a commenter stated that CMS does not provide an indication as to the percentage of participants that would have to be exempt for the qualified registry or QCDR to not have to accept and submit Promoting Interoperability data, while another commenter sought clarity as to which specific specialties would be subject to the exemption.

Response: QCDRs and qualified registries are expected to support data submission in the MIPS performance category for Promoting Interoperability for each of its MIPS eligible clinicians, groups or virtual groups to which this performance category applies. However, a third party could be excepted from this requirement if all of the third party intermediary's MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(1)(7) or § 414.1380(c)(2)(i)(C)(*9*) (84 FR 40811). Accordingly, a third party intermediary may not be required to submit data for the Promoting Interoperability performance category if it only represents MIPS eligible clinicians, groups, and virtual groups that are eligible for reweighting under the Promoting Interoperability performance category. For example, as discussed in the CY 2019 PFS final rule (83 FR 59819 through 59820), physical therapists generally are eligible for reweighting of the Promoting Interoperability performance category to zero percent of the final score; therefore, under this exception, a QCDR or qualified registry that represents only physical therapists that reweighted the Promoting Interoperability performance category to zero percent of the final score, would not be required to support the Promoting Interoperability performance category. Similarly, a QCDR or qualified registry may not be required to support the Promoting Interoperability performance category if it supported only following clinician types: Occupational therapists; qualified speech-language pathologists; qualified audiologists; clinical psychologists; and registered dieticians or nutrition professionals, as described in § 414.1380(c)(2)(i)(A)(4). In contrast, a QCDR or qualified registry cannot be excepted from this requirement and must be able to submit data for the Promoting Interoperability performance category so long as it supports any clinician, group or virtual group that uses CEHRT and is not identified as eligible for reweighting of the Promoting Interoperability performance category. We refer readers to section III.K.3.c.(4) of this final rule for additional details on the Promoting Interoperability performance category.

After consideration of the comments, we are finalizing our proposals with technical modifications for clarity and consistency with the existing provisions of § 414.1400. Specifically, we are finalizing changes to § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all of the MIPS performance categories identified in the regulation, and Health IT vendors must be able to submit data for at least one such category. We are also finalizing our proposal to amend § 414.1400(a)(2)(iii), as proposed, to state that for the Promoting Interoperability, if the eligible clinician, group, or virtual group is using CEHRT; however, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (*5*) or § 414.1380(c)(2)(i)(C)(*1*) through (*7*) or § 414.1380(c)(2)(i)(C)(*9*).

(2) Approval Criteria for Third Party Intermediaries

We refer readers to § 414.1400(a)(4) and the CY 2019 PFS final rule (83 FR 59894 through 59895, 60088) for previously finalized policies related to the approval criteria for third party intermediaries.

Based on experience with third party intermediaries thus far, in the CY 2020 PFS proposed rule (84 FR 40811), we proposed to adopt two additional criteria for approval at § 414.1400(a)(4) to ensure continuity of services to MIPS eligible clinicians, groups, and virtual groups that utilize the services of third party intermediaries. Specifically, we have experienced instances where a third party intermediary withdraws mid-performance period, which impacts the clinician or group's ability to participate in the MIPS program, through no fault of their own. We proposed two changes to help prevent these disruptions (84 FR 40811 through 40812). First, we proposed at § 414.1400(a)(4) to add a new paragraph (v) to establish that a condition of approval for a third party intermediary is for the entity to agree to provide services for the entire performance period and applicable data submission period (84 FR 40812). In addition, we proposed at § 414.1400(a)(4) to add a new paragraph (vi) to establish that a condition of approval is for a third party intermediary to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate data submission mechanism or third party intermediary according to a CMS approved transition plan (84 FR 40812). We believe it is important to condition the approval of a third party intermediary on the entity agreeing to follow this process so that in the case a third-party intermediary fails to meet its obligation under the proposed § 414.1400(a)(4)(v) to provide services for the entire performance period and corresponding data submission period, the third party intermediary and the clinicians, groups, and virtual groups it serves have common expectations of the support the third party intermediary will provide to its users in connection with its withdrawal (84 FR 40812). We believe these proposed conditions of approval will help ensure that entities seeking to become approved as third party intermediaries are aware of the expectations to provide continuous service for the duration of the entire performance period and corresponding data submission period, will help reduce the extent to which the clinicians, groups, and virtual groups are inadvertently impacted by a third

party intermediary withdrawing from the program, and will help clinicians, groups, and virtual groups avoid additional reporting burden that may result from withdrawals mid-performance period (84 FR 40812). We note that we proposed, if CMS determines that a third party intermediary has ceased to meet either of these proposed criteria for approval, CMS may take remedial action or terminate the third party intermediary in accordance with § 414.1400(f) (84 FR 40812). We also refer readers to sections III.K.3.g.(3) and III.K.3.g.(4) of this final rule where we discuss these topics for QCDRs and qualified registries specifically.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported the proposal to require third party intermediaries to attest that they will provide services for the entire performance period and to agree to provide a transition plan to an alternative data submission mechanism or third-party intermediary prior to discontinuing services.

Response: We thank the commenters for their support.

Comment: One commenter stated that the requirement to provide transition plans for participants in the case of service discontinuation should not be approved as it would be extremely burdensome for a third party intermediary to have to do individual transition plans given that the decision in this circumstance lies with the clinicians and their practices to make such a transition. In place of the requirement, the commenter recommended that a ''CMS-approved transition advisory plan'' be developed due to its belief that additional requirements are unnecessary, without proven benefit, and would not lead to any earlier identification of quality issues. The same commenter encouraged CMS to remain sensitive to and flexible in dealing with any extenuating circumstances outside the registry's direct control that could lead to or cause an interruption in MIPS reporting services.

Response: We thank the commenter for their suggestions. We clarify that in instances where a clinician or group is leaving a third party intermediary on its own volition, a transition plan, while encouraged, is not required from a QCDR or a qualified registry. Our proposal addresses the opposite scenario—if QCDRs and qualified registries discontinue services to their MIPS eligible clinician, group or virtual group during a performance period. We believe it is important for a third party intermediary to agree that prior to discontinuing services, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate submitter type (and as needed alternate collection type) or third party intermediary according to a CMS approved a transition plan. We have experienced scenarios where QCDRs and qualified registries have withdrawn from participation in the middle of the performance period, which causes inadvertent burden on eligible clinicians and groups who have to then scramble to find alternative methods of submitting their data to us in order to satisfy the reporting requirements for a given performance year. Eligible clinicians and groups that use qualified registries or QCDRs, utilize them as a way to mitigate reporting burden. We disagree that requiring a transition plan is unnecessary and without benefit; QCDRs and qualified registries should explain their mitigation strategy in informing their clients on alternative methods of reporting. We appreciate the commenter's recommendation that we develop a ''CMS-approved transition advisory plan'', but disagree that it is appropriate. The strategy utilized in transitioning clients off a QCDR or qualified registry's platform should be left to the QCDR or qualified registry to determine, based on their size, volume of clinicians and groups, the timing to which they will completely discontinue service as a QCDR or registry, and other factors that may be unique to a given QCDR/qualified registries specific business relationship with a clinician. We believe it is important for each transition plan to take into consideration the above mentioned factors, which is why we believe it is appropriate to provide flexibility to the third party intermediaries to craft a transition plan for our review and approval. While we understand that sometimes issues arise outside of the registry's direct control, impacting a registry's ability to provide services, we believe that a transition plan should be required regardless of the reason that the third party intermediary is discontinuing services.

After consideration of the comments, we are finalizing at § 414.1400(a)(4), as proposed, to add a new paragraph (v) to establish that a condition of approval for a third party intermediary is for the entity to agree to provide services for the entire performance period and applicable data submission period. Also, we are finalizing at § 414.1400(a)(4) to add paragraph (vi) with modification. Instead of requiring the third party intermediary to support the transition of such MIPS eligible clinician, group, or virtual group to an alternate data submission mechanism or third party intermediary, we are finalizing that the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate submitter type, or for any measures on which data has been collected, alternate collection type or third party intermediary according to a CMS approved a transition plan. This modification to the specific submission terms in this policy is to be consistent with the terminology used in §§ 414.1325 and 414.1335 (83 FR 59749 through 59754). As such, we are finalizing at § 414.1400(a)(4) to add a new paragraph (vi) to establish that a condition of approval is for the third party intermediary to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan.

Third party intermediaries are not required to support the transition of MIPS eligible clinicians, groups, or virtual groups to an alternate collection type for measures on which no data has been collected. We note that for QCDR measures, supporting the transition to an alternate collection type may not be feasible in every case. If we determine that a third party intermediary has ceased to meet either of these criteria for approval, we may take remedial action or terminate the third party intermediary in accordance with § 414.1400(f).

(3) Qualified Clinical Data Registries (QCDRs)

In the CY 2020 PFS proposed rule (84 FR 40812 through 40814), we proposed: (a) QCDR approval criteria; and (b) various policies related to QCDR measures. These proposed policies would also affect the QCDR self-nomination process.

(a) QCDR Approval Criteria

We generally refer readers to section 1848(m)(3)(E) of the Act, as added by section 601(b)(1)(B) of the American Taxpayer Relief Act of 2012, which requires the Secretary to establish requirements for an entity to be

considered a Qualified Clinical Data Registry (QCDR) and a process to determine whether or not an entity meets such requirements. We refer readers to section 1848(m)(3)(E)(i), (v) of the Act, the CY 2019 PFS final rule (83 FR 60088), and § 414.1400(a)(4) through (b) for previously finalized policies about third party intermediaries and QCDR approval criteria. In the CY 2020 PFS proposed rule (84 FR 40812 through 40814), we proposed to add to those policies to require QCDRs to: (a) Support all three performance categories where data submission is required; (b) engage in activities that will foster improvement in the quality of care; and (c) enhance performance feedback requirements.

(i) Requirement for QCDRs To Support All Three Performance Categories Where Data Submission Is Required

In the CY 2020 PFS proposed rule (84 FR 40811), we proposed to require QCDRs and qualified registries to support three performance categories: Quality, improvement activities, and Promoting Interoperability. In this section, we discuss QCDRs specifically. As previously stated in the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364), section 1848(q)(1)(E) of the Act encourages the use of QCDRs in carrying out MIPS. Although section 1848(q)(5)(B)(ii)(I) of the Act specifically requires the Secretary to encourage MIPS eligible clinicians to use QCDRs to report on applicable measures for the quality performance category, and section 1848(q)(12)(A)(ii) of the Act requires the Secretary to encourage the provision of performance feedback through QCDRs, the statute does not specifically address use of QCDRs for the other MIPS performance categories (81 FR 77363). Although we previously could have limited the use of QCDRs to assessing only the quality performance category under MIPS and providing performance feedback, we believed (and still believe) it would be less burdensome for MIPS eligible clinicians if we expand QCDRs' capabilities (81 FR 77363). By allowing QCDRs to report on quality measures, improvement activities, and Promoting Interoperability measures, we alleviate the need for individual MIPS eligible clinicians and groups to use a separate mechanism to report data for these performance categories (81 FR 77363). It is important to note that QCDRs do not need to submit data for the cost performance category since these measures are administrative claims-based measures (81 FR 77363).

As noted above, based on previously finalized policies in the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at § 414.1400(a)(2) (83 FR 60088), the current policy is that QCDRs, qualified registries, and health IT vendors may submit data for any of the following MIPS performance categories: Quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability.

Through education and outreach, we have become aware of stakeholders' desires to have a more cohesive participation experience across all performance categories under MIPS. Specifically, we have heard of instances where clinicians would like to use their QCDR for reporting the improvement activities and promoting interoperability performance categories, but their particular QCDR does not support all categories, only quality. This results in the clinician needing to enter into a business relationship with another third party to complete their MIPS reporting or leverage a different submitter type or submission type, which can create additional burden to the clinician. We believe that requiring QCDRs to be able to support these performance categories will be a step towards addressing stakeholders concerns on having a more cohesive participation experience across all performance categories under MIPS. In addition, we believe this proposal will help to reduce the reporting burden MIPS eligible clinicians and groups face when having to utilize multiple submission mechanisms to meet the reporting requirements of the various performance categories. Furthermore, as we move to a more cohesive participation experience under the MIPS Value Pathways (MVP), as discussed in the CY 2020 PFS proposed rule (84 FR 40732 through 40745), we believe this proposal will assist clinicians in that transition. We also refer readers to section III.K.3.a. of this final rule where the MIPS MVP is discussed.

Based on our review of existing 2019 QCDRs through the 2019 QCDR Qualified Posting, approximately 92 QCDRs, or about 72 percent of the QCDRs currently participating in the program, are supporting all three performance categories. When the CY 2020 PFS proposed rule was published the 2019 QCDR Qualified Posting was available at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/347/2019%20QCDR%20Qualified%20Posting_Final_v3.xlsx* (84 FR 40813). Since the publication of that proposed rule, the link has since been updated and is now available in the Quality Payment Program Resource Library at *https://qpp.cms.gov/about/resource-library* by searching for the ''2019 QCDR Qualified Posting.'' In addition, in our review of prior data through previous qualified postings for the 2017 and 2018 performance periods, we have observed that a majority of the QCDRs participating in the program supported the three performance categories that require data submission. In 2017, 73 percent (approximately 83 QCDRs) and in 2018, 73 percent (approximately 110 QCDRs) have supported all three performance categories. While we do not yet have data to share for how clinicians participated in 2019 (year 3), we do want to indicate that we have observed from 2017 (year 1) to 2018 (year 2) approximately 24 percent increasing to 36 percent of clinicians have used their QCDR/qualified registry for submitting for all 3 performance categories. We believe when this policy becomes finalized, more MIPS eligible clinicians may want to use this method as a burden reduction on data submission. Based on this data, we believe it is reasonable to want to continue to strengthen our policies at § 414.1400(a)(2) by requiring that QCDRs have the capacity to support the reporting requirements of the quality, improvement activities, and promoting interoperability performance categories.

Therefore, beginning with the 2021 performance period and for future years, we proposed to require QCDRs to support three performance categories: Quality, improvement activities, and Promoting Interoperability (84 FR 40813). We note that the 2021 performance period corresponds to the 2023 MIPS payment years and are updating our policies here in this final rule to reflect this terminology for consistency. Additionally, for reasons, as discussed above, we proposed to amend § 414.1400(a)(2) to state, beginning with the 2023 MIPS payment year (2021 performance period) and for all future years, for the following MIPS performance categories, QCDRs must be able to submit data for all categories, and Health IT vendors must be able to submit data for at least one category: Quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability with an exception. As discussed in the CY 2020 PFS proposed rule (84 FR 40811), we proposed that based on the amendment to § 414.1400(a)(2)(iii), for the Promoting Interoperability performance category, the requirement applies if the eligible clinician, group, or virtual group is using CEHRT; however, a third party

could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4), (c)(2)(i)(A)(5), (c)(2)(i)(C)(1) through (c)(2)(i)(C)(7), or (c)(2)(i)(C)(*9*) (84 FR 40813). As part of this proposal, we would require QCDRs to attest to the ability to submit data for these performance categories, as applicable, at time of self-nomination.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal to require QCDRs to support the reporting of data for the quality, Promoting Interoperability, and the improvement activities performance categories, as well as the exemption for QCDRs who serve specialties that are exempt from the Promoting Interoperability performance category. Some commenters noted their QCDRs are already submitting data on all three performance categories, while other QCDRs report measures in the Quality Category and attest to improvement activities.

Response: We thank commenters for their support.

Comment: One commenter noted that the proposal should not be considered until after the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Rule (21st Century Cure Act) final rule is published and the updated standards are implemented.

Response: We understand the interest in coordinating with the updates to standards that may be included in the 21st Century Cures Act final rule, however we do not believe that the proposals under the 21st Century Cures Act will have a significant impact on the ability of QCDRs to report measures for the Promoting Interoperability category. We note this requirement was proposed with a delayed implementation, beginning with the 2023 MIPS payment year (2021 performance period), which should accommodate timing for any updates to standards. When the 21st Century Cures Act final rule is published we will determine if additional modifications are necessary and may address in future rule making.

Comment: One commenter requested CMS provide additional clarification regarding the number of measures from each performance category that will be required for approval.

Response: As described in the CY 2017 Quality Payment Program final rule (81 FR 77368), QCDRs and qualified registries are required to support the minimum number of measures to meet the reporting requirements of the Quality performance category. Through the finalization of the policy to require QCDRs and qualified registries to support all three performance categories in this final rule, we encourage third parties to support the minimum number of measures and activities to support the Promoting Interoperability performance category as discussed in § 414.1375 (83 FR 59798 through 59817) and Improvement Activities performance category as discussed in the CY 2017 Quality Payment Program final rule (81 FR 77185, in order to offer a complete reporting experience to eligible clinicians and groups.

Comment: One commenter questioned whether the QCDR will be required to audit data submitted for all performance categories. One commenter stated their belief that if the proposal is finalized, CMS should define more clearly how improvement activities should be documented to help standardize auditing by third party intermediaries and alleviate any additional burden associated with the requirement.

Response: Under our current data validation processes, as described in the CY 2017 Quality Payment Program final rule (81 FR 77368 through 77369) and (81 FR 77384 through 77385), QCDRs and qualified registries are required to provide information on their sampling methodology. For example, it is encouraged that 3 percent of TIN/NPIs submitted be sampled with a minimum sample of 10 TIN/NPIs or a maximum sample of 50 TIN/NPIs. For each TIN/NPI sampled, it is encouraged that 25 percent of the TIN/NPI's patients (with a minimum sample of 5 patients (with a maximum sample of 50 patients). We would expect that this review of patient medical records would be done to validate that the pertinent quality actions were done for measures and activities done by the clinician and group. In addition, validation guidance clarifications can be found within the improvement activities validation document at the MIPS Data Validation Document link. With regards to auditing whether improvement activities have been completed by a clinician or group, it is important for a third party intermediary to validate that an action has been done through review of medical records or other forms of documentation that will indicate that the quality action and/or improvement activity has been completed.

After consideration of the comments, we are finalizing our proposals with technical modifications for clarity and consistency with the existing provisions of § 414.1400. As discussed in section III.K.3.g.(1) of this final rule, we are amending § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all of the MIPS performance categories identified in the regulation, and Health IT vendors must be able to submit data for at least one such category. We are also finalizing our proposal to amend § 414.1400(a)(2)(iii), as proposed, to state that for the Promoting Interoperability, if the eligible clinician, group, or virtual group is using CEHRT; however, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (*5*) or § 414.1380(c)(2)(i)(C)(*1*) through (*7*) or § 414.1380(c)(2)(i)(C)(*9*). We refer readers to section III.I.3.d.(2) of this final rule where reweighting policies are discussed. We are also finalizing that QCDRs are required to attest to the ability to submit data for these performance categories, as applicable, at time of self-nomination.

(ii) Requirement for QCDRs To Engage in Activities That Will Foster Improvement in the Quality of Care

We generally refer readers to section 1848(m)(3)(E)(i) and (v) of the Act, which requires the Secretary to establish requirements for an entity to be considered a qualified clinical data registry and a process to determine whether or not an entity meets such requirements. Section 1848(m)(3)(E)(ii)(IV) of the Act provides that in establishing such requirements, the Secretary must consider whether an entity, among other things, supports quality improvement initiatives for participants.

As detailed at § 414.1305(1) a QCDR means: For the 2019, 2020 and 2021 MIPS payment year, a CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

Although ''improvement in the quality of care'' is broadly included under paragraph (2) of the definition of a QCDR at § 414.1305 in the 2019 PFS final rule (83 FR 59897), we want to further clarify how a QCDR can be successful in fostering improvement in the quality of care provided to patients by clinicians and groups. We understand putting parameters around exactly what improvement in the quality of care may be can be difficult due to the varying nature of QCDRs

organizational structures. For example, we have QCDRs that are founded by both large and small specialty societies, and healthcare systems where the volumes of services, available resources, and volume of members may vary. However, we believe QCDRs should enhance education and outreach to clinicians and groups to improve patient care.

The definition of qualified clinical data registry (QCDR) at § 414.1305(2) currently states that beginning with the 2022 MIPS payment year, an entity that demonstrates clinical expertise in medicine and quality measurement development experience and 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. In the CY 2020 PFS proposed rule (84 FR 40813), we proposed policies with regards to ''foster improvement in the quality of care''.

Therefore, we proposed to add § 414.1400(b)(2)(iii) that beginning with the 2023 MIPS payment year, the QCDRs must foster services to clinicians and groups to improve the quality of care provided to patients by providing educational services in quality improvement and leading quality improvement initiatives (84 FR 40813). Quality improvement services may be broad, and do not necessarily have to be specific towards an individual clinical process. An example of a broad quality improvement service would be for the QCDR to provide reports and educating clinicians on areas of improvement for patient populations by clinical condition for specific clinical care criteria. Furthermore, an example of an individual clinical process specific quality improvement service would be if the QCDR supports a metric that measures blood pressure management, the QCDR could use that data to identify best practices used by high performers and broadly educate other clinicians and groups on how they can improve the quality of care they provide. We believe educational services in quality improvement for eligible clinicians and groups would encourage meaningful and actionable feedback for clinicians to make improvements in patient care. To be clear, these QCDR quality improvement services would be separate and apart from any activities that are reported on under the improvement activities performance category. We believe improvement activities can be distinguished from quality improvement services, because they are actions taken by MIPS eligible clinicians under the improvement activities performance category. Improvement activities means an activity that relevant MIPS eligible clinician, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes (§ 414.1305). Quality improvement services, on the other hand, would be actions taken by the QCDR. While these QCDR quality improvement services could potentially overlap with an improvement activity, requirements for the improvement activities performance category would still apply to MIPS eligible clinicians and groups.

We proposed to require QCDRs to describe the quality improvement services they intend to support in their self-nomination for CMS review and approval. We intend on including the QCDR's approved quality improvement services in the qualified posting for each approved QCDR (84 FR 40813).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal to require QCDRs to engage in activities that improve quality of care and further cited their appreciation for the flexibility provided by CMS to meet the requirement. A few commenters suggested that CMS should provide a minimum threshold such as sharing links to the quality improvement education website or a QCDR platform with trending performance graphs. One commenter expressed its concern the terminology being used due to its opinion that improvement activities conducted by the MIPS eligible clinician and improvement services provided by the QCDR can be confusing.

Response: We thank commenters for their support, and while we agree this proposal is important to engage QCDRs in activities that will foster improvement in the quality of care; after reviewing public comments received, we are not finalizing this proposal. However, since this policy is important to the quality of care, as well as, CMS, we want to prepare QCDRs for this policy to be considered for future rulemaking and would encourage QCDRs to start planning for this possibility. While we did not state a minimum threshold of the type of service that needs to be provided as part of our proposal, as described in the CY 2020 PFS proposed rule (84 FR 40813), we provided examples of services, such as enhanced education and outreach, or providing reports and educating clinicians on areas of improvement for patient populations by clinical condition for specific clinical care criteria. We appreciate the commenters' suggestions for providing a minimum threshold, and may consider this feedback for future rulemaking. As part of future rulemaking we may also consider requirements that would require that the QCDRs describe the activities they are proposing to support as a part of their self-nomination application, as well as the ability of the QCDR to provide this service to all the clinicians and groups it supports for a given performance period. We appreciate the concern with potential confusion between quality improvement services and improvement activities, in any future rulemaking we would be sure to clearly communicate that they are different as a part of our subregulatory guidance to educate stakeholders.

Comment: Several commenters disagreed with the proposal to require QCDRs to engage in activities that improve quality of care citing concerns that the policy is vague, unclear, and could be used in an arbitrary fashion to possibly compare or rank QCDRs. A few commenters stated that additional details are necessary regarding what activities would meet this requirement, with a few commenters expressing that in place of finalizing this proposal, CMS should search for additional alternatives or publish a separate request for information followed by rulemaking that describes this proposal in more detail so that the public can provide a more thoughtful response.

Response: We thank the commenters' for their suggestions and agree that clarity is an important part of rulemaking. We agree with commenters that there needs to be more specificity in this proposal, and therefore, are not finalizing this requirement for this rule. Additionally, even though we are not finalizing this proposal, we continue to believe this policy is important, especially in the regard that QCDR applicants can innovate ideas for quality improvement services as they self-nominate, based on their capabilities and the needs of their clinicians and groups.

We did not intend on the policy to be vague, unclear, or arbitrary but intended to provide flexibility to the QCDR as to the type of improvement service they may offer; the services offered would not be used to rank the QCDRs in any way but to serve as a helpful resource for clinicians and groups. To that end, we did not want to standardize the type of quality improvement services a QCDR should offer, and so we intentionally crafted a policy that was not overly

specific. With the understanding that QCDRs differ in size, we wanted to leave the type of service available up to the QCDR to determine what is feasible and appropriate for the clinicians and groups they support. An example of a broad quality improvement service would be for the QCDR to provide reports and educating clinicians on areas of improvement for patient populations by clinical condition for specific clinical care criteria. Furthermore, an example of an individual clinical process specific quality improvement service would be if the QCDR supports a metric that measures blood pressure management, the QCDR could use that data to identify best practices used by high performers and broadly educate other clinicians and groups on how they can improve the quality of care they provide. Our intention was not to compare QCDRs to one another, but to expand the quality improvement initiatives a QCDR could support and offer. This policy was meant to require QCDRs to describe the activities they would plan to support as a part of their self-nomination application. We will take these comments into consideration for future rulemaking.

Comment: One commenter stated their belief that if this proposal is finalized, implementation should be delayed to give QCDRs the time to develop the necessary processes and identify the resources required to develop these types of services. Several commenters stated that this would require budgeting, planning and coordinating across staff or departmental areas that may not already be in place. Others stated that it would be too difficult or infeasible for QCDRs to change their business models to adopt.

Response: As discussed in the CY 2020 PFS proposed rule (84 FR 40813), this policy was proposed with a delayed implementation beginning with the 2023 MIPS payment year (for the 2021 performance period). We understand that there may be time needed to prepare for this requirement, including time to budget, plan, coordinate from a staffing perspective, and possibly prepare for from a business perspective. Taking these public comments into account we are not finalizing this proposal in this rule. We will take these comments into consideration for future rulemaking.

Comment: Several commenters stated this policy may be unnecessary considering the reports and activities QCDRs already conduct aimed at improving quality.

Response: As stated above, we are not finalizing this policy at this time. However, we do want to clarify that while some of the activities currently being done by QCDRs could fulfill the proposal for fostering quality improvement, not all QCDRs are consistently providing these reports to their participating clinicians. We intended to provide flexibility to the QCDR as to the type of improvement service they may offer. We will consider this feedback as we develop a potential proposal for future rulemaking.

Comment: Several commenters stated that this policy would expand responsibilities of QCDRs beyond their initially intended functions. Other commenters stated that this would create undue burden especially for small QCDRs.

Response: As stated above, we are not finalizing this policy at this time. However, we believe that there are many existing QCDRs that already provide quality improvement services, even outside of the Quality Payment Program. Our vision for QCDRs requires the need for evolvement by the QCDRs to potentially providing additional services that what was initially required under the legacy PQRS program or under the first few years of MIPS. We do not believe that such a policy would create undue burden on smaller QCDRs. We will take this feedback into consideration when developing a potential proposal for future rulemaking.

After consideration of the comments, we are not finalizing our proposals. Specifically, we are not finalizing at § 414.1400(b)(2)(iii) that beginning with the 2023 MIPS payment year, the QCDRs must foster services to clinicians and groups to improve the quality of care provided to patients by providing educational services in quality improvement and leading quality improvement initiatives. We are also not finalizing the proposed requirement that QCDRs describe the quality improvement services they intend to support in their self-nomination for CMS review and approval. While we are not including the QCDR's approved quality improvement services in the qualified posting for each approved QCDR, we will consider proposing this requirement in subsequent future rulemaking, and would encourage QCDRs to prepare as such.

(iii) Enhanced Performance Feedback Requirement

Section 1848(q)(12)(A)(ii) of the Act requires the Secretary to encourage the provision of performance feedback through QCDRs. In addition, in establishing the requirements, the Secretary must consider, among other things, whether an entity provides timely performance reports to participants at the individual participant level (section 1848(m)(3)(E)(ii)(III) of the Act). Currently, CMS requires QCDRs to provide timely performance feedback at least 4 times a year on all of the MIPS performance categories that the QCDR reports to CMS (82 FR 53812). Based on our experiences thus far under the Quality Payment Program, we agree that providing feedback at least 4 times a year is appropriate. However, in the future CMS would like to see, and therefore, encourages QCDRs, to provide timely feedback on a more frequent basis more than 4 times a year. Receipt of more frequent feedback will help clinicians and groups make more timely changes to their practice to ensure the highest quality of care is being provided to patients. We see value in providing more timely feedback to meet the objectives [117] of the Quality Payment Program in improving the care received by Medicare beneficiaries, lowering the costs to the Medicare program through improvement of care and health, and advance the use of healthcare information between allied providers and patients. We also believe there is value in this performance feedback, and therefore, encourage QCDRs to work with their clinicians to get the data in earlier in the reporting period so the QCDR can give meaningful, timely feedback.

In the QCDR performance feedback currently being provided to clinicians and groups, we have heard from stakeholders that that not all QCDRs provide feedback the same way. We have heard through stakeholder comments that some QCDR feedback contains information needed to improve quality, whereas other QCDR feedback does not supply such information due to the data collection timeline. Additionally, we believe that clinicians would benefit from feedback on how they compare to other clinicians who have submitted data on a given measure (MIPS quality measure or QCDR measure) within the QCDR they are reporting through, so they can identify areas of measurement in which improvement is needed, and furthermore, they can see how they compare to their peers based within a QCDR, since the feedback provided by the QCDR would be limited to those who reported on a given measure using that specific QCDR.

[117] Quality Payment Program Overview. *https://qpp.cms.gov/about/qpp-overview.*

Therefore, we proposed a change so that QCDRs structure feedback in a similar manner (84 FR 40814). We proposed a new paragraph at § 414.1400(b)(2)(iv), beginning with the 2023 MIPS payment year, to require that QCDRs provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR (84 FR 40814). (*Note:* Since we are not finalizing § 414.1400(b)(2)(iii) (see section III.K.3.g.(3)(a)(ii) of this final rule), the previously proposed § 414.1400(b)(2)(iv) will now become § 414.1400(b)(2)(iii).) Exceptions to this requirement may occur if the QCDR does not receive the data from their clinician until the end of the performance period. We also solicited comment on other exceptions that may be necessary under this requirement.

We also understand that QCDRs can only provide feedback on data they have collected on their clinicians and groups, and realize the comparison would be limited to that data and not reflect the larger sample of those that have submitted on the measure for MIPS, which the QCDR does not have access to. We believe QCDR internal comparisons can still help MIPS eligible clinicians identify areas where further improvement is needed. The ability for MIPS eligible clinicians to be able to know in real time how they are performing against their peers, within a QCDR, provides immediate actionable feedback. We believe this provides value gained for clinicians as the majority of QCDRs are specialty specific or regional based, therefore the clinician can gain peer comparisons that are specific to their peer cohort, which can be specialty specific or locality based. Furthermore, we also proposed to strengthen the QCDR self-nomination process at § 414.1400(b)(1) to add that beginning with the 2023 MIPS payment year, QCDRs are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at § 414.1400(b)(2)(iii)) (84 FR 40814). We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal for QCDRs to provide enhanced performance feedback at least 4 times a year including comparisons to other clinicians who reported the same measure, at minimum. Commenters expressed their belief that the feedback and comparison is very beneficial to their participants and helps them identify potential areas for performance improvement as compared to their peers.

Response: We thank commenters for their support.

Comment: A few of the commenters stated their opinion that CMS should finalize exceptions for occasions when the QCDR does not receive data from the clinician until the end of the performance period.

Response: As proposed in the CY 2020 PFS proposed rule (84 FR 40814), we also stated that exceptions to this requirement may occur if the QCDR does not receive the data from their clinician until the end of the performance period. We would depend on the QCDRs to let us know as soon as possible when there are issues that arise that would cause a delay in providing performance feedback.

Comment: Another commenter stated its opinion that while it agrees with the intent of providing enhanced feedback at least 4 times per year, without requiring data be submitted regularly and consistently across all collection types, improvement in individual patient and population health outcomes may not be experienced as originally intended in the MACRA legislation.

Response: We appreciate the feedback on requiring data to be submitted regularly and consistently across all collection types, but believe that improvements in individual patients and population health outcomes can still be experienced in smaller cohorts on a QCDR by QCDR basis.

After consideration of the comments, we are finalizing our proposal with technical modifications to update the numbering, § 414.1400(b)(2)(iv) will now become § 414.1400(b)(2)(iii) because we did not finalize the requirement for QCDRs to engage in activities that would foster improvement in the quality of care proposal at § 414.1400(b)(2)(iii) per section III.K.3.g.(3)(a)(ii) of this final rule. Specifically, we are finalizing at § 414.1400(b)(2)(iii), beginning with the 2023 MIPS payment year, to require that QCDRs provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR. Exceptions to this requirement may occur if the QCDR does not receive the data from their clinician until the end of the performance period. In addition, we are also finalizing our proposal as proposed, to strengthen the QCDR self-nomination process at § 414.1400(b)(1) to add that beginning with the 2023 MIPS payment year, QCDRs are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at § 414.1400(b)(2)(iii)) (84 FR 40814).

In addition, the current performance period begins January 1 and ends on December 31st, and the corresponding data submission deadline is typically March 31st as described at § 414.1325(e)(1). As discussed above, we have heard from QCDR stakeholders that in some instances clinicians wait until the end of the performance period to submit data to the third party intermediary, who are then unable to provide meaningful feedback to their clinicians 4 times a year. Therefore, in the CY 2020 PFS proposed rule (84 FR 40814), we sought comment for future notice-and-comment rulemaking on whether we should require MIPS eligible clinicians, groups, and virtual groups who utilize a QCDR to submit data throughout the performance period, and prior to the close of the performance period (that is, December 31st). We also sought comment for future notice-and-comment rulemaking, on whether clinicians and groups can start submitting their data starting April 1 to ensure that the QCDR is providing feedback and the clinician or group during the performance period (84 FR 40814). This would allow QCDRs some time to provide enhanced and actionable feedback to MIPS eligible clinicians prior to the data submission deadline.

While we are not summarizing and responding to these comments we received in this final rule, we thank the commenters for their responses and will take them into consideration as we develop future policies for QCDRs.

(b) QCDR Measures

We refer readers to § 414.1400(b)(1), the CY 2018 Quality Payment Program final rule (82 FR 53814) and the CY 2019 PFS final rule (83 FR 59898 through 59900) for our previously established policies for the QCDR measure self-nomination process. In the CY 2020 PFS proposed rule (84 FR 40814 through 40819), we proposed policies related to: (a) Considerations for QCDR measure approval; (b) requirements for QCDR measure approval; (c) considerations for QCDR measure rejections; (d) the approval process; and (e) QCDR measures that have failed to reach benchmarking thresholds. These are discussed in detail below.

(c) QCDR Measure Requirements

In this final rule, we are clarifying that the newly finalized QCDR measure considerations and requirements for approval apply to all QCDR measures, regardless of whether they have been approved for previous performance periods or are new QCDR measures for the 2021 performance period and future years. We will not be grandfathering in previously approved QCDR measures.

(i) QCDR Measure Considerations and Requirements for Approval or Rejection

Through education and outreach, we have heard stakeholders' concerns about the complexity of reporting when there is a large inventory of QCDR measures to choose from, and believe our proposals will help to ensure that the measures made available in MIPS are meaningful to a clinician's scope of practice. In the CY 2020 PFS proposed rule (84 FR 40814), we proposed to codify established QCDR measure considerations and proposed, beginning with the CY 2021 performance period, a number of QCDR measure specific requirements, that would generally align with MIPS measure policies, which can be found in the CY 2018 Quality Payment Program final rule (82 FR 53636), and as described in the CY 2020 PFS proposed rule (84 FR 40745 through 40752), as well as section III.K.3.c.(1) of this final rule.

(A) QCDR Measure Considerations

(aa) Previously Finalized QCDR Measure Considerations

We generally refer readers to the § 414.1400(b)(3), CY 2017 Quality Payment Program final rule (81 FR 77374 through 77375) and the CY 2019 PFS final rule (83 FR 59900 through 59902) for previously finalized standards and criteria used for selecting and approving QCDR measures. QCDR measures are reviewed for inclusion on an annual basis during the QCDR measure review process that occurs once the self-nomination period closes (82 FR 53810). All previously approved QCDR measures and new QCDR measures are currently reviewed on an annual basis to determine whether they are appropriate for the program (82 FR 53811). The QCDR measure review process occurs after the self-nomination period closes on September 1st. QCDR measures are not finalized or removed through notice and comment rulemaking; instead, they are currently approved or not approved through a subregulatory processes (82 FR 53639).

In the CY 2019 PFS final rule (83 FR 59902), we finalized our proposal to apply the following criteria beginning 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.

In the CY 2020 PFS proposed rule (84 FR 40815), we proposed to codify a number of those previously finalized QCDR measure considerations that we had finalized in the CY 2019 PFS final rule (83 FR 59902). We also proposed to amend § 414.1400 by adding § 414.1400(b)(3)(iv) to include the following previously finalized QCDR measure considerations for approval (84 FR 40815):

- Preference for 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 of care coordination.
- Measures that address the domain for patient and caregiver experience.
- Measures that address efficiency, cost, and resource use.

More information on QCDR measure approval criteria can be found in the QCDR/qualified registry Self-Nomination Tool-Kit in the Quality Payment Program Resource Library.

We refer readers to the CY 2020 PFS proposed rule (84 FR 40815) and section III.K.3.g.(3)(c)(i)(B) of this final rule where we discuss changes to the following previously finalized considerations into requirements:

- Measures that are beyond the measure concept phase of development.
- Measures that address significant variation in performance.

We did not receive public comments on this proposal.

Therefore, we are finalizing our proposal as proposed by adding § 414.1400(b)(3)(iv) to include the following QCDR measure considerations for approval:

- Preference for 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 of care coordination.
- Measures that address the domain for patient and caregiver experience.
- Measures that address efficiency, cost, and resource use.

We refer readers to section III.K.3.g.(3)(c)(i)(B)(aa) of this final rule, for a discussion regarding the following previously finalized considerations into requirements (84 FR 40815):

- Measures that are beyond the measure concept phase of development.
- Measures that address significant variation in performance.

(bb) New QCDR Measure Considerations for Approval

(AA) QCDR Measure Availability

In the CY 2018 Quality Payment Program final rule (82 FR 53813 through 53814), we finalized a policy beginning with the 2018 performance period, that allowed QCDRs to seek permission from another QCDR to use an existing and approved QCDR measure. If a QCDR would like to report on an existing QCDR measure that is owned by another QCDR, they must have permission from the QCDR that owns the measure that they can use the measure for the performance period. Permission must be granted at the time of self-nomination, so that the QCDR that is using the QCDR measure can include written proof of permission for CMS review and approval. We also finalized in the CY 2018 Quality Payment Program final rule (82 FR 53814) that once QCDR measures are approved, we will assign QCDR measure IDs, and the same measure IDs must be used by the other QCDRs that have permission to also report on the measure.

We generally encourage QCDR measure owners to permit other QCDRs to report their measures on behalf of MIPS eligible clinicians for purposes of MIPS. To the extent that QCDR measure owners limit the availability of their measures, such limitations may adversely affect a QCDR's ability to benchmark the measure, the robustness of the benchmark, or the comparability of MIPS eligible clinicians' performance results on the measure. For these reasons, we proposed to amend § 414.1400 to add paragraph (b)(3)(iv)(H) to state that CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS (84 FR 40815). If CMS determines

that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure.

We received public comments on this proposal. The following is a summary of the comments we received and our responses. We also acknowledge that we received several comments that were out of scope for this final rule, and therefore, are not addressing in this rule, but thank commenters for this feedback.

Comment: A few commenters supported the proposal to consider QCDR measure availability as part of the QCDR measure approval process due to their beliefs that it would encourage harmonization and collaboration among QCDRs while reducing duplication resulting from the unwillingness of some QCDRs to share measures.

Response: We thank commenters for their support.

Comment: Several commenters stated that CMS should provide an opportunity for QCDR measure owners to respond to allegations of unavailability before this is allowed to be a consideration in the measure approval process.

Response: We agree that QCDR measure owners should be given a chance to respond to instances where there is alleged blocking of the use of a QCDR measure. Therefore, we request that QCDRs keep documentation as to why a QCDR measure licensing agreement could not be reached, and on a case by case basis we will review the information on why the QCDR measure was not made available to another QCDR. We would expect that QCDR measure owners would be able to provide evidence to support their claim, should it be requested, as to why a given QCDR should not be allowed to use their QCDR measure.

Comment: Many commenters disagreed with the proposal to consider the extent to which a QCDR measure is available to other QCDRs as part of the measure approval process citing concerns regarding inappropriate or inconsistent implementation, incorrect understanding of measure specifications, and lack of standardized data methods resulting in inaccurate benchmarking by the borrowing QCDR. Another commenter stated they would consider the sharing of measures if the other QCDR adhered to certain standards and terms set out by the QCDR measure owner.

Response: We thank the commenters for raising these concerns. To respond, we first clarify that the intent of this proposal was to ensure that all QCDR measures that are considered for a given performance period, are readily available for other QCDRs to license. In practice, this would mean that should the borrowing QCDR meet the terms of a QCDR measure owner's license agreement, the borrowing QCDR should be able to report on the measure. We do not dictate what is to be included in a QCDR measure licensing agreement, or if fees and to what amount are tied to QCDR measure licensure, and ultimately defer to the QCDR measure owner, borrower, and their respective legal teams to come to an agreement. We would expect that if QCDRs decide to require a QCDR measure licensure agreement for its QCDR measures, it would include the QCDR measure owner's terms of use. The terms may include implementation criteria to ensure that the measure is programmed and collected in a way that is consistent with what the QCDR measure owner intends, thereby avoiding concerns with inappropriate or inconsistent implementation. In the CY 2019 PFS final rule (83 FR 59895 through 59897), we finalized changes to the definition of a QCDR at § 414.1305 that beginning with the 2022 MIPS payment year, that a QCDR is 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. We believe that QCDRs that are approved based on the revised QCDR definition for the 2022 MIPS payment year and future years, will be able to understand measure specifications since they are required to have measure development expertise and thereby understand measure specifications in order to be approved as a QCDR. Furthermore, as a part of the QCDR measure license user agreement, QCDR measure owners could include the data standardization methods they wish to be used to ensure consistent data collection, to ensure that borrowing QCDRs are utilizing the same standards consistently. We believe approved QCDRs should be able to comprehend and adhere to a preferred standardized data methodology, should the QCDR measure owner have one. In addition, QCDRs that are approved for the 2020 performance period and future years, should be able to utilize standardized data methodologies based on their measure experience. For QCDR measure owners that implement QCDR measure licensing agreements which include terms of use, they may come to find instances where a borrowing QCDR does not meet their terms prior to granting permission to borrowing the measure. We would expect QCDR measure owners to be able to provide evidence to justify instances where their measure was made available but ultimately could not be borrowed by another QCDR, for CMS' consideration on a case-by-case basis. Our intention with this policy is to move away from having duplicative measures in the program, simply because QCDRs are unwilling to license their QCDR measures to one another. Continuously retaining duplicative QCDR measures in the program because QCDRs are unwilling to license measures to one another is counterintuitive to the Meaningful Measure Initiative, and leads to measure bloat. In instances where CMS finds that QCDRs are blocking the use of their QCDR measure from other QCDRs without any evidence that proves the borrowing QCDR is unable to meet the QCDR measure owner's terms, we will likely approve another similar QCDR measure over this one. All factors will be considered prior to CMS determining which QCDR measure will continue on in the program.

Comment: Some commenters were concerned with the dilution of important feedback that is needed to drive key improvements in care.

Response: We disagree that allowing other QCDRs to borrow a QCDR's measure will lead to the dilution of important feedback that is needed to drive key improvements in care. Having a larger cohort of MIPS eligible clinicians reporting on a given QCDR measure will provide for more meaningful data that will give MIPS eligible clinicians and groups a better idea of how they compare to their peers. Therefore, the data will provide a more accurate picture of where there are areas of improvement in order to drive quality in the care provided.

Comment: Several commenters expressed other concerns with the proposal including their beliefs that: The term ''available'' is not well defined and that CMS should elaborate on what criteria it would use to determine whether a measure is truly unavailable for reporting through other QCDRs. One commenter requested that CMS provide scenarios of what the proposal was trying to address.

Response: We thank the commenters for raising these concerns. To clarify, a QCDR measure is available when the QCDR measure owner is willing to allow other QCDRs to borrow their QCDR measure with the appropriate permissions and/or licensing. We leave measure license user agreements, expectations, and terms between the measure owner and borrower. We are

trying to address scenarios in which a QCDR measure is approved, but the QCDR measure owner does not allow any outside QCDRs to use their QCDR measure. We wish to place higher priority on measures that can be used by all clinicians participating in the program.

Comment: Some commenters stated that withholding measure approval based on lack of availability would potentially deprive clinicians of an otherwise valid and useful measure to report on.

Response: We understand the commenters concern, but want to ensure that duplicative measures are not approved because QCDRs are unwilling to license QCDR measures to one another. If a QCDR measure is not approved, it does not mean it cannot be collected on by the QCDR for purposes of quality improvement, rather the measure would not be available for MIPS eligible clinicians to use for participating under MIPS and any data collected on that measure would not be applicable for MIPS.

After consideration of the comments, we are finalizing our proposal as proposed to amend § 414.1400 to add paragraph (b)(3)(iv)(H) to state that CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, we may not approve the measure.

(BB) QCDR Measure Addresses a Measurement Gap

As a part of the QCDR measure development process, QCDRs should conduct an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy program, PQRS; and review the most recent CMS Quality Measure Development Plan Annual Report, which is currently available for 2019 at *https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/2019-Quality-MDP-Annual-Report-and-Appendices.zip* and the Blueprint for the CMS Measures Management System: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf* for guidance in areas where CMS has identified gaps in quality measurement to reduce the possibility of duplicative measure development. In the CY 2020 PFS proposed rule (84 FR 40815), we proposed to amend § 414.1400 to add § 414.1400(b)(3)(iv)(I) to state that we would give greater consideration to measures for which QCDRs: (a) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development (84 FR 40815).

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: One commenter requested clarification on whether a performance gap needs to be demonstrated by data collection via a registry over a specified period of time (for example, 2 years), or if a health care survey would sufficiently demonstrate evidence of a performance gap. The commenter also questioned what constitutes ''significant variation'' to ensure proposed measures meet CMS' expectations.

Response: In the proposed rule, we proposed that we would give greater consideration to measures for which QCDRs: (a) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development (84 FR 40815). The Blueprint for the CMS Measures Management System *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf* defines a performance gap as when there is known variation in performance. A measure that is considered to have a performance gap would not be considered topped out, as described in the CY 2017 Quality Payment Program final rule (81 FR 77282 through 77283). The performance gap may be identified by data submitted to the registry on the given measure, or through current clinical study citations (within the past 5 years), a health care survey would not provide sufficient evidence of a performance gap.

After consideration of the comments, we are finalizing our proposal as proposed, to amend § 414.1400 to add § 414.1400(b)(3)(iv)(I) to state that we would give greater consideration to measures for which QCDRs: (a) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development.

(CC) QCDRs Measures Meeting Benchmarking Thresholds

Over the first 2 years of MIPS, we have observed instances where QCDR measures have been approved for continued use in the program, but have had low reporting volumes, below the case minimum and reporting volume thresholds required for a measure to be benchmarked within the program. As described in the CY 2017 Quality Payment Program final rule (81 FR 77277 through 77282), for benchmarks to be developed, a measure must have a minimum of 20 individual clinicians or groups who reported the measure to meet the data completeness requirement and the minimum case size criteria. QCDRs should be aware of which measures are considered low-reported, since measures that do not meet benchmarking thresholds result in a 3-point floor, as described in the CY 2017 Quality Payment Program final rule (81 FR 77282). QCDR measures are reviewed and approved on an annual basis, and as a part of the review process, we review: The benchmarking file from the previous year (for example, the 2019 Quality Benchmark file, found on the Quality Payment Program Resource Library, which is available at *https://qpp.cms.gov/about/resource-library*); production submission data submitted from the previous year's data submission period; and data provided to us by the QCDRs themselves. Note to readers when the CY 2020 PFS proposed rule was published the 2019 Quality Benchmark file could be found at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip* however after publishing that rule, the link has since been updated and can now be found at the link above (*https://qpp.cms.gov/about/resource-library*) by searching for ''2019 Quality Benchmark file.''

In the CY 2020 PFS proposed rule (84 FR 40816), as discussed in our QCDR measure rejection considerations, we proposed that a QCDR measure that does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance may not continue to be

approved in the future if our proposal is finalized as proposed. We noted that this factor is parallel to what was proposed for MIPS quality measures in section III.K.3.c.(1) of the proposed rule (84 FR 40816), which is being finalized in section III.K.3.c.(1) of this final rule, and is important when considering the volume of QCDR measures that are currently in the program that have had low reporting rates year-over-year. We proposed to amend § 414.1400 to add paragraph (b)(3)(iv)(J) to state that, beginning with the 2020 performance period, we place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods (84 FR 40816). Those that do not, may not continue to be approved. We refer readers to section III.K.3.g.(3)(c)(ii) in the proposed rule (84 FR 40816) and section III.K.3.g.(3)(c)(ii) of this final rule, for a discussion on how QCDRs may create participation plans for existing approved QCDR measures that have failed to reach benchmarking thresholds, in order to be reconsidered for future use. We also refer readers to § 414.1330 for additional information.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: A few commenters disagreed with the proposal to potentially reject QCDR measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods due to their beliefs that the policy of awarding fewer points for reporting non-benchmarked measures is enough to discourage use of these measures without further negatively impacting clinicians who have few other measures to report.

Response: While the quality scoring policy referenced by the commenters that provides a 3-point floor for measures that are submitted, but is unable to be scored because it does not meet the required case minimum, does not have a benchmark, or does not meet the data completeness requirement could have an impact on reduced reporting volumes, we believe this 2-year lifecycle and participation plan will more directly address the issue of low reported measures. We refer readers to section III.K.3.d.(1) and § 414.1380(b)(1)(i)(A) and (B) which provides details on the MIPS performance category scores.

Comment: A few commenters disagreed with the proposal due to their beliefs that it would reduce the number of available measures to a point that it would be a hardship for certain specialties to participate in MIPS; and eliminating a measure after 2 years in the program would deter QCDRs from investing in and developing new measures, maintaining existing measures, and putting forward MVP proposals. A few commenters expressed their opinion that prior to rejecting a QCDR measure that is not meeting thresholds, CMS should work with QCDR measure stewards to understand why a measure is not meeting thresholds and the importance of these measures to clinicians in specialized fields or clinicians treating less common diseases or conditions.

Response: While we appreciate the commenters concerns, we believe that maintaining low-reported measures in the program over multiple years, is counterintuitive to the Meaningful Measurement Initiative and indicative of metrics that are not of interest to the majority of clinicians within a given specialty. We believe that removing low-reported measures should not deter QCDRs in investing and developing new measures, maintaining existing measures, or putting forward MVP proposals. We believe that tracking measure reporting volumes over the years will allow QCDRs to determine whether the metric is meaningful to their eligible clinicians and group and allow for them to make revisions to existing measures or develop new measures accordingly. In addition, we are aware of instances in which measures may be low-reported due to being highly sub-specialized. Because of that, we proposed a potential mitigation strategy for QCDR measures with low-reporting volumes that do not meet benchmarking thresholds. As described in the CY 2020 PFS proposed rule (84 FR 40819), in instances where a QCDR believes a low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist's practice, the QCDR may develop and submit a QCDR measure participation plan for our consideration. The QCDR measure participation plan must include the QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program. As examples, a QCDR measure participation plan could include one or more of the following: Development of an education and communication plan; update the QCDR measure's specification with changes to encourage broader participation, which would require review and approval by us; or require reporting on the QCDR measure as a condition of reporting through the QCDR. Prior to measures being eliminated from the program for a given specialty, we do conduct a review of remaining MIPS quality measures and QCDR measures to determine if there is a sufficient number of measures left. Once a participation plan is implemented, we plan to monitor the QCDR measure to determine if there is an increase in reporting volumes. We understand that the measure development process is time-consuming and costly, however. If a QCDR measure is removed because of low-reporting volumes, but a QCDR continues to collect data on the measure outside of the MIPS program, the measure could be reconsidered for the program in the future. As we develop MVPs, we will consider how each policy interacts and make any appropriate adjustments in future rulemaking.

Comment: A few commenters opposed the proposal due to their beliefs that: The 2-year period is not long enough for some measures to achieve acceptable numbers of adoption or for EHR vendors to complete data integration to support QCDR measures and that failure to achieve benchmark status does not necessarily indicate that a measure is not meaningful. In regards to the time necessary for EHR vendors to support QCDR measures, one commenter noted this process can take up to 18 months from the time a vendor learns of a new or revised set of QCDR measures until the development life cycle is complete.

Response: The 2-year timeframe was decided upon after review and consideration of benchmarking trends as indicated in the quality measure benchmark files, for the appropriate amount of time a measure typically needs to reach benchmarking thresholds. While we appreciate the commenters concerns, to clarify, EHR vendors would only be able to report on QCDR measures if they self-nominate to be a QCDR, and meet the QCDR definition, as described at § 414.1400(b)(2)(ii) in the CY 2019 PFS final rule (83 FR 59895 through 59896). Since QCDRs will be required to test their measures prior to self-nominating them, as reflected at § 414.1400(b)(3)(v)(C), it is assumed that the QCDR would have considered the time it takes for data integration from an EHR prior to testing the measure to ensure that measure is feasible. If a QCDR cannot timely complete the data integration process for a QCDR measure, it should delay self-nominating that QCDR measure until it is

implementable. We note that QCDR measures should not be submitted for consideration until they are fully developed and tested, including the ability to be supported by EHR vendors. In addition, we believe this issue is mitigated, as described in the CY 2020 PFS proposed rule (84 FR 40817) and in this final rule, by our requirement to add paragraph (b)(3)(v)(D) that QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. The data collected must demonstrate whether the QCDR measure is valid and reflects an important clinical concept(s) that clinicians wish to be measured on. By collecting data on the QCDR measure prior to self-nomination, QCDRs would be able to demonstrate whether the measure is implementable and data collection on the metric is possible.

As described in the CY 2020 PFS proposed rule (84 FR 40819), in instances where a QCDR believes a low-reported QCDR measure, that did not meet benchmarking thresholds within the 2-year timeframe, is still important and relevant to a specialist's practice, the QCDR may develop and submit a QCDR measure participation plan for our consideration. As discussed in section III.K.3.g.(3)(c)(iii) of this final rule, the QCDR measure participation plan must include the QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program.

Comment: A few commenters stated their opinion that CMS should delay implementation of the proposal due to their belief that it would be inappropriate to finalize a requirement after the deadline for 2020 QCDR self-nominations has passed, as well as not allowing QCDRs enough time to reevaluate their measure submission strategies.

Response: We disagree with the commenters suggestion that we delay this policy based on the passed deadline for 2020 QCDR self-nominations. We believe that enacting this policy for the 2020 performance period allows us to ensure that the QCDR measures available for the performance period are meaningful and believe that the participation plan policy, as discussed in section III.K.3.g.(3)(c)(iii) of this final rule provides additional flexibility for low-reported QCDR measures that are currently under review for the 2020 performance period. If the QCDR measure is identified as an existing measure that is continuously low-reported, the QCDR has a chance to develop and submit a participation plan as a part of the QCDR measure reconsideration process.

Comment: One commenter requested additional clarity on the proposal to reject QCDR measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive CY performance periods. The commenter requested clarification as to whether a measure would be rejected if it failed to meet benchmarking thresholds via one collection type but met thresholds via another.

Response: To clarify, QCDR measures are available through only a single collection type, a QCDR, and therefore, for purposes of the MIPS program a QCDR would only be submitting data on a QCDR measure only through a QCDR for purposes of MIPS reporting. However, if a QCDR has additional information or performance rate related information to share, utilizing data collected outside of the MIPS program, they may do so in the development of a participation plan as discussed above.

After consideration of the comments, we are finalizing § 414.1400 to add paragraph (b)(3)(iv)(J), as proposed, to state that, beginning with the 2020 performance period, we place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. Those that do not meet this requirement, may not continue to be approved. We refer readers to section III.K.3.g.(3)(c)(ii) in the final rule, for discussion on how QCDRs may create participation plans for existing approved QCDR measures that have failed to reach benchmarking thresholds, in order to be reconsidered for future use.

(B) QCDR Measure Requirements

(aa) Previously Finalized Requirements Considerations Codified as Requirements

In the CY 2020 PFS proposed rule (84 FR 40815), we proposed to change two previously finalized measure considerations into requirements and codify those requirements. In the CY 2019 PFS final rule, we previously finalized that we would apply certain criteria beginning with the 2021 MIPS payment year when considering QCDR measures for possible inclusion in MIPS (83 FR 59902). We refer readers to section III.K.3.g.(3)(c)(i)(A) of this final rule where we discuss our proposal to codify the majority as measure considerations (84 FR 40816). However, for two of those previously finalized considerations, in the CY 2020 PFS proposed rule, we proposed them as requirements (84 FR 40816):

- Measures that are beyond the measure concept phase of development.
- Measures that address significant variation in performance.

We believe the previously finalized consideration that measures are beyond the measure concept phase of development should be a requirement because measures that do not surpass the measure concept phase will not be able to complete another QCDR measure requirement, measure testing. In addition, we believe the previously finalized consideration that measures address significant variation in performance should be a requirement because QCDR measures that do not demonstrate performance variation will likely be identified as topped out and will not be approved.

Therefore, beginning with the 2020 performance period, we proposed to change both of those considerations into requirements and proposed to amend § 414.1400 by adding § 414.1400(b)(3)(v) to include the following (84 FR 40816):

- Measures that are beyond the measure concept phase of development.
- Measures that address significant variation in performance.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: A few commenters agreed with the proposed requirements for a QCDR measure to be beyond the concept phase of development and address a significant variation in performance during the approval process.

Response: We thank the commenters for their support.

After consideration of the comments, we are finalizing our proposal as proposed, beginning with the 2020 performance period, to change both of the below listed considerations into requirements and add § 414.1400(b)(3)(v) to include the following for QCDR measure requirements for approval:

- Measures that are beyond the measure concept phase of development.
- Measures that address significant variation in performance.

(bb) Linking QCDR Measures to Cost Measures, Improvement Activities, and MIPS Value Pathways (MVP)

To prepare QCDR measures for self-nomination, we believe there should be consideration of how these QCDR measures relate to similar topics covered through the other performance categories. We believe (as noted in the

CY 2020 PFS proposed rule (84 FR 40816)) that to transform the MIPS program to one of value, MIPS measures and QCDR measures, should have an associated cost measure, improvement activity, and eventually a corresponding MVP. This would strengthen the QCDR measure's relevance in the program. We believe that evaluating the strength of these linkages may decrease the frequency of receiving extraneous QCDR measures that are not relevant or meaningful within the framework of the MIPS program.

Therefore, in the CY 2020 PFS proposed rule, beginning with the 2021 performance period and future years, we proposed that QCDRs must identify a linkage between their QCDR measures to the following, at the time of self-nomination: (a) Cost measure (as found in the CY 2020 PFS proposed rule (84 FR 40752 through 40762); (b) Improvement Activity (as found in Appendix 2: Improvement Activities Tables of the CY 2020 PFS proposed rule (84 FR 41275 through 41283)); or (c) CMS developed MVPs (as described in Table 34 of the CY 2020 PFS proposed rule (84 FR 40737 through 40738). Under the pathway framework for example, a surgery specific QCDR should be able to correlate their surgery-related QCDR measure to an MVP, such as the Major Surgery pathway.

We understand that not all measures may have a direct link. In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or an MVP, we would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure requirements defined above.

However, we believe that when possible, it is important to establish a strong linkage between quality, cost, and improvement activities. Therefore, we also proposed to amend § 414.1400 to add paragraph (b)(3)(iv)(G) to require, beginning with the 2021 performance period, that QCDRs link their QCDR measures to the following at the time of self-nomination: (a) Cost measure; (b) improvement activity; and (c) an MVP (84 FR 40816). If the potential QCDR measure otherwise meets the QCDR measure requirements but does not have a clear link to a cost measure, improvement activity, or an MVP, we would consider exceptions for measures that otherwise meet the QCDR measure requirements and considerations as discussed above.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal to require that QCDR measures be linked to cost measures, improvement activities, and MVPs. Several commenters supported an exception in cases where a QCDR measure lacks a clear link to either a cost measure, improvement activity, or MVP.

Response: We thank commenters for their support.

Comment: One commenter cited its belief that the proposal is not consistent with the regulatory language in that, the proposal states the linkage must be made to at least one of the categories while the regulatory language states the linkage must be made to all three. Another commenter stated that it is unclear whether the QCDR measure should be linked to at least one or all three of the performance categories. A few commenters sought clarification on the proposal to require QCDR measures be linked to cost measures, Improvement Activities, and MVPs, specifically whether QCDRs must link their measures to a cost measure, improvement activity, or a CMS-developed MVP, or all three; and how QCDRs will be required to identify linkages.

Response: In the CY 2020 PFS proposed rule (84 FR 40816), we stated that ''we believe that to transform the MIPS program to one of value, MIPS measures and QCDR measures, should have an associated cost measure, improvement activity, and eventually a corresponding MVP.'' In addition, we also stated, ''therefore, we also propose to amend § 414.1400 to add paragraph (b)(3)(iv)(G) to require, beginning with the 2021 performance period, that QCDRs link their QCDR measures as feasible to the following at the time of self-nomination: (a) Cost measure; (b) improvement activity; and (c) an MVP'' (84 FR 40816). However, we also proposed (84 FR 40816) that beginning with the 2021 performance period and future years, QCDRs must identify a linkage between their QCDR measures to the following, at the time of self-nomination: (a) Cost measure (as found in the CY 2020 PFS proposed rule (84 FR 40752 through 40762); (b) Improvement Activity (as found in Appendix 2: Improvement Activities Tables of the CY 2020 PFS proposed rule (84 FR 41275 through 41283)); or (c) CMS developed MVPs. We apologize for the confusion. We intended for the proposal to consistently use the term ''or,'' meaning that QCDRs would be required to link their measure to at least one performance category as feasible. Therefore, we are clarifying our requirement here in this final rule that QCDRs would not be required to link to all three performance categories at this time; but should try to link their measure to the performance categories as feasible.

Comment: A few commenters expressed concerns with the proposal to require QCDR measures to be linked with cost measures, improvement activities, and MIPS Value Pathways, noting that some specialties are not currently included in the cost category and/or MIPS Value Pathways and therefore, urged CMS to account for these types of clinicians by building flexibility into QCDR measure requirements. Other commenters noted linking to cost measures, improvement activities, and MIPS Value Pathways should be optional and not required.

Response: We appreciate the concerns raised by these commenters. We refer readers to our clarification above—QCDRs would be required to link their measure to at least one, not all three, performance category as feasible. In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or MVP, we proposed that we would consider exceptions if the potential QCDR measure otherwise met the QCDR measure requirements and considerations such as addressing a measurement gap. As stated in our proposal in the CY 2020 PFS proposed rule (84 FR 40926), in cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or MVP, we would consider exceptions if the potential QCDR measure otherwise met the QCDR measure requirements and considerations. If a QCDR measure cannot be linked to a cost measure because the specialty isn't reflected in the cost measures, then the QCDR would indicate there are no cost measures to link in their QCDR measure submission for us to note as a part of our review.

Comment: Several commenters stated that the method for linking QCDR measures is unclear as is the information required to explain the link. One commenter requested CMS provide additional education and guidance to QCDRs to assist them in adequately meeting the new requirement.

Response: As QCDRs consider which QCDR measures they want to submit for consideration, they should work to identify relationships that can link their QCDR measure to measures and activities in other performance categories. For example, a link can be established if the associated measures and activities address the same clinical condition or disease. We will require the QCDR to provide a narrative with their QCDR measure specification that

identifies the other measures and activities that relate, and explain why they believe there is a link. We agree that additional education and guidance would be beneficial. We plan to provide education to QCDRs to ensure that they adequately understand this requirement.

Comment: Several commenters disagreed with the proposal to require QCDR measures be linked to cost measures, improvement activities, and MIPS Value Pathways, citing their beliefs that: CMS should not implement any changes related to MIPS Value Pathways until the Agency has received and considered all comments related to the proposal and conducted outreach and meetings prior to the publication of next year's proposed rule (or alternatively a separate request for information (RFI) soliciting feedback). These commenters also expressed concern that continued development of new episode-based cost measures and MVPs may mean applicable measures and MVPs are not available at the time of self-nomination. One commenter noted that the effective date of this proposal is too soon and should be deferred until the MVP framework is established and measure developers have the necessary time to adapt to the new requirements and establish new measures to align with this new focus.

Response: This policy was proposed with a delayed implementation, to take into effect for the 2021 performance period, in order for QCDRs to get acclimated with developing linkages between QCDR measures and measures and activities found within other performance categories, as a way to prepare for MVPs. In the time between the proposed and final rule, we have conducted stakeholder outreach through listening sessions and public facing webinars, while also reviewing comments received as it related to MVPs. We believe the 2021 performance period is an appropriate timeframe because it coincides with the timing, since the MVP framework is being finalized in this final rule, in which the first set of MVPs will be developed for 2021. Furthermore, we note that this policy establishes linkages as feasible, therefore while it's preferable, it is not mandatory to link a QCDR measure to a future MVP. If an MVP is not available at the time of self-nomination, a QCDR should try to link their QCDR measure to a relevant cost measure and improvement activity as feasible.

After consideration of the comments, we are finalizing our proposal with clarification that QCDRs are required to link their measure to at least one performance category as feasible. Therefore, we are amending § 414.1400 to reflect this clarification and add paragraph (b)(3)(iv)(G) to require, beginning with the 2021 performance period, that QCDRs link their QCDR measures as feasible to at least one of the following at the time of self-nomination: (a) Cost measure; (b) improvement activity; or (c) an MVP. In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or an MVP, we would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure requirements and considerations as discussed above.

(cc) Completion of QCDR Measure Testing

We refer readers to the CY 2019 PFS final rule, where we gave notice to the public that we were considering proposing to require reliability and feasibility testing as an added criteria in order for a QCDR measure to be considered for MIPS in future rulemaking (83 FR 59901 through 59902). After consideration of the previous public comments received, and our priority to ensure that all measures available in MIPS are reliable and valid thereby reducing reporting burden on eligible clinicians and groups, we moved forward with a proposal in the CY 2020 PFS proposed rule (84 FR 40816).

Beginning with the 2021 performance period and future years, we proposed, that for a QCDR measure to be considered for use in the program, all QCDR measures submitted at the time of self-nomination must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System (available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf*), and as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures (84 FR 40816 through 40817). We believe that full development and testing with completed testing results at the clinician level helps to demonstrate whether the QCDR measure is ready for implementation at the time of self-nomination. We intend to include only measures that are valid, reliable, and feasible for use by clinicians and will be consistent with the criteria that is expected of MIPS quality measures. As a result, we also proposed to amend § 414.1400 to add paragraph (b)(3)(v)(C) to reflect this proposal (84 FR 40817). At § 414.1400(b)(3)(v)(C), we proposed beginning with the 2021 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination (84 FR 40817).

We noted that the testing process for quality measures is dependent on the measure type (for example, a measure that is specified as an eCQM measure has additional steps it must undergo when compared to other measure types). The National Quality Forum (NQF) has developed guides for measure testing criteria and standards which further illustrate these differences based on measure type. Additionally, the costs associated with testing vary based on the complexity of the measure and the developing organization. The Journal of the American Medical Association states that the costs associated with quality measures are generally unknown or unreported.[118] While we understand the proposed policy will result in additional costs for QCDRs to develop measures, given the uncertainty regarding the number and types of measures that will be proposed in future performance periods coupled with the lack of available cost data on measure development and testing, we are unable to determine the financial impact of this proposal on QCDRs beyond the likelihood of it being more than trivial. Likewise, we understand that some QCDRs already perform measure testing prior to submission for approval while others do not. This variability makes it difficult to estimate the incremental impact of this regulation. Please refer to section VII., the Regulatory Impact Analysis, of this final rule for additional details.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters agreed with the proposal to require measure testing prior to a QCDR measure being submitted for approval.

Response: We thank commenters for their support.

Comment: A few commenters requested clarification on the level of testing for which CMS is asking and whether it is full NQF-level specification and endorsement or a feasibility and validity test within the QCDR due to their opinion that NQF-level specification testing is both burdensome and expensive.

[118] Schuster, Onorato, and Meltzer. ''Measuring the Cost of Quality Measurement: A Missing Link in Quality Strategy'', Journal of the American Medical Association. 2017; 318(13):1219–1220. *https://jamanetwork.com/journals/jama/fullarticle/2653111?resultClick=1.*

Response: As stated in the CY 2020 PFS proposed rule (84 FR 40816 through 40817), we proposed that all QCDR measures submitted at the time of self-nomination must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System (available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf*), and as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures. As a reminder, we do not currently require QCDR measures to be NQF endorsed in order to be approved for use in the program. We believe in utilizing the existing NQF testing standard without variation, to avoid inconsistencies that may result from substandard results. We understand that measure testing requires an additional level of effort, cost, and time, but believe that measure testing ensures that measures are reliable, valid, and feasible. By completing this testing, QCDRs will avoid instances of discovering mid-year that their measure is not feasible or collectible, and will avoid adding to clinician reporting burden.

Comment: A commenter cited their opinion that should the proposal be finalized, CMS should provide leniency on following the CMS Blueprint for the CMS Measures Management System due to its belief that it was developed for use by measure contractors who presumably have dedicated resources, both in staffing and funding, to do the sole work of measure development, testing and maintenance; and that the measure development timeline and requirements as laid out in the Blueprint are aggressive, particularly for organizations dependent on limited funds and expert volunteers to complete the work.

Response: We disagree on providing leniency on testing requirements, as we expect to uphold the testing requirements that are utilized for MIPS quality measures through the CMS Blueprint for Measures Management System, and that the standard is upheld consistently for all QCDR measures and MIPS quality measures within the program. We believe QCDRs should research testing requirements for planning purposes from a timing and budget perspective. We will not consider measures that have incomplete testing results or those that do not meet the testing standards. Further the process outlined in the CMS Blueprint for the CMS Measures Management System is very thorough and following the Blueprint will substantially increase the scientific acceptability of the measure, and likelihood of the measure receiving endorsement. We note that while the Blueprint is required for CMS measure development contractors, it is a resource that can be used by any measure developer. We do recognize that resource availability in measure testing may vary, however, we reiterate the importance of following the Blueprint to produce a sound measure. Additionally, CMS provides support through webinars, resources, etc. through the Measure Management System: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Content-Page.html* For Measure Management System webinar sign-up we direct readers to email *MMSsupport@battelle.org.*

Comment: Many commenters disagreed with the proposal to require QCDR measures to have completed testing prior to nomination due to their beliefs that: It would delay the creation and submission of new measures by a number of months or even years; the process would be cost prohibitive for many QCDRs, especially those administered by non-profit medical societies; may result in some QCDRs electing to cease measure development or no longer participating in the MIPS program; could lead to increased licensing fees or participation fees for clinicians; and it removes the ability for clinicians to report on measures that are not in the CMS measure inventory.

Response: While we understand the increased time and cost burdens associated with measure testing, we believe the benefits of completed measure testing far outweigh the burdens of it. We want all measures available in the MIPS program to be reliable, feasible, valid, and implementable within the program. We want to avoid scenarios that would arise by allowing measures that do not meet these standards which then may lead to issues with the measure mid-performance period. We do not believe it is appropriate to have untested measures within the MIPS program since clinician's performance on measures have impacts on their payments. Furthermore, as we have signaled through previous rulemaking cycles (83 FR 59901 through 59902), we have intended to raise the bar for QCDR measures that are available for reporting within the MIPS program. We disagree that measure testing removes the ability for clinicians to report on measures that are not within the CMS inventory. To clarify, QCDRs can collect data on measures for purposes of quality improvement outside of the program, without reporting the data to CMS for purposes of MIPS.

Comment: Some commenters stated that this policy is contrary to Congress' initial intent for QCDRs to serve as testbeds for more robust and creative measures.

Response: We disagree with the commenter that this policy is contrary to Congress' intent for QCDRs as there is no reference in section 1848(q) of the Act to QCDRs serving as ''testbeds'' for more robust and creative measures.

Comment: A few commenters suggested testing measures during a trial period during which performance would not be counted against clinicians, and they may be offered some small incentive to report on the measures so that the developer can continue to refine them; or using interim testing results which could be collected while the measure is in use. One commenter expressed its belief that the proposal is unreasonable for smaller specialties or specialties where clinicians are more likely in small/solo practices due to the difficulty in operationalizing new measures and providing test data; and that the limited ability to use the Bonnie eCQM test deck also contributes to requiring large facilities with significant resources. This commenter also stated their belief that testing methodologies employed by academic medical centers could lack applicability and could cause measures commonly used by small/solo practitioners to fail external validity testing.

Response: We thank the commenters for their suggestions. We believe there is value and importance in ensuring the scientific rigor of measures through measure testing; and therefore, we will not accept trial testing in place of fully completed testing data at the clinician level. We understand there may be limitations with small specialties and the lack of resources to test measures, but believe it is important to only include measures that are valid, reliable, and feasible in the program. We want to ensure that the testing methodology used by all, including academic medical centers, in a consistent manner to ensure that results meet testing standards. In response to commenters on the limited ability to use the Bonnie eCQM test deck, we clarify that testing verifies the behavior of the eCQM logic. Bonnie tests the measure logic against the constructed patient test deck and evaluates whether the logic aligns with the intent of the measure. This is an element of the testing and is not full validity, reliability and feasibility testing. Bonnie is open source and free to use, so it is an available option for testing measure logic. We refer readers

to *https://bonnie.healthit.gov/* for additional information on Bonnie.

Comment: A few commenters expressed their opinion that since QCDRs may have access to real-world EHR data, it should be recognized by CMS as a means to achieve the goals of measure testing without having to test measures according to the methods outlined by NQF and the CMS measures blueprint. Finally, one commenter suggested that in place of this proposal, the proposal to require collection of 12 months of data prior to nominating a new QCDR measure could be used in its place.

Response: We disagree that having real-world access to EHR data is comparable to that of measure testing data or that requiring collection of 12 months of data on a QCDR measure could replace measure testing. Regardless of the QCDR measure's data source, all QCDR measures should be fully tested to ensure the measure is valid, reliable, and implementable at the clinician level. We clarify that the requirement to collect data on a QCDR measure prior to self-nominating is separate and apart from the requirement to fully test the measure. Data collection is meaningful because it demonstrates whether a measure is implementable and if there is interest by the clinician community on reporting on that metric.

Comment: One commenter stated that if the proposal if finalized, CMS should provide additional flexibility to their proposed timeframes for measures dealing with less common medical problems as it is often not feasible to measure rare surgical outcome events during the course of 1 year in a way that is statistically appropriate or reliable.

Response: We clarify that all QCDR measures, regardless of whether they have been approved for previous performance periods or are new QCDR measures will be expected to meet these new QCDR measures requirements and considerations to be approved for the 2021 performance period and future years. We will not be grandfathering in previously approved QCDR measures. To further clarify, we have not proposed timeframes for measure testing. As described in the CY 2020 PFS proposed rule (84 FR 40817), the testing process for quality measures is dependent on the measure type, for example, a measure that is specified as an eCQM measure has additional steps that it undergoes when compared to other measure types. We defer to QCDR measure owners as the experts in their specialty. We refer QDCRs to the Blueprint for the CMS Measures Management System (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf*) for measure testing criteria and standards to determine timeframes that are appropriate for individual QCDR measure testing to ensure consistent and reliable standards are used. If a QCDR believes that they need more than 1 year is needed to ensure a measure is statistically appropriate, reliable, and to complete measure testing at the clinician level, then they should delay self-nominating the QCDR measure until testing is completed. Furthermore, we refer readers to the CY 2020 PFS proposed rule (84 FR 40818), where we proposed, and are finalizing in section III.K.3.g.(3)(c)(i) of this final rule, to reject QCDR measures that focus in on rare events or ''never events'' in the measurement period, and provided fires in the operating room as an example of a rare event.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are finalizing § 414.1400(b)(3)(v)(C), to state that beginning with the 2021 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination. We are also finalizing our proposal that all QCDR measures submitted at the time of self-nomination must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System (available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf*), and as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures.

(dd) Collection of Data on QCDR Measures

We have observed several instances in which QCDRs have attempted to use the MIPS Program to ''test'' out measure concepts without concrete evidence that there is a measurement performance gap. We want to discourage that and ensure QCDR measures used for the MIPS Program are valid and reliable. In addition, through reviews of QCDR measure submissions, where reporting data was provided by the QCDR or through submission data from the 2017 performance period, we have identified some current QCDR measures in the program that have continuously low reporting rates, which affects the ability to meet benchmarking criteria. The data submitted is insufficient in meeting the case minimum and volume thresholds required for benchmarking.

Therefore, in the CY 2020 PFS proposed rule, we proposed to require QCDRs to collect data on the potential QCDR measure (84 FR 40817). For a QCDR measure to be considered for use in the program, beginning with the 2021 performance period and future years, we proposed to amend § 414.1400 to add paragraph (b)(3)(v)(D) that QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period (84 FR 40817). The data collected must demonstrate whether the QCDR measure is valid and reflects an important clinical concept(s) that clinicians wish to be measured on. By collecting data on the QCDR measure prior to self-nomination, QCDRs would be able to demonstrate whether the measure is implementable and data collection on the metric is possible. In addition, the data collected on the QCDR measure prior to self-nomination, could be used to demonstrate that there is a performance gap and need for measurement. We suggest QCDRs to collect data on as many months as possible, but encourage QCDRs to collect data for 12 months prior to submitting the QCDR measure for our consideration at the time of self-nomination, since quality reporting requires 12 months of data, as described in § 414.1335, as this will also likely increase the chance that the measure will be able to be benchmarked.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: One commenter agreed with the proposal to require collection of data prior to submitting a QCDR measure for approval.

Response: We thank the commenter for their support.

Comment: One commenter advised CMS to delay implementation of this requirement for an additional year due to their belief that in order to meet this standard in 2021, QCDRs would need to begin immediately in 2020 to work on collection of this data, which may not be feasible given that budgets and timelines have already been planned for the year.

Response: We thank the commenter for their suggestion but disagree that there needs to be a delay in the implementation of this policy. We believe that implementing this requirement beginning with the 2021 performance period would allow for sufficient time needed for planning and

budgeting. We believe that this requirement to collect data on the measure prior to submitting it to CMS coincides with the need for data collection as a part of the measure testing process, and therefore, would believe that if a QCDR measure has completed testing as outlined in the CMS Blueprint *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf,* the QCDR would also be able to collect data on the measure to meet this requirement.

Comment: Several commenters disagreed with the proposal to require collection of data on QCDR measures prior to nomination due to their beliefs that it would unnecessarily delay the creation and submission of new measures, further challenging participation of specialists who have very few measures to report; would create additional burden and may cause some QCDRs to end participation in MIPS; and would require financial resources most specialty societies do not have. One commenter expressed its opinion that collection of data should not be a determinant of clinical importance as public comments may reveal importance and given that similar measures may be approved, clinicians may elect to report to one even when both are clinically important.

Response: We thank the commenters for raising these concerns. We believe that the benefits of this policy outweigh the burdens. While we understand that data collection may not be a determinant of clinical importance of a measure, data collection is important because it demonstrates whether a measure is implementable and if there is interest by the clinician community on reporting on that metric. We expect there to be a need for some data collection for testing purposes, as described in section III.K.3.g.(3)(c)(i)(B) of this final rule, and therefore, would believe that if a QCDR measure has completed testing as outlined in the CMS Blueprint, the QCDR measure would also be able to meet this requirement.

Comment: One commenter suggested that in place of the proposal, QCDR measures could be approved under a testing/provisional status during which CMS would allow credit, such as a base 3–5 points or fully meeting improvement activity requirements.

Response: We disagree with the commenter's suggestion of giving QCDR measures provisional approval prior to meeting this requirement. We want all measures available in the MIPS program to be reliable, feasible, and valid, and implementable within the program. We do not believe QCDRs should be using the MIPS program as a test-bed for measure development, particularly since this is a pay-for-performance program and clinician's performance on measures have impacts on their payments.

Comment: One commenter stated that CMS should not penalize a QCDR for providing data for a period of less than 12 months for QCDR measures as collecting data for a 12-month period may be difficult given that the timelines of the MIPS submission cycle during the months of January–March, the requirement for QCDRs to be operational on January 1, and the self-nomination deadlines September 1; around which the QCDR's measure development and update processes have been established.

Response: To clarify, as described in the CY 2020 PFS proposed rule (84 FR 40817), we suggest QCDRs to collect data on as many months as possible, but encourage QCDRs to collect data for 12 months prior to submitting the QCDR measure for our consideration at the time of self-nomination. While we encourage 12 months of data, we do understand there may be instances where less than 12 months of data may be available, depending on the data available as a result of measure testing or the availability of the QCDR measure during past performance periods in MIPS.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are requiring QCDRs to collect data on potential QCDR measures. Beginning with the 2021 performance period and future years, for a QCDR measure to be considered for use in the program, we are adding § 414.1400 (b)(3)(v)(D) to state that QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. The data collected must demonstrate whether the QCDR measure is valid and reflects an important clinical concept(s) that clinicians wish to be measured on.

(ee) Duplicative QCDR Measures

As first discussed by commenters in the CY 2018 Quality Payment Program final rule (82 FR 53814), the topic of ''shared'' measures was discussed and how would CMS intend to harmonize. In the CY 2019 PFS proposed rule (83 FR 35983), and further discussed in CY 2019 PFS final rule (83 FR 59901), we shared that we believe duplicative measures are counterintuitive to the Meaningful Measures initiative that promotes more focused quality measure development towards outcomes that are meaningful to patients, families and their providers. Therefore, it is our intent to move toward measure harmonization, which supports our efforts to increase measure alignment and eliminate redundancy both within the MIPS measure set and across our programs (83 FR 59901). Taking the previous feedback into consideration, we moved forward with a proposal in the CY 2020 PFS proposed rule (84 FR 40817).

In the CY 2020 PFS proposed rule (84 FR 40817), we proposed, beginning with the 2020 performance period, that after the self-nomination period closes each year, we will review newly self-nominated and previously approved QCDR measures based on considerations as described in the CY 2019 PFS final rule (83 FR 59900 through 59902). In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. The QCDR could do so by harmonizing its measure with, or significantly differentiating its measure from, other similar QCDR measures. QCDR measure harmonization may require two or more QCDRs to work collaboratively to develop one cohesive QCDR measure that is representative of their similar yet, individual measures. In other words, we would not approve duplicative QCDR measures (which will be identified as a part of our scan of previously approved measures, and new QCDR measure submissions) if QCDRs choose not to address the areas of duplication with other approved QCDR measures identified by us during the previous year's QCDR measure review period. We believe this policy would help to reduce the number of duplicative QCDR measures that are submitted as a part of the self-nomination process. Adding a structured timeframe provides transparency to QCDRs who will know what next steps to expect if they do not address the identified areas of duplication as requested. Therefore, we proposed to amend § 414.1400 to add paragraph (b)(3)(v)(E) to state beginning with the 2022 MIPS payment year (2020 performance period), CMS may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other

approved QCDR measures in order to be considered for the program in subsequent years (84 FR 40818). If the QCDR measures are not harmonized, CMS may reject the duplicative QCDR measure(s) as discussed in the CY 2020 PFS proposed rule (84 FR 40818).

We received public comments on these proposals. We acknowledge that we received several comments that were out of scope for this final rule, which we are not addressing in this rule, but thank commenters for the feedback. The following is a summary of the in-scope comments we received and our responses.

Comment: One commenter expressed its opinion that allowing duplicative measure concepts to go forward in the MIPS program fosters confusion among clinicians and competition among QCDRs, rather than collaboration; and that organizations will not be able to continue to invest in advancing meaningful quality measures if their measure concepts are able to be appropriated with superficial changes and then supported by CMS.

Response: We agree with the commenter's concerns on duplicative measures creating confusion for clinicians. However, we note that we have continuously encouraged QCDRs to collaborate to develop cohesive, robust QCDR measures through the use of QCDR measure informal group discussions, reminders on monthly support calls and at QCDR measure preview calls. We have come across instances where QCDRs have refused to collaborate with one another, exacerbating the issue of competition rather than mitigating it.

To clarify, as a part of the QCDR measure review process, we review all new QCDR measures submitted at the time of self-nomination and compare the new measures to previously approved QCDR measures. In instances where there are no significant differences, for example, in patient population or quality action, and the specification of the new measure is duplicate of an existing measure, we would reject the new measure and recommend the QCDR to seek permission to use the existing approved QCDR measure. In instances where there is overlap, and both measures cover a similar clinical concept, but with differing quality actions or patient populations, we will request measure harmonization. In instances where QCDRs cannot or refuse to collaborate to harmonize their measures, we will select and approve the most robust QCDR measure and reject any duplicative ones.

Comment: Some commenters requested additional clarification and guidance should the proposal be finalized. Some commenters stated that CMS should provide clear guidance when and how measures should be harmonized in order to ensure that contractor decisions are as uniform as possible Other commenters requested timelines for making changes or harmonizing measures, what safeguards will be implemented to ensure harmonization will only occur when clinically appropriate; and accountability of QCDRs that do not have appropriate experience or expertise in the field of medicine covered by the measure.

Response: We agree that clear guidance should be communicated to QCDRs who have been identified to collaborate on harmonization efforts. After the close of the self-nomination period, we will review QCDR self-nomination applications. As a part of this measure review process, we will identify similar QCDR measures for harmonization and then notify the relevant QCDRs through the Self-Nomination Portal that their QCDR measures have been identified for measure harmonization. In this communication, we will include our reasons as to why we believe harmonization is appropriate, including where we believe duplication exists, points of contact from the other identified QCDRs, and information regarding provisional approval for the given year. As proposed in the CY 2020 PFS proposed rule (84 FR 40818), we specified that we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures within that year, prior to the next self-nomination period. With regards to ensuring that harmonization will only occur when clinically appropriate, we do review clinical appropriateness when requesting harmonization; however, we rely on the QCDRs to indicate, as a part of their QCDR measure reconsideration, when and why they believe harmonization is not appropriate. The additional information provided may be used to reconsider whether the QCDR measure should be harmonized or not.

Comment: Several commenters cited their belief that CMS should grant 2 years of provisional approval instead of 1.

Response: We disagree that a 2-year provisional approval cycle should be granted in these scenarios, as we believe it is important not to prolong measure harmonization. We understand that measure harmonization takes time for there to be agreement amongst the QCDRs and their technical expert panels. However, we believe it is counterintuitive to the Meaningful Measure Initiative to prolong retaining duplicative measures in the program.

Comment: A few commenters stated their concerns over the process CMS will utilize to determine which QCDR measures are duplicative. Some commenters stated that CMS clarify the criteria for determinations that QCDR measures are duplicative. A few commenters encouraged CMS to: Consider the level of rigor in evidence or testing process between QCDRs; make determinations based on a comparison of the technical specifications; consider that an existing measure with baseline performance should not be rejected in favor of a new measure without prior data collection or baseline performance; consider a QCDR's relevant expertise or experience in the specialty or treatment area covered by a particular measure should be given. One commenter stated that if CMS identifies a measure that needs to be harmonized, CMS should provide the clinical rationale for harmonization. Another commenter stated that CMS and their contractors should consult with clinicians and measurement staff in the specialty societies regarding clinical aspects of measurement.

Response: We thank the commenters for raising these concerns. As a part of the review process, QCDR measure specifications are comparatively reviewed for similarities and differences when they address the same clinical topic. QCDR measures are considered duplicative if there are no differences between the measure specifications from a comparative perspective. To clarify, in instances where a new QCDR measure is duplicative of an existing QCDR measure, we would reject the new duplicative QCDR measure and tell the QCDR to request permission to use the existing QCDR measure. We would request measure harmonization in instances where QCDR measures are identified as similar. QCDR measures are reviewed to identify similarities and differences in areas that include (but are not limited to): Clinical concept being measured, quality action (for example, screening versus screening and follow-up), patient population, clinical setting (place of service), and the clinician type eligible to report on the measure. We thank the commenters for their suggestions of what CMS should consider, but note that for the 2020 performance period and in previous years, we have not previously required measure testing, and it would, therefore,

be difficult to evaluate all QCDR measures with this criteria, if it is not consistently required. With regards to the suggestion that an existing measure with baseline performance should not be rejected in favor of a new measure without prior data collection or baseline performance, we believe that the data collection requirement for QCDR measures, beginning with the 2021 performance period will mitigate this concern. However, this would not be the only reason we would select an existing measure over a new QCDR measure. While some consideration would be given to an existing measure, there have been instances where a similar measure with a more vigorous (or robust) quality action had been submitted for consideration. In instances where we are able to identify strong qualities in both similar measures, we ask for measure harmonization. In instances, where one measure completely overlaps another's clinical concept but includes a more robust quality action, our preference would be to select the more robust QCDR measure (regardless of a given QCDR measure's history within the program). We expect QCDRs to be nimble and innovative and work collaboratively and independently to develop inventive measures that go beyond standard-of-care, process measures. A QCDR's relevant expertise in the specialty is given some consideration, but would not be the deciding factor as several QCDRs may have overlapping expertise. In instances in which a QCDR has simply duplicated another existing approved QCDR measure without modification, we would not approve the newly duplicated QCDR measure. Furthermore, we appreciate the commenter's suggestion that we consult with clinicians and measurement staff in the specialty societies regarding clinical aspects of measurement. We want to note that QCDR measures are reviewed by staff and contractors who have various clinical backgrounds and experience with quality measures, including input from physicians on CMS staff and on our contracting team. There may be instances where the QCDR is affiliated with a specialty society, but this is not always the case. We would expect that QCDRs would develop QCDR measures reflective of their area of clinical experience and strength, and continuously engage in discussions with the QCDRs regarding the clinical aspects of their QCDR measures through QCDR measure preview calls and QCDR measure reconsideration calls. It is at these meetings where QCDRs are given the opportunity to present and rationalize the need for quality metrics around the topic at hand. We disagree that specialty societies should be involved in evaluating QCDR measures for which they are not the owners of, while we understand they may be experts in their respected field, we believe conflicts of interest may arise when the specialty society themselves have their own QCDR and are then allowed to evaluate QCDR measures from another QCDR of the same specialty.

Comment: A few commenters stated that CMS should not encourage harmonization in cases where one QCDR is effectively trying to use another QCDR's measure without license or compensation.

Response: In instances in which a QCDR has simply duplicated another existing approved QCDR measure without modification, we would not request harmonization or approve the newly duplicated QCDR measure. The QCDR will be requested to seek permission from the QCDR who owns the previously approved QCDR measure. Ultimately, any concerns with infringement of intellectual property of QCDR measures between QCDRs will be left between the QCDRs to mitigate and resolve.

Comment: A few commenters disagreed with CMS' encouragement of harmonization due to their belief that the process of achieving harmonization is difficult ''when one QCDR may own the changes and carry them out while another QCDR may act as the measure steward.'' One commenter asserted that harmonization places undue burden to reporting clinicians and eliminates the flexibility that had been originally built into QCDR measure reporting.

Response: We thank the commenter for raising these concerns. In our view, QCDR measures that are not harmonized place undue burden on reporting clinicians and eliminates flexibility. The brunt of the responsibility falls to QCDRs to resolve duplication and harmonization efforts to submit a consolidated QCDR measure. We believe measure harmonization is consistent with the Meaningful Measure Initiative. The purpose of measure harmonization is to reduce and consolidate the number of duplicative or similar measures within the program, which would result in a larger cohort of clinicians reporting on a consolidated measure. We believe this would improve the likelihood that newly harmonized measures will be able to reach benchmarking thresholds. We expect that if QCDRs are unable to determine roles and responsibilities as it pertains to measure harmonization efforts, they would inform CMS; we would use such information to help determine whether the most robust measure should instead just be selected.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, beginning with the 2020 performance period, we are finalizing that after the self-nomination period closes each year, we will review newly self-nominated and previously approved QCDR measures based on considerations as described in the CY 2019 PFS final rule (83 FR 59900 through 59902). We are also finalizing our proposal to amend § 414.1400 to add paragraph (b)(3)(v)(E) to state that beginning with the 2022 MIPS payment year, CMS may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. If the QCDR measures are not harmonized, CMS may reject the duplicative QCDR measure(s) as discussed in section III.K.3.g.(3)(c)(i)(C) of this final rule.

(C) QCDR Measure Rejections

In the CY 2020 PFS proposed rule (84 FR 40818), we proposed QCDR measure rejection criteria that generally align with finalized removal criteria for MIPS quality measures in the CY 2019 PFS final rule (83 FR 59763 through 59765). Utilizing these considerations would help to ensure that QCDR measures available in the program are truly meaningful and measurable areas where quality improvement is sought. As part of the proposal (84 FR 40818), all previously approved QCDR measures and new QCDR measures would be reviewed on an annual basis (as a part of the QCDR measure review process that occurs after the self-nomination period closes on September 1st) to determine whether they are appropriate for the program.

We proposed to amend § 414.1400 to add paragraph (b)(3)(vii) to state that beginning with the 2020 performance period, QCDR measure rejection criteria, include, but are not limited to, the following factors (84 FR 40818):

- QCDR measures that are duplicative or identical to other QCDR measures or MIPS quality measures that are currently in the program.
- QCDR measures that are duplicative or identical to MIPS quality measures that have been removed from MIPS through rulemaking.
- QCDR measures that are duplicative or identical to quality measures used under the legacy Physician Quality

Reporting System (PQRS) program, which have been retired.

• QCDR measures that meet the ''topped out'' definition as described at § 414.1305 and in the CY 2017 Quality Payment Program final rule (81 FR 77282 through 77283). If a QCDR measure is topped out and rejected, it may be reconsidered for the program in future years if the QCDR can provide evidence through additional data and/or recent literature that a performance gap exists and show that the measure is no longer topped out during the next QCDR measure self-nomination process.

• QCDR measures that are process-based, with considerations to whether the removal of the process measure impacts the number of measures available for a specific specialty.

• Whether the QCDR measure has potential unintended consequences to a patient's care. For example, the measure disqualifies a patient from receiving oxygen therapy or other comfort measures.

• Considerations and evaluation of the measure's performance data, to determine whether performance variance exists.

• Whether the previously identified areas of duplication have been addressed as requested. (We refer readers to our proposal discussed in section III.K.3.g.(3)(c)(i)(B) of the CY 2020 PFS proposed rule (84 FR 40816).)

• QCDR measures that split a single clinical practice or action into several QCDR measures. For example, splitting a measure into multiple measures based on a particular body extremity: Improvement in toe pain—the 5th toe, and a separate measure for the 2nd toe.

• QCDR measures that are ''check-box'' with no actionable quality action. For example, a QCDR measure that measures that a survey has been distributed to patients.

• QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years (we also refer readers to our proposal in section III.K.3.g.(3)(c)(ii) of the proposed rule (84 FR 40818).

• Whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality action, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization.

• QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician. (That is, the quality aspect being measured cannot be attributed to the clinician or is not under the direct control of the reporting clinician).

• QCDR measures that focus on rare events or ''never events'' in the measurement period. An example of a ''never event'' would be a fire in the operating room.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters agreed with the proposed QCDR measure rejection criteria, specifically noting that the criteria make QCDRs a more comprehensive solution for providers and allow them to better leverage the data they are collecting.

Response: We thank commenters for their support.

Comment: A few commenters urged CMS to consider the limited number of measures available to non-patient facing clinicians when evaluating process-based measures.

Response: As a part of our QCDR measure considerations, we will take into consideration the availability of measures for a given specialty, particularly those for non-patient facing clinicians. While our general preference is to have more outcome measures in the program, we do understand a need for process measures, particularly for non-patient facing clinicians. Non-patient facing clinicians are limited in the availability of outcome measures that are available and measurable within their practice. Therefore, in instances where the outcome related metrics are limited or topping out, we encourage non-patient facing specialties to develop measures that address a high priority area (such as patient experience or care coordination) when it is not feasible to develop outcome measures.

Comment: One commenter disagreed with what they believe is the routine removal of QCDR process measures without regard to their relationship to outcome, impact on safety, demonstrated gap in practice, or the duration of time before an outcome measure exists or before outcome data are available. The commenter further noted that process measures should not be rejected if QCDR data proves that they improve outcomes and they are not topped out, as process measures require considerable work, are not ''check box'' measures, are difficult to perform, and target a demonstrated gap in practice.

Response: While our general preference is to have more outcome measures in the program, we do understand a need for process measures, particularly for non-patient facing clinicians. We would encourage specialties to develop measures that address a high priority area when it is not feasible to develop outcome measures. In addition, we will take into consideration performance gap information that is provided by a QCDR that demonstrates a process measure is not topped out. As a part of the QCDR measure review process, we do take into consideration any concerns with safety, any gap information a QCDR can provide to demonstrate one exists. We note that while we generally prefer outcome measures, and would like to move away from process measures in the program, we understand the time it takes to develop outcome measures. We consider ''check box'' measures, as measures that we have observed to be low-bar process measures that require a limited quality action that top out fairly quickly within the MIPS program and in our legacy PQRS program. If QCDRs are able to demonstrate a gap in practice for their process measure that information will be considered as a part of the QCDR measure approval process. In instances where QCDRs may disagree with their QCDR measure rejection, they may request a reconsideration call to discuss their position with CMS.

Comment: One commenter disagreed with the following rejection criteria: ''QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician. (That is, the quality aspect being measured cannot be attributed to the clinician or is not under the direct control of the reporting clinician)''. The commenter believed that it is often the case that a quality action is not in a clinician's direct control, but that does mean the clinician should not take responsibility for ensuring high quality of care; another words in instances when the measure is not directly attributable to the clinician, the clinician should not be held responsible for the quality of care. The commenter further cited their belief that this criterion is contrary to CMS' overarching goal of promoting and rewarding coordinated care.

Response: We understand the importance of care coordination, but we also believe it is important that clinicians and groups are not inadvertently penalized for actions that are outside of their control. We understand that clinicians may not always have direct control of the quality action taking place, and that there are instances where care utilizes a team-based approach. We have discussed our concerns regarding attribution and holding an individual clinician responsible for the results of a team-based approach with QCDRs during

some of their QCDR measure reconsideration calls, and they have clarified that in some specialties, this is the approach they choose to use to provide high quality care. Many patient outcomes are multi-factorial and can be influenced by the actions of multiple clinicians, even if none of them control it directly. After the QCDR measure self-nomination period, as part of our measure review process, we review clinician attribution criteria. As part of the QDCR measure nomination, for measures that do not have a clear clinician attribution, we encourage QCDRs to submit a short explanation. We continue to be open to having discussions with QCDRs as they develop QCDR measures to understand the way in which they have attributed a measure. We do note that we will expect that QCDRs will provide evidence that shows that their attribution methodologies are valid, and will note that we will ultimately decide the QCDR measures approval status on a case-by-case basis.

Comment: One commenter expressed concern that the term ''robust'' is not clearly defined as part of the rejection criteria: ''whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality action, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization''.

Response: A robust measure refers to measures with the most vigorous quality action or guidance or as a descriptor to describe strong, vigorous, or thoroughly vetted components of a measure. We also refer readers to the CMS Blueprint where we have similarly defined ''robust'': *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf.*

Comment: A few commenters disagreed with the policy for rejecting topped-out QCDR measures due to their beliefs that CMS is limiting the number of specialty-specific measures available in the MIPS program by not providing QCDRs a grace period to phase out measures; and that CMS should allow QCDR measure developers to re-tool measures removed from the program into specialty or procedure-specific measures. One commenter expressed its belief that allowing QCDR measures to be phased out over more than a 1-year period will give measure owners time to appropriately phase out the measure, and determine what subsequent action to take, such as retiring the measure, modifying the measure to make it more robust, or creating a complementary measure. Another commenter requested that CMS publicly report measure data stratified by specialty, as well as practice size and type, prior to removing a measure due to it being topped out.

Response: We thank the commenter for their input but note that we do not see the need for a grace period to phase out QCDR measures. It is not consistent with the Meaningful Measures Initiative to retain topped out QCDR measures in the program when there are other relevant measures available for a given specialty. As a part of the review process, consideration is given to the number of measures remaining for a given specialty, whether there are additional specialty related measures in other QCDRs, and considerations to the MIPS quality measures inventory prior to rejecting a QCDR measure. In addition, QCDRs are expected to be nimble and innovative to work collaboratively and independently to develop inventive measures, which go beyond standard-of-care, process measures, that are often considered low-bar. We anticipate that QCDRs monitor the progress of their QCDR measures throughout the performance period, as well as year-over-year, and through their innovation, will work to submit new QCDR measures in future self-nomination periods. As a part of our QCDR measure removal process, we do give consideration to the availability of other specialty-specific measures, particularly outcome or high priority measures, available in the MIPS program prior to flagging any given measure for removal. In addition, performance data provided in the QCDR measure self-nomination demonstrating that a performance gap still exists will be taken into consideration prior to a final decision.

Comment: One commenter stated its opinion that a topped out measure should not be retired without having an alternative measure in place.

Response: As a part of the measure removal process, we typically evaluate the availability of measures to a given specialty as a part of the removal process. QCDRs are expected to be innovative in their development, and we believe since they can support QCDR and MIPS quality measures, there should be a sufficient number of measures left for a given specialty.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are finalizing that all previously approved QCDR measures and new QCDR measures would be reviewed on an annual basis (as a part of the QCDR measure review process that occurs after the self-nomination period closes on September 1st) to determine whether they are appropriate for the program. We are also amending § 414.1400 to add paragraph (b)(3)(vii) to state that beginning with the 2020 performance period, we will reject QCDR measures with consideration of, but not limited to, the following factors:

- QCDR measures that are duplicative or identical to other QCDR measures or MIPS quality measures that are currently in the program.
- QCDR measures that are duplicative or identical to MIPS quality measures that have been removed from MIPS through rulemaking.
- QCDR measures that are duplicative or identical to quality measures used under the legacy Physician Quality Reporting System (PQRS) program, which have been retired.
- QCDR measures that meet the ''topped out'' definition as described at § 414.1305 and in the CY 2017 Quality Payment Program final rule (81 FR 77282 through 77283). If a QCDR measure is topped out and rejected, it may be reconsidered for the program in future years if the QCDR can provide evidence through additional data and/or recent literature that a performance gap exists and show that the measure is no longer topped out during the next QCDR measure self-nomination process.
- QCDR measures that are process-based, with considerations to whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the QCDR measure has potential unintended consequences to a patient's care. For example, the measure disqualifies a patient from receiving oxygen therapy or other comfort measures.
- Considerations and evaluation of the measure's performance data, to determine whether performance variance exists.
- Whether the previously identified areas of duplication have been addressed as requested. (We refer readers to our proposal discussed in section III.K.3.g.(3)(c)(i)(B) of this final rule.)
- QCDR measures that split a single clinical practice or action into several QCDR measures. For example, splitting a measure into multiple measures based on a particular body extremity: Improvement in toe pain- the 5th toe, and a separate measure for the 2nd toe.
- QCDR measures that are ''check-box'' with no actionable quality action. For example, a QCDR measure that measures that a survey has been distributed to patients.
- QCDR measures that do not meet the case minimum and reporting

volumes required for benchmarking after being in the program for 2 consecutive years (we also refer readers to our proposal in section III.K.3.g.(3)(c)(ii) of this final rule).

- Whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality action, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization.
- QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician. (That is, the quality aspect being measured cannot be attributed to the clinician or is not under the direct control of the reporting clinician).
- QCDR measures that focus on rare events or ''never events'' in the measurement period. An example of a ''never event'' would be a fire in the operating room.

(ii) QCDR Measure Review Process

(A) Current QCDR Measure Approval Process

We refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77374 through 77375), the CY 2018 Quality Payment Program final rule (82 FR 53813 through 53814), and the CY 2019 PFS final rule (83 FR 59900 through 59906), and § 414.1400(b)(3) for our previously established policies for the QCDR measure self-nomination process. QCDR measures are reviewed for inclusion on an annual basis during the QCDR measure review process that occurs once the self-nomination period closes (82 FR 53810). All previously approved QCDR measures and new QCDR measures are currently reviewed on an annual basis to determine whether they are appropriate for the program (82 FR 53811). The QCDR measure review process occurs after the self-nomination period closes on September 1st. QCDR measures are not finalized or removed through notice and comment rulemaking; instead, they are currently approved or not approved through a subregulatory processes (82 FR 53639). While we would continue to review measures on an annual basis, in the CY 2020 PFS proposed rule, we proposed the addition of a multi-year approval process (84 FR 40818).

(B) Multi-Year QCDR Measure Approval

Previously in the CY 2018 Quality Payment Program final rule (82 FR 53808), we discussed our concerns with multi-year approval for QCDR measures and sought comment from stakeholders as to how to mitigate our concerns. Based on the evolution of public comments in the CY 2019 PFS final rule (83 FR 59898 through 59901) and ongoing engagement with QCDRs, we are made a proposal in the CY 2020 PFS proposed rule (84 FR 40818).

Currently, our QCDR measure approvals are on a year-to-year basis (82 FR 53811), from September to December once self-nomination occurs. In addition to that process, to help reduce yearly self-nomination burden and address stakeholder feedback (83 FR 59898 through 59901), in the CY 2020 PFS proposed rule (84 FR 40818), we proposed to amend § 414.1400 to add paragraph (b)(3)(vi) to implement, beginning with the 2021 performance period, 2-year QCDR measure approvals (at our discretion) for QCDR measures that attain approval status by meeting the QCDR measure considerations and requirements described above.

However, as proposed, upon annual review, we may revoke the second year's approval if a QCDR measure approved for 2 years is (84 FR 40818 through 40819):

- Topped out (we refer readers to § 414.1305, in the CY 2017 Quality Payment Program final rule (81 FR 77282 through 77283));
- Duplicative of a more robust measure (this proposal aligns with our proposal at section III.K.3.g.(3)(c) in the proposed rule (84 FR 40814 through 40819);
- Reflects an outdated clinical guideline;
- Requires measure harmonization (this proposal aligns with our proposal at section III.K.3.g.(3)(c)(i)(B) in the proposed rule (84 FR 40816)); or
- The QCDR self-nominating the QCDR measure is no longer in good standing, as described in the CY 2018 Quality Payment Program final rule (82 FR 53808).

We believe that this policy should be an incentive for QCDRs who have remained in good standing in the program. Additionally, for QCDRs not in good standing, we want to make clear that we would not remove a measure mid-year; rather, the measure's 2-year approval would be revoked during annual review after 1 year and the QCDR's measures would no longer qualify for multi-year approval in the future. For example, if QCDR ABC is placed on probation in July, all of the QCDR's measures still would be available for reporting for that performance period (until December 31st); however, if any of QCDR ABC's QCDR measures were previously approved for 2 years, the approval would be revoked for the second year.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal to approve QCDR measures for multiple years due to their beliefs that approving measures for multiple years and posting updated specifications by November 1 would: Allow individuals and groups a better opportunity to meet the proposed 70 percent data completeness threshold; allow sufficient time for measure implementation, data collection for the next year's self-nomination, and improvement opportunities for practices; provide stability to MIPS; reduce burden; and allow for additional resources to be utilized for development of new measures.

Response: We thank commenters for their support.

Comment: A few commenters stated that QCDR measures should be approved for 2 years without being subject to CMS discretion as long as the measure satisfies QCDR measure requirements.

Response: We believe a 2-year approval should be left to our discretion, because many considerations must be given: QCDR's ability to comply with program requirements, considerations to other QCDR measures with more robust quality actions, future changes to program requirements, and in consideration of future transitions to MVPs.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are amending § 414.1400 to add paragraph (b)(3)(vi) to implement, beginning with the 2021 performance period, 2-year QCDR measure approvals (at our discretion) for QCDR measures that attain approval status by meeting the QCDR measure considerations and requirements described above. However, upon annual review, we may revoke the second year's approval if a QCDR measure approved for 2 years is:

- Topped out (we refer readers to § 414.1305, in the CY 2017 Quality Payment Program final rule (81 FR 77282 through 77283));
- Duplicative of a more robust measure (this proposal aligns with our proposal at section III.K.3.g.(3)(c) in this final rule);
- Reflects an outdated clinical guideline;
- Requires measure harmonization (this proposal aligns with our proposal at section III.K.3.g.(3)(c)(i)(B) in this final rule); or
- The QCDR self-nominating the QCDR measure is no longer in good

standing, as described in the CY 2018 Quality Payment Program final rule (82 FR 53808).

(iii) Participation Plan for Existing QCDR Measures That Have Failed To Reach Benchmarking Thresholds

We refer readers to the CY 2020 PFS proposed rule for discussion of the consideration of QCDR measures that fail to meet benchmarking thresholds after being in the program for 2 consecutive CY performance may not continue to be approved in the future (84 FR 40814 through 40818).

However, we understand that there are instances where measures that are low-reported may still be considered important to a respective specialty. Therefore, in the CY 2020 PFS proposed rule (84 FR 40819), beginning with the 2020 performance period, we proposed to amend § 414.1400 to add paragraph (b)(3)(iv)(J)(*1*) to state that in instances where a QCDR believes the low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist's practice, that the QCDR may develop and submit a QCDR measure participation plan for our consideration (84 FR 40819). This QCDR measure participation plan must include the QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program. As examples, a QCDR measure participation plan could include one or more of the following:

- Development of an education and communication plan.
- Update the QCDR measure's specification with changes to encourage broader participation, which would require review and approval by us.
- Require reporting on the QCDR measure as a condition of reporting through the QCDR.

To be clear, implementation of a participation plan would not guarantee that a QCDR measure would be approved for a future performance period, as we consider many factors in whether to approve QCDR measures. At the following annual review of QCDR measures, we would analyze the measure's data submissions to determine whether the QCDR measure participation plan was effective (meaning, reporting volume increased, thereby increasing the likelihood of the QCDR measure being benchmarked). If the data does not show an increase in reporting volume, we may not approve the QCDR measure for the subsequent year.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: A few commenters agreed with the proposal to allow QCDRs to submit measure participation plans for QCDR measures that have failed to meet benchmarking thresholds and urge CMS to leave open a mechanism for the retention of measures that are important to small segments of reporting clinicians, even if those measures fail to reach a benchmark, as this is very critical to ensuring that important measures are not removed from the program due to scoring methodologies and preferences, and to encourage reporting on high value measures.

Response: We thank the commenters for their support.

Comment: One commenter requested that CMS specify in the final rule when notice of low reporting volume will be given so that QCDRs may have ample time to develop and implement the participation plan.

Response: QCDRs should be monitoring the reporting of their QCDR measures throughout the year and should be able to identify when their measures are low-reported. In addition, existing QCDR measures who have reached benchmarking thresholds would be included in the Quality benchmarking file that is posted annually in the Quality Payment Program Resource Library.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, beginning with the 2020 performance period, we are amending § 414.1400 to add paragraph (b)(3)(iv)(J)(*1*) to state in instances where a QCDR believes the low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist's practice, that the QCDR may develop and submit a QCDR measure participation plan for our consideration. This QCDR measure participation plan must include the QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program.

(4) Qualified Registries

We refer readers to §§ 414.1305 and 414.1400, the CY 2018 Quality Payment Program final rule (82 FR 53815 through 53818) and the CY 2019 PFS final rule proposed rule (83 FR 59906) for our previously finalized policies regarding qualified registries. In the CY 2020 PFS proposed rule (84 FR 40819), we proposed to update qualified registry required services. These proposed policies would also affect the qualified registry self-nomination process.

(a) Qualified Registry Required Services

(i) Requirement for Qualified Registries To Support All Three Performance Categories Where Data Submission Is Required

We refer readers to section 1848(k)(4) of the Act for statutory authority. We also refer readers to section III.K.3.g.(1) in this final rule, where we discuss our proposal to require QCDRs and qualified registries to support three performance categories: Quality, improvement activities, and Promoting Interoperability (84 FR 40811). In addition, we refer readers to section III.K.3.g.(3)(a)(i) of this final rule where we discuss a parallel requirement for QCDRs (84 FR 40812 through 40813). In this section, we discuss qualified registries specifically. Based on previously finalized policies the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at (83 FR 60088) and § 414.1400(a)(2), the current policy is that QCDRs, qualified registries, and health IT vendors may submit data for any of the following MIPS performance categories: Quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability.

We want to continue to strengthen our policies at § 414.1400(a)(2). Based on our review of existing 2019 qualified registries, approximately 95 qualified registries, or about 70 percent of the qualified registries currently participating in the program are supporting all three performance categories. While we do not yet have data to share for how clinicians participated in 2019 (year 3), we do want to indicate that we have observed from 2017 (year 1) to 2018 (year 2) approximately 24 percent increasing to 36 percent of clinicians have used their QCDR/qualified registry for submitting for all 3 performance categories. We believe when this policy becomes finalized, more MIPS eligible clinicians may want to use this method as a burden reduction on data submission. When the CY 2020 PFS proposed rule was published the 2019 Qualified Registries Qualified Posting was available at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/348/2019%20Qualified%20Registry%20Posting_Final_v1.0.xlsx* (84 FR 40819). Since the publication of that proposed rule, the link has since been updated and is now available on the Quality Payment Program resource library at *https://qpp.cms.gov/about/resource-library* by searching ''2019 Qualified Registries Qualified Posting.''

We believe it is reasonable that all qualified registries have the capacity to support the improvement activities and promoting interoperability performance categories.

We believe that requiring qualified registries to be able to support these performance categories will be a step towards addressing stakeholders concerns on having a more cohesive participation experience across all performance categories under MIPS. In addition, we believe this proposal will help to reduce the reporting burden MIPS eligible clinicians and groups face when having to utilize multiple submission mechanisms to meet the reporting requirements of the various performance categories. Furthermore, as we move to a more cohesive participation experience under the MVPs, as discussed in the CY 2020 PFS proposed rule (84 FR 40732 through 40745), we believe this proposal will assist clinicians in that transition. We also refer readers to section III.K.3.a. of this final rule where the MIPS MVP is discussed.

Therefore, as discussed in the CY 2020 PFS proposed rule (84 FR 40819), beginning with the 2023 MIPS payment year (2021 performance period) and for future years, we proposed at § 414.1400(a)(2) to require qualified registries to support all three performance categories: Quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability with an exception. As discussed in the CY 2020 PFS proposed rule (84 FR 40819), we proposed that based on the amendment to § 414.1400(a)(2)(iii), to state that for the Promoting Interoperability performance category, the requirement applies if the eligible clinician, group, or virtual group is using CEHRT; however, a third party could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4), (c)(2)(i)(A)(5), (c)(2)(i)(C)(1) through (c)(2)(i)(C)(7), or (c)(2)(i)(C)(*9*). As part of this proposal, we will (84 FR 40819 through 40821) require qualified registries to attest to the ability to submit data for these performance categories, as applicable, at time of self-nomination. We also proposed this same requirement for QCDRs in section III.K.3.g.(3) of the CY 2020 PFS proposed rule (84 FR 40813) and refer readers to section III.K.3.g.(3) of this final rule for a discussion.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters agreed with the proposal to require qualified registries to support the reporting of data for the quality, Promoting Interoperability, and improvement activities performance categories, as well as the exemption for qualified registries who serve specialties that are exempt from the Promoting Interoperability performance category.

Response: We thank the commenters for their support.

Comment: A few commenters noted that the proposal should not be considered until after the final 21st Century Cures rules are published and the updated standards are implemented.

Response: We understand the interest in coordinating with the updates to standards that may be included in the 21st Century Cures Act final rule, however we do not believe that the proposals under the 21st Century Cures Act will have a significant impact on the ability of qualified registries to report measures for the Promoting Interoperability category. We note this requirement was proposed with a delayed implementation, beginning with the 2023 MIPS payment year (2021 performance period), which should accommodate timing for any updates to standards. When the 21st Century Cures Act final rule is published we will determine if additional modifications are necessary and may address in future rule making.

Comment: One commenter cited its opinion that if the proposal is finalized, the resulting burden may result in many qualified registries electing to reevaluate their decisions to seek approval to submit MIPS data.

Response: While we understand that this requirement may add burden to qualified registries, we want to note a majority of existing qualified registries already support all three performance categories. In addition, we believe it is important that qualified registries act as one-stop-shops for reporting to reduce the reporting burden on eligible clinicians and groups.

Comment: Multiple commenters also stated their opinion that if the proposal to require qualified registries to support the three performance categories is finalized, they would need CMS to provide additional guidance and descriptions of what data would be necessary to validate that an individual MIPS eligible clinician or group could appropriately attest to a specific activity.

Response: Under our current data validation processes, as described in the CY 2017 Quality Payment Program final rule (81 FR 77368 through 77369) and (81 FR 77384 through 77385), QCDRs and qualified registries are required to provide information on their sampling methodology. For example, it is encouraged that 3 percent of TIN/NPIs submitted be sampled with a minimum sample of 10 TIN/NPIs or a maximum sample of 50 TIN/NPIs. For each TIN/NPI sampled, it is encouraged that 25 percent of the TIN/NPI's patients (with a minimum sample of 5 patients (with a maximum sample of 50 patients). We would expect that this review of patient medical records would be done to validate that the pertinent quality actions were done for measures and activities done by the clinician and group. In addition, validation guidance clarifications can be found within the improvement activities validation document at the *MIPS Data Validation Document* link. Third party intermediaries should utilize existing validation procedures to audit data submitted. With regards to auditing whether improvement activities have been completed by a clinician or group, a third party vendor can validate that an action has been done through review of medical records or other forms of documentation that will indicate that the quality action and/or improvement activity has been completed.

Comment: One commenter requested that CMS provide a mechanism for exempting MIPS qualified registries approved for the 2019 MIPS performance period if they submit a rationale for not supporting all three performance categories.

Response: We clarify that this requirement to support all three performance categories will take into effect starting with the 2021 performance period. Qualified registries will be required to support the quality and improvement activity performance categories. A third party intermediary may not be required to submit data for the Promoting Interoperability performance category if it only represents MIPS eligible clinicians, groups, and virtual groups that are eligible for reweighting under the Promoting Interoperability performance category. For example, as discussed in the CY 2019 PFS final rule (83 FR 59819 through 59820), physical therapists generally are eligible for reweighting of the Promoting Interoperability performance category to zero percent of the final score; therefore, under this exception, a QCDR or qualified registry that represents only physical therapists that reweighted the Promoting Interoperability performance category to zero percent of the final score, would not be required to support the Promoting Interoperability performance category. In addition, QCDRs or

qualified registries that supported one of the following clinician types (and no others): Occupational therapists; qualified speech-language pathologists; qualified audiologists; clinical psychologists; and registered dieticians or nutrition professionals, as described in § 414.1380(c)(2)(i)(A)(4) would be excepted from supporting the Promoting Interoperability performance category. In contrast, a QCDR or qualified registry cannot be excepted from this requirement and must be able to submit data for the Promoting Interoperability performance category so long as it supports any clinician, group or virtual group that uses CEHRT and is not identified as eligible for reweighting of the Promoting Interoperability performance category.

After consideration of the comments, we are finalizing our proposals with technical modifications for clarity and consistency with the existing provisions of § 414.1400. As discussed in section III.K.3.g.(1), above in this final rule, we are amending § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all of the MIPS performance categories identified in the regulation, and Health IT vendors must be able to submit data for at least one such category. We are also finalizing our proposal to amend § 414.1400(a)(2)(iii), as proposed, to state that for the Promoting Interoperability, if the eligible clinician, group, or virtual group is using CEHRT; however, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (*5*) or § 414.1380(c)(2)(i)(C)(*1*) through (*7*) or § 414.1380(c)(2)(i)(C)(*9*)). We will require qualified registries to attest to the ability to submit data for these performance categories, as applicable, at time of self-nomination (84 FR 40819 through 40821).

(ii) Enhanced Performance Feedback Requirement

Section 1848(q)(12)(A)(ii) of the Act requires the Secretary to encourage the provision of performance feedback through qualified registries. In addition, in establishing the requirements, the Secretary must consider, among other things, whether an entity ''provides timely performance reports to participants at the individual participant level''. Currently, CMS requires qualified registries to provide feedback on all of the MIPS performance categories at least 4 times per year (81 FR 77367 through 77386). While based on our experiences thus far during the initial years of the Quality Payment Program, we agree that providing feedback at least 4 times a year is appropriate. However, in the future CMS would like to see, and therefore, encourages qualified registries, to provide timely feedback on a more frequent basis more than 4 times a year. Receipt of more frequent feedback will help clinicians and groups make more timely changes to their practice to ensure the highest quality of care is being provided to patients. We see value in providing more timely feedback to meet the objectives [119] of the Quality Payment Program in improving the care received by Medicare beneficiaries, lowering the costs to the Medicare program through improvement of care and health, and advance the use of healthcare information between allied providers and patients. We also believe there is value in this performance feedback, and therefore, encourage qualified registries to work with their clinicians to get the data in earlier in the reporting period so the qualified registry give that meaningful timely feedback.

Surrounding the qualified registry performance feedback provided to clinicians and groups, we have heard from stakeholders that not all qualified registries provide feedback the same way. We have heard through stakeholder comments some qualified registries feedback contains information needed to improve quality, whereas other qualified registries feedback does not supply such information due to the data collection timeline. Additionally, we believe that clinicians would benefit from feedback on how they compare to other clinicians who have submitted data on a given MIPS quality measure within the qualified registry they are reporting through, so they can identify areas of measurement in which improvement is needed, and furthermore they can see how they compare to their peers based within a qualified registry, since the feedback provided by the qualified registry would be limited to those who reported on a given measure using that specific qualified registry.

As a result, we proposed to add a new paragraph at § 414.1400(c)(2) to require (i) and (ii) (84 FR 40820). We simply proposed to revise the current § 414.1400(c)(2) to reclassify at paragraph (c)(2)(i) that beginning with the 2022 MIPS payment year, the qualified registry must have at least 25 participants by January 1 of the year prior to the applicable performance period (84 FR 40820). Additionally, we proposed to add a new paragraph, § 414.1400(c)(2)(ii), beginning with the 2023 MIPS payment year, to require that qualified registries provide the following as a part of the performance feedback given at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the qualified registry (84 FR 40820). We understand that there would be instances in which the qualified registry cannot meet this requirement; and therefore, we also proposed an exception to this requirement: If the qualified registry does not receive the data from their clinician until the end of the performance period, this will preclude the qualified registry from providing feedback 4 times a year, and the qualified registry could be excepted from this requirement (84 FR 40820). We also solicited comment on other exceptions that may be necessary under this requirement.

We also understand that qualified registries can only provide feedback on data they have collected on their clinicians and groups, and realize the comparison would be limited to that data and not reflect the larger sample of those that have submitted on the measure for MIPS, which the qualified registry does not have access to. We believe qualified registry internal comparisons can still help MIPS eligible clinicians identify areas where further improvement is needed. The ability for MIPS eligible clinicians to be able to know in real time how they are performing against their peers, within a qualified registry, provides immediate actionable feedback.

Furthermore, in the CY 2020 PFS proposed rule (84 FR 40820), we also proposed to strengthen the qualified registry self-nomination process at § 414.1400(c)(1) to add that beginning with the 2023 MIPS payment year, qualified registries are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at § 414.1400(c)(2)(ii)). We refer readers to section III.K.3.g.(3)(1) of this final rule where we discuss a parallel requirement for QCDRs (84 FR 40814); we intend to have the same requirements for both QCDRs and qualifies registries.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters agreed with the proposal for qualified registries to provide enhanced performance feedback at least 4 times a year including comparisons to other

[119] Quality Payment Program Overview. *https://qpp.cms.gov/about/qpp-overview.*

clinicians who reported the same measure, at minimum. A few commenters agreed with the proposal that beginning in 2021, feedback from qualified registries must be provided at least 4 times a year and must include information on how participants compare to other clinicians within the qualified registry who have submitted data on a given measure. Commenters noted that this feedback and comparison is very beneficial to their participants and helps them identify potential areas for performance improvement as compared to their peers.

Response: We thank the commenters for their support.

Comment: Other commenters expressed concern that this would not provide participants with feedback on their performance from a programmatic perspective as a single registry does not represent a participant's entire peer cohort and providing registry-specific comparative performance feedback to compare their performance with that of their peers or predict their potential MIPS performance. Instead, the commenters stated their belief that it would be more appropriate to compare a MIPS eligible clinician or group's performance against the published benchmark.

Response: We thank the commenter for raising this concern. To clarify, the intent of providing eligible clinicians and groups with this performance feedback is to give them feedback on how they compare to other clinicians (their peers) who have submitted data on a given MIPS quality measure within the qualified registry they are reporting through. Additionally, the intent of this feedback is so clinicians can identify areas of quality measurement in which improvement is needed, and furthermore, they can see how they compare to their peers based within a qualified registry. While we understand that it is not feasible for a single registry to represent the cohort of all clinicians who have reported on a given measure, it at least gives the clinicians within the single registry an idea of how well they performed with other fellow clinicians within the registry. We believe that it is important to provide meaningful data back to clinicians to understand and identify areas for improvement. We are only able to compare a MIPS eligible clinician or group's performance against a published benchmark when the qualified registry measure has reached the appropriate benchmarking and reporting thresholds, after the submission period for a given performance period closes. However, we believe it is important that clinicians and groups receive performance feedback in a timely fashion, by their qualified registry, in order to make real-time process improvements to their practice to improve the quality of care.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are amending § 414.1400(c)(2) to add (i) and (ii). We are amending the current § 414.1400(c)(2) to reclassify at paragraph (c)(2)(i) that beginning with the 2022 MIPS payment year, the qualified registry must have at least 25 participants by January 1 of the year prior to the applicable performance period. Additionally, we are also finalizing a new paragraph at § 414.1400(c)(2)(ii) to require that, beginning with the 2023 MIPS payment year, qualified registries provide the following as a part of the performance feedback given at least 4 times a year, provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the qualified registry. We are also finalizing an exception to this requirement: If the qualified registry does not receive the data from their clinician until the end of the performance period, this will preclude the qualified registry from providing feedback 4 times a year, and the qualified registry could be excepted from this requirement. We are also finalizing, as proposed, at § 414.1400(c)(1) to add that beginning with the 2023 MIPS payment year, qualified registries are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at § 414.1400(c)(2)(ii)).

In the CY 2020 PFS proposed rule (84 FR 40814), we sought comment for future notice-and-comment rulemaking on whether we should require MIPS eligible clinicians, groups, and virtual groups who utilize a qualified registry to submit data throughout the performance period, and prior to the close of the performance period (that is, December 31st). The current performance period begins January 1 and ends on December 31st, and the corresponding data submission deadline is typically March 31st as described at § 414.1325(e)(1). We also sought comment for future notice-and-comment rulemaking, on whether clinicians and groups can start submitting their data starting April 1 to ensure that the qualified registry is providing feedback and the clinician or group during the performance period. This would allow qualified registries some time to provide enhanced and actionable feedback to MIPS eligible clinicians prior to the data submission deadline.

While we are not summarizing and responding to comments we received on this topic in this final rule, we thank the commenters for their responses and will take them into consideration as we develop future policies for qualified registries.

(5) Remedial Action and Termination of Third Party Intermediaries

We refer readers to § 414.1400(f), the CY 2017 Quality Payment Program final rule (81 FR 77548) and the CY 2019 PFS final rule (83 FR 59908 through 59910) for previously finalized policies for remedial action and termination of third party intermediaries.

As explained in the CY 2020 PFS proposed rule (84 FR 40820), based on experience with third party intermediaries thus far, we have concerns that certain third party intermediaries may not fully appreciate their existing compliance obligations or the implications of non-compliance. Among other provisions, § 414.1400(a)(5) specifically obligates each third party intermediary to certify that all data it submits to CMS on behalf of a MIPS eligible clinician, group or virtual group is true, accurate and complete to the best of its knowledge. Section 414.1400(f)(1) states that, after providing written notice, CMS may take remedial action or terminate a third party intermediary if CMS determines that the third party intermediary has ceased to meet one or more of the applicable criteria for approval or has submitted data that is inaccurate, unusable or otherwise compromised. Moreover, § 414.1400(f)(3) identifies specific circumstances under which CMS may determine that data submitted by a third party intermediary meets the standard for inaccurate, unusable or otherwise compromised data.

Third parties intermediaries have an affirmative obligation to certify that the data they submit on behalf of a MIPS eligible clinician, group or virtual group are true, accurate and complete to the best of its knowledge. MIPS data that are inaccurate, incomplete, unusable or otherwise compromised can result in improper payment. Using data selection criteria to misrepresent a clinician or group's performance for an applicable performance period, commonly referred to as ''cherry-picking,'' results in data submissions that are not true, accurate or complete. A third party intermediary cannot certify that data submitted to CMS by the third party intermediary are true, accurate and complete to the best of its knowledge if the third party intermediary knows the data submitted

are not representative of the clinician's or group's performance. Accordingly, a third party intermediary that submits a certification under § 414.1400(a)(5) in connection with the submission of data it knows are cherry-picked has submitted a false certification in violation of existing regulatory requirements. If CMS believes cherry-picking of data may be occurring, we may subject the third party intermediary and its clients to auditing in accordance with § 414.1400(g).

In the CY 2020 PFS proposed rule (84 FR 40821), we explained that despite these existing obligations, we have received inquiries from third party intermediaries regarding perceived opportunities to selectively submit data that are unrepresentative of the MIPS performance of the clinician or group for which the third party intermediary is submitting data. These inquires suggest that certain third party intermediaries may not fully appreciate their current regulatory obligations or their implications.

The current regulations at § 414.1400(f) clearly establish that CMS enforcement authority includes the authority to pursue remedial actions or termination based on its determination that a third party intermediary was non-compliant with any applicable criteria for approval in § 414.1400(a) through (e) or if the third party intermediary submitted data that are inaccurate, unusable or otherwise compromised. Compliance with § 414.1400(a)(5) is a criteria for approval. Using data selection criteria to misrepresent a clinician or group's performance for an applicable performance period results in data that are inaccurate, unusable and otherwise compromised. Accordingly, if CMS determined that third party intermediary knowingly submitted data that are not representative of the clinician's or group's performance and certified that the submitted data were true, accurate and complete, CMS would have multiple grounds to impose remedial action or termination under existing regulations.

As described in the CY 2020 PFS proposed rule (84 FR 40821), we proposed two changes to more expressly emphasize CMS enforcement authority. First, we proposed to clarify that remedial action and termination provisions at § 414.1400(f)(1) are triggered if we determine that a third party intermediary submits a false certification under paragraph (a)(5). Second, we proposed to clarify that CMS authority to bring remedial actions or terminate a third party intermediary for submitting data that is inaccurate, unusable or otherwise compromise extends beyond the specific examples set forth in § 414.1400(f)(3). We explained that with these revisions and a grammatical correction proposed at § 414.1400(f)(1), we would affirm existing CMS authority to purse remedial actions or termination if we determine that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, submits a false certification under paragraph (a)(5), or has submitted data that are inaccurate, incomplete, unusable, or otherwise compromised (84 FR 40821). We noted that we anticipate that these revisions will emphasize to third party intermediaries the sanctions they may face from CMS if they submit improper data to CMS. In addition, we noted that third party intermediaries may face liability under the federal False Claims Act if they submit or cause to submission of false MIPS data.

We proposed revisions to § 414.1400(f)(3) to clarify the intent of this provision (84 FR 40821). We also refer readers to CY 2019 PFS final rule (83 FR 59908 through 59910) for the discussion of the evolution of policies regarding remedial actions and termination of a third party intermediary. The agency's enforcement authority as codified in § 414.1400(f) broadly extends to include instances of willful misconduct by the third party intermediary and well as other instances in which a third party intermediary inadvertently submits data with deficiencies and errors that render the data ''inaccurate, unusable or otherwise compromised.'' To facilitate a more fulsome understanding on when inadvertent conduct could trigger an enforcement action against a third party intermediary, the current regulatory text in § 414.1400(f)(3) provides that the threshold for ''inaccurate, unusable or otherwise compromised'' may be met if the submitted data includes TIN/NPI mismatches, formatting issues, calculation errors, or data audit discrepancies that affect more 3 percent of the total number of MIPS eligible clinicians or groups for which data was submitted by the third party intermediary. Through the CY 2020 PFS proposed rule (84 FR 40821), we proposed to add the phrase ''including but not limited to'' to the text of § 414.1400(f)(3) to emphasize that this provision is illustrative of circumstances that may result in enforcement action and should not be misinterpreted to limit the agency's ability to impose remedial actions or terminate a third party intermediary that knowingly submits inaccurate data.

Lastly, we proposed grammatical corrections related to the use of the plural term ''data'' (84 FR 40821).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters expressed support for CMS conducting audits if we believe data have been ''cherry-picked'' or are otherwise not accurate.

Response: We thank commenters for their support.

Comment: Another commenter further encouraged CMS to publish aggregate information from their 2018 auditing of MIPS eligible clinicians and groups with regard to suspected instances of cherry-picked data in regard to third party intermediaries.

Response: We thank the commenter for their suggestion, and would encourage them to clarify what type of aggregated data they are looking for as these types of audit results are not typically published.

Comment: A few commenters stated that although CMS has provided some indication of what may constitute an inaccuracy, greater clarity and transparency is critical so that registries can implement appropriate checks and identify additional data inaccuracies or errors beyond those that are detected through each registry's CMS approved data validation plan. The commenters further urged CMS to: Clearly define a registry's responsibility to address data inaccuracies that can be attributed to data that the registry has access to, controls and manages; consider developing a report that describes and differentiates errors, as well as other ''issues'' that should be brought to the registry's attention; clearly define what is considered when calculating an error rate; and provide additional detail regarding CMS' description of criteria that may disqualify a third-party intermediary. One commenter specifically stated its belief that when individuals or practices withhold Medicare billing data, this unavailable data should not be counted against the registry as an inaccuracy since the registry has no readily available solution to address this issue without access to current CMS' claims data. One commenter encouraged CMS to release additional instructions for individual clinicians and groups to understand their responsibilities in submitting accurate and complete data and not hold third-parties accountable for data issues outside their control.

Response: We thank the commenters for their suggestions. As described in the CY 2017 Quality Payment Program

final rule (81 FR 77366 through 77374), and through our resources in the Quality Payment Program Resource Library, such as our 2020 Self-Nomination Tool Kit for QCDR and qualified registries: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip* we provide further descriptions of the expectations of data validation plans and examples of what would constitute data inaccuracies, including the guidance that the QCDR should make CMS aware of any errors that may impact a clinician's ability to report or how the clinician may score on a measure or overall. We refer commenters to the MIPS Data Validation Execution Report (DVER) template and the self-nomination factsheet for further details on expectations of data validation and discussion of remedial action and termination due to these error rates, both documents can be found on the Quality Payment Program Resource Library *https://qpp.cms.gov/about/resource-library.* In addition, on a monthly basis through our mandatory support calls (81 FR 77368), we have typically reminded our approved QCDRs and qualified registries of our expectations for the data validation execution report and the methodology for calculating error rates and we anticipate using these calls and other guidance for additional education of third party intermediaries in the future. We will look to provide additional education to clinicians and groups in understanding their responsibility to help ensure the data submitted on their behalf by third party intermediaries are true, accurate, and complete data. However, we believe third parties intermediaries are also accountable for the accuracy of what they submit to CMS. If a third party intermediary finds inaccuracies or data integrity issues, it should ensure that it does not knowingly submit data that are misrepresentative, and are not true, accurate, or complete. We will take the commenters suggestions into future consideration.

Comment: A few commenters requested clarification on whether specific scenarios involved data inaccuracies that would trigger remedial action. One commenter sought clarification on whether a data submission is inaccurate if the submission misstates whether a clinician is a non-MIPS eligible clinician, a Qualified APM Participant or other APM participant; and if that misstatement would trigger a remedial action under § 414.1400(f). Another commenter sought clarification as to whether a qualified registry would be subject to remedial action if the data submitted did not meet appropriate data completeness thresholds.

Response: We believe it is the responsibility of the third party intermediary to validate data prior to submission to CMS and to ensure that the data is true, accurate, and complete to the best of its knowledge. This certification is applicable to information regarding a clinician's eligibility status. We expect that data submitted by third party intermediaries are true, accurate and complete to the best of the submitter's knowledge. If a third party intermediary knows data are not true, accurate or complete, the third party intermediary should not submit those data. Whether CMS will bring remedial action or terminate a third party intermediary under § 414.1400(f) for submitting a false certification or for submitting data that are inaccurate, unusable or otherwise compromised depends on the particular facts and circumstances. If a third party intermediary submits data that misstate whether a clinician is non-eligible, a Qualified APM Participant, or other APM participant then the third party intermediary has submitted data that are inaccurate. We believe that third party intermediaries should be able to track the eligibility status of the clinicians and groups they support MIPS reporting for, particularly as it pertains to MIPS eligible, voluntary participation, and opt-ins. That is to also to account for those clinicians and groups who have chosen to opt-in participating in the program. If we determine a third party intermediary is misrepresenting the status of its clinicians, we would anticipate seeking a corrective action plan from the third party intermediary to address these deficiencies. If its submission meets applicable program requirements, such as a submission of data on a single patient to meet a minimum threshold, a third party intermediary may be able to accurately certify that the data it is submitting are true, accurate and complete even if the data does not meet the data completeness threshold for an individual eligible clinician. Data submissions that do not meet appropriate data completeness thresholds (as described in section III.K.3.c of this final rule) will not receive an error message from the system, and will be scored according to the scoring regulations at § 414.1380. If the data submitted does not satisfy the data completeness thresholds, the submission is unlikely to receive full credit, and will be scored accordingly; however, this alone would not render the third party intermediary's submission incomplete for purposes § 414.1400. Through our resources in the Quality Payment Program Resource Library, known as our 2020 Self-Nomination Tool Kit (*https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip*), we provide further descriptions of the expectations of data validation plans and examples of what would constitute data inaccuracies. Failure to comply with program regulations could result in remedial action. From the data error perspective, we remind third party intermediaries that they are expected to certify that their data submissions are true, accurate, and complete to the best of their knowledge.

Comment: One commenter expressed their belief that the provision in § 414.1400(f)(3)(ii) which gives weight to data errors that affect 3 percent of the MIPS eligible clinicians and groups whose data was submitted by the third party intermediary may unfairly penalize third party intermediaries with a small number of participants. The commenter provided the example that a quality registry reporting for only 25 clinicians triggering the 3 percent threshold if its submission included a data error on a single patient of a single clinician. The commenter recommended revising the provision such that the threshold was measured based on the percentage of patients reported by third party intermediary rather than the percentage of clinicians.

Response: We believe it is important to hold third party intermediaries responsible for data errors regardless of the volume of clinicians and groups they support. Third party intermediaries with smaller volumes of reporting clinicians and groups should be able to ensure the accuracy of the data they submit and have fewer errors when compared to larger third party intermediaries. To facilitate a more fulsome understanding on when inadvertent conduct could trigger an enforcement action against a third party intermediary, the current regulatory text in § 414.1400(f)(3) provides that the threshold for ''inaccurate, unusable or otherwise compromised'' may be met if the submitted data includes TIN/NPI mismatches, formatting issues, calculation errors, or data audit discrepancies that affect more 3 percent of the total number of MIPS eligible

clinicians or groups for which data was submitted by the third party intermediary. Through the CY 2020 PFS proposed rule (84 FR 40821), we proposed to add the phrase ''including but not limited to'' to the text of § 414.1400(f)(3) to emphasize that this provision is illustrative of circumstances that may result in enforcement action and should not be misinterpreted to limit the agency's ability to impose remedial actions or terminate a third party intermediary that knowingly submits inaccurate data. We disagree with the commenter's suggestion to revise the policy to state that the threshold should be measures based on the percentage of patients reported by the third party intermediaries rather than the percentage of clinicians because this auditing at the patient level does not allow us to determine the overall impact of the data error to the cohort of clinicians who utilized the third party to report. Utilizing the percentage of patients as the data error threshold may lead to inaccurate representations of the overall impact of a data error found through third party reporting.

Comment: Some commenters urged CMS to be mindful that from their perspective third party intermediaries, especially specialty society clinical data registries, do not have the capacity to tell whether a group has specifically submitted false or incomplete data. These commenters believed it is the responsibility of the MIPS eligible clinician or group to demonstrate to CMS that their data are accurate and complete using documentation as described by CMS in this rule. Moreover, if ''cherry-picking'' is found by CMS, these commenters believed the audit should be sent to the MIPS eligible clinician or group, and not the third party intermediary.

Response: We believe it is the responsibility of the third party intermediary to validate data prior to submission to CMS and to ensure that the data it submits are true, accurate, and complete to the best of its knowledge. It should be a joint responsibility of the eligible clinician and the third party intermediary to ensure that data submitted to CMS is true and reflective of their scope of practice, while avoiding selection bias.

After consideration of the comments, we are finalizing our proposals as proposed. Specifically, we are finalizing that remedial action and termination provisions at § 414.1400(f)(1) are triggered if we determine that a third party intermediary submits a false certification under paragraph (a)(5). Additionally, we are finalizing that CMS authority to bring remedial actions or terminate a third party intermediary for submitting data that are inaccurate, unusable or otherwise compromised extends beyond the specific examples set forth in § 414.1400(f)(3). We added the phrase ''including but not limited to'' to the text of § 414.1400(f)(3) to emphasize that this provision is illustrative of circumstances that may result in enforcement action and should not be misinterpreted to limit the agency's ability to impose remedial actions or terminate a third party intermediary that knowingly submits inaccurate data. In addition, we note that third party intermediaries may face liability under the federal False Claims Act if they submit or cause to submission of false MIPS data.

Lastly, we are finalizing the corrections related to the use of the plural term of ''data.''

h. Public Reporting on Physician Compare

(1) Background

For previous discussions on the background of Physician Compare, we refer readers to the CY 2016 PFS final rule (80 FR 71116 through 71123), the CY 2017 Quality Payment Program final rule (81 FR 77390 through 77399), the CY 2018 Quality Payment Program final rule (82 FR 53819 through 53832), the CY 2019 PFS final rule (83 FR 59910 through 59915), and the Physician Compare Initiative website at *https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/.*

We proposed to publicly report on Physician Compare: (1) Aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians, beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible; and (2) an indicator on the profile page or in the downloadable database that displays if a MIPS eligible clinicians is scored using facility-based measurement, as specified under § 414.1380(e)(6)(vi), as technically feasible (see 84 FR 40821 through 40824). A summary of the comments received and our finalized policies are discussed in more detail in this final rule.

(2) Regulation Text Changes

Section 1848(q)(9)(A) and (D) of the Act requires that we publicly report on Physician Compare in an easily understandable format:

- The final score for each MIPS eligible clinician;
- Performance of each MIPS eligible clinician for each performance category;
- Periodic aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category; and
- The names of eligible clinicians in advanced APMs and, to the extent feasible, the names of such advanced APMs and the performance of such APMs.

Section 1848(q)(9)(B) of the Act requires that the information made available under section 1848(q)(9) of the Act must indicate, where appropriate, that publicized information may not be representative of the eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated.

To more completely and accurately reference the data available for public reporting on Physician Compare, we proposed to amend § 414.1395 by adding paragraph (a)(1) stating that CMS posts on Physician Compare, in an easily understandable format: (i) Information regarding the performance of MIPS eligible clinicians, including, but not limited to, final scores and performance category scores for each MIPS eligible clinician; and (ii) the names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs. As discussed in section III.K.3.h.(3) of this final rule, we also proposed to amend § 414.1395 by adding paragraph (a)(2) stating that CMS periodically posts on Physician Compare aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians with respect to each performance category. Finally, we proposed to amend § 414.1395 by adding paragraph (a)(3) stating that the information made available under § 414.1395 will indicate, where appropriate, that publicized information may not be representative of an eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated.

We did not receive public comments on the proposed regulation text changes. As such, we are finalizing our policy as proposed to amend § 414.1395 by adding paragraph (a)(1) stating that CMS posts on Physician Compare, in an easily understandable format: (1) Information regarding the performance of MIPS eligible clinicians, including, but not limited to, final scores and

performance category scores for each MIPS eligible clinician; and (2) the names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs. In addition, we are finalizing our policy as proposed to amend § 414.1395 by adding paragraph (a)(3) stating that the information made available under § 414.1395 will indicate, where appropriate, that publicized information may not be representative of an eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated.

(3) Final Score, Performance Categories, and Aggregate Information

Section 1848(q)(9)(D) of the Act requires the Secretary to periodically post on Physician Compare aggregate information on the MIPS, including the range of composite scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians with respect to each performance category. We refer readers to the CY 2018 Quality Payment Program final rule (82 FR 53823), where we previously finalized policies to publicly report on Physician Compare, either on profile pages or in the downloadable database, the final score for each MIPS eligible clinician and the performance of each MIPS eligible clinician for each performance category, and to periodically post aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category, as technically feasible, for all future years.

Although we previously finalized a policy to periodically post aggregate information on the MIPS, as technically feasible, for all future years, we have not proposed or finalized in rulemaking a specific timeframe for doing so. As part of our phased approach to public reporting, we wanted to first gain experience with the MIPS data prior to publicly reporting it in aggregate, since we had not publicly reported on Physician Compare aggregate data under legacy programs. For example, we publicly reported the Physician Quality Reporting System (PQRS) performance information only at an individual clinician and group practice level. Now that we have experience with the MIPS data, including the Year 1 performance information which was not available for analysis at the time of prior rulemaking, we can now propose a specific timeframe for publicly reporting aggregate MIPS data on Physician Compare.

Therefore, in accordance with section 1848(q)(9)(D) of the Act, we proposed to publicly report on Physician Compare aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians, beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible, and to codify this policy at § 414.1395(a) (84 FR 40822). We clarify that the aggregate data publicly reported would be inclusive of all MIPS eligible clinicians. We also note that some aggregate MIPS data is already publicly available in other places, such as via the Quality Payment Program Experience Report. We note that the 2017 Quality Payment Program Experience Report is available at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/491/2017%20QPP%20Experience%20Report.pdf.* As noted in the CY 2018 Quality Payment Program final rule (82 FR 53823), we will use statistical testing and user testing, as well as consultation with the Physician Compare Technical Expert Panel, to determine how and where these data are best reported on Physician Compare (for example in the Physician Compare Downloadable Database or on the Physician Compare Initiative page). In addition to minimum and maximum MIPS performance category and final scores, we also solicited comment on any other aggregate information that stakeholders will find useful for future public reporting on Physician Compare.

We received public comments on other aggregate information that stakeholders will find useful for future public reporting on Physician Compare. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported publicly reporting aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians, beginning with Year 2 (2018 data available starting in late 2019). A few commenters supported the goals of public reporting information on Physician Compare yet remained concerned that Medicare patients and their caregivers may not be able to accurately understand and interpret aggregated information, such as the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians. Two commenters supported publicly reporting information on Physician Compare, but expressed concern about the accuracy of the data while another commenter that supported public reporting also noted that publishing aggregate information may not be meaningful for certain clinician types. One commenter recommended delaying publicly reporting aggregate information until concerns around accuracy of the data can be resolved.

Response: We appreciate commenters support and the concerns raised. We note that section 1848(q)(9)(D) of the Act requires the Secretary to periodically post on Physician Compare aggregate information on the MIPS, including the range of composite scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians with respect to each performance category. In addition, we will use statistical testing and user testing, as well as consultation with the Physician Compare Technical Expert Panel, to determine how and where these data are best reported on Physician Compare to ensure these data are understood and interpreted accurately. We believe we should employ the same phased approach to ensure the data made public accurately represents clinical performance and is understood by website users. We will actively work to ensure that the language on the website and the additional education and outreach conducted for patients and caregivers continues to make this information clear. In addition, we will work to ensure all data publicly reported on Physician Compare is accurate. As such, all data available for public reporting are available for review and correction during the targeted review process, as specified at § 414.1385. Data under review will not be publicly reported until the review is complete. We clarify that aggregate data will reflect MIPS eligible clinicians and groups collectively and will not be specialty-specific.

After consideration of the comments, we are finalizing our proposal to publicly report on Physician Compare aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians, beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible. We are also finalizing our proposal to amend § 414.1395 by adding paragraph (a)(2) stating that we periodically post on Physician Compare aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible

clinicians with respect to each performance category.

(4) Quality

For previous discussions on publicly reporting quality performance category information on the Physician Compare website, we refer readers to the CY 2018 Quality Payment Program final rule (82 FR 53824) and the CY 2019 Quality Payment Program final rule (83 FR 59912).

Although we did not make any proposals regarding publicly reporting quality performance category information, we solicited additional comments on adding patient narratives to the Physician Compare website in future rulemaking, to the extent consistent with our authority to collect such information under section 1848(q) of the Act and our authority to include an assessment of patient experience and patient, caregiver, and family engagement under section 10331(a)(2)(E) of the Affordable Care Act.

Physician Compare website user testing has repeatedly shown that Medicare patients and caregivers greatly desire narrative reviews, quotes and testimonials by their peers, and a single overall ''value indicator,'' reflective for each MIPS eligible clinician and group, and will expect to find such information on the Physician Compare website already, based on their experiences with other consumer-oriented websites. We currently do not display any narrative patient satisfaction information on Physician Compare or any single overall value indicator for MIPS eligible clinicians and groups (except MIPS performance category and final scores); currently all performance information on Physician Compare is publicly reported at the individual measure level. Therefore, we solicited comment on the value of and considerations for publicly reporting such information to assist patients and caregivers with making healthcare decisions, building upon the feedback received in response to the CY 2018 Quality Payment Program proposed rule (82 FR 30166 through 30167), in which we specifically sought comment on publicly reporting responses to five open-ended questions that are part of the Agency for Healthcare Research and Quality (AHRQ)'s CAHPS Patient Narrative Elicitation Protocol (*https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html*). While we are not summarizing and responding to comments we received in this final rule, we appreciate the responses from the commenters and may take them into account as we develop future policies for public reporting on Physician Compare.

We refer readers to section III.K.3.c.(1)(c)(i) of this final rule for an additional solicitation for comments to add narrative reviews into the CAHPS for MIPS group survey in future rulemaking.

To be publicly reported on Physician Compare, patient narrative data will have to meet our public reporting standards, described at § 414.1395(b), and reviewed in consultation with the Physician Compare Technical Expert Panel, to determine how and where these data would be best reported on Physician Compare. We solicited comment on the value of collecting and publicly reporting information from narrative questions and other patient-reported outcome measures (PROMs), as well as publishing a single ''value indicator'' reflective of cost, quality and patient experience and satisfaction with care for each MIPS eligible clinician and group, on the Physician Compare website and will consider feedback from the patient, caregiver, and clinician communities before proposing any policies in future rulemaking. We also noted that if we propose to publicly report patient narratives in future rulemaking, we will address all related patient privacy safeguards consistent with section 10331(c) of the Affordable Care Act, which requires that information on physician performance and patient experience is not disclosed in a manner that violates the Freedom of Information Act (5 U.S.C. 552) or the Privacy Act of 1974 (5 U.S.C. 552a) with regard to the privacy individually identifiable health information, and other applicable law. While we are not summarizing and responding to comments we received in this final rule, we appreciate the responses from the commenters and may take them into account as we develop future policies for public reporting on Physician Compare.

(5) Promoting Interoperability

We refer readers to the CY 2018 Quality Payment Program final rule (82 FR 53827) and the CY 2019 Quality Payment Program final rule (83 FR 59913) for previously finalized policies related to the Promoting Interoperability performance category and Physician Compare.

Although we did not make any proposals regarding publicly reporting Promoting Interoperability category information, we refer readers to the ''Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally Facilitated Exchanges and Health Care Providers'' proposed rule (referred to as the Interoperability and Patient Access proposed rule) published in the March 4, 2019 **Federal Register** (84 FR 7646 through 7647), where we proposed to include an indicator on Physician Compare for the eligible clinicians and groups that submit a ''no'' response to any of the three prevention of information blocking attestation statements in § 414.1375(b)(3)(ii)(A) through (C). To report successfully on the Promoting Interoperability performance category, in addition to satisfying other requirements, a MIPS eligible clinician must submit an attestation response of ''yes'' for each of these statements. These statements contain specific representations about a clinician's implementation and use of CEHRT and are intended to verify that a MIPS eligible clinician has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology. In the event that these statements are left blank, that is, a ''yes'' or a ''no'' response is not submitted, the attestations would be considered incomplete, and we would not include an indicator on Physician Compare. We also proposed to post this indicator on Physician Compare, either on the profile pages or the downloadable database, as feasible and appropriate, starting with the 2019 performance period data available for public reporting starting in late 2020. We refer readers to the CY 2017 Quality Payment Program final rule for additional information on these attestation statements (81 FR 77028 through 77035).

(6) Facility-Based Clinician Indicator

As discussed in the CY 2018 Quality Payment Program final rule (82 FR 53823), we finalized a policy to publicly report the MIPS performance category and final scores earned by each MIPS eligible clinician on Physician Compare, either on profile pages or in the downloadable database. We also finalized that we will make all measures under the MIPS quality performance category available for public reporting on Physician Compare, either on profile pages or in the downloadable database, as technically feasible (82 FR 53824). We will use statistical testing and user testing to determine how and where measures are reported on Physician Compare. We established at

§ 414.1380(e) a facility-based measurement scoring option under the MIPS quality and cost performance categories for clinicians that meet certain criteria beginning with the 2019 MIPS performance period/2021 MIPS payment year. Section 414.1380(e)(1)(ii) provides that the scoring methodology applicable for MIPS eligible clinicians scored with facility-based measurement is the Total Performance Score methodology adopted for the Hospital VBP Program, for the fiscal year for which payment begins during the applicable MIPS performance period.

With this in mind, we have considered how to best display facility-based MIPS eligible clinician quality and cost information on Physician Compare, appreciating our obligation to publicly report certain MIPS data for MIPS eligible clinicians and groups. As those clinicians and groups scored under the facility-based option are MIPS eligible, we will publicly report their performance category and MIPS final scores on Physician Compare and considered two options for publicly reporting their facility-based measure-level performance information on Physician Compare: (a) Displaying hospital-based measure-level performance information on Physician Compare profile pages, including scores for specific measures and the hospital overall rating; or (b) including an indicator showing that the clinician or group was scored using the facility-based scoring option with a link from the clinician's Physician Compare profile page to the relevant hospital's measure-level performance information on Hospital Compare. We believe that a link from the clinician's Physician Compare profile page to the relevant hospital's performance information on Hospital Compare is preferable for several reasons including: Concerns about duplication with Hospital Compare, interpretability by Physician Compare website users expecting to find clinician-level, rather than hospital-level, information and operational feasibility. Additionally, we believe this approach is consistent with our consumer testing findings that Medicare patients and caregivers find value in information on the relationships clinicians and groups may have with facilities where they perform services. We note that the facility-based scoring indicator would be separate from the hospital affiliation information for admitting privileges currently posted on Physician Compare profile pages.

For these reasons, we proposed to make available for public reporting an indicator on the Physician Compare profile page or downloadable database that displays if a MIPS eligible clinician is scored using facility-based measurement, as specified under § 414.1380(e)(6)(vi), as technically feasible (84 FR 40824). We also proposed to provide a link to facility-based measure-level information, as specified under § 414.1380(e)(1)(i), for such MIPS eligible clinicians on Hospital Compare, as technically feasible. In addition, we proposed to post this indicator on Physician Compare with the linkage to Hospital Compare beginning with CY 2019 performance period data available for public reporting starting in late CY 2020 and for all future years, as technically feasible. We requested comment on this proposal.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported making available for public reporting an indicator on the Physician Compare profile page or downloadable database that displays if a MIPS eligible clinician is scored using facility-based measurement and provide a link to facility-based measure-level information for such MIPS eligible clinicians on Hospital Compare, as technically feasible. One commenter supported the goals of public reporting information on Physician Compare yet remained concerned that Medicare patients and their caregivers may not be able to accurately understand and interpret the facility-based indicator. A few commenters supported publicly reporting the facility-based indicator and recommended providing context and/or CMS providing explanatory text mentioning that facility-level measures assess care provided at a facility level, rather than a clinician or group level.

Response: We note that findings from our consumer testing indicate that Medicare patients and caregivers find value in information on the relationships clinicians and groups may have with facilities where they perform services. In addition, we note that with the exception of data that must be mandatorily reported on Physician Compare, data included on Physician Compare must meet our public reporting standards, as described at § 414.1395(b). This means data included on Physician Compare public facing profile pages must resonate with website users as determined by CMS. We will use statistical testing and user testing, as well as consultation with the Physician Compare Technical Expert Panel, to determine how and where these data are best reported on Physician Compare, including either on profile pages or the downloadable database and to provide the appropriate context and explanatory text for Medicare patients and caregivers.

After consideration of the comments, we are finalizing our proposal to make available for public reporting an indicator on the Physician Compare profile page or downloadable database that displays if a MIPS eligible clinician is scored using facility-based measurement, as specified under § 414.1380(e)(6)(vi), as technically feasible. We are also finalizing our proposal to provide a link to facility-based measure-level information, as specified under § 414.1380(e)(1)(i), for such MIPS eligible clinicians on Hospital Compare, as technically feasible. In addition, we are finalizing our proposal to post this indicator on Physician Compare with the linkage to Hospital Compare beginning with CY 2019 performance period data available for public reporting starting in late CY 2020 and for all future years, as technically feasible.

4. Overview of the APM Incentive

a. Overview

Section 1833(z) of the Act requires that an incentive payment be made in years 2019 through 2024 (or, in years after 2025, a different PFS update) to Qualifying APM Participants (QPs) for achieving threshold levels of participation in Advanced APMs. In the CY 2017 Quality Payment Program final rule (81 FR 77399 through 77491), we finalized the following policies:

- Beginning in payment year 2019, if an eligible clinician participated sufficiently in an Advanced APM during the QP Performance Period, that eligible clinician may become a QP for the year. Eligible clinicians who are QPs are excluded from the MIPS reporting requirements for the performance year and payment adjustment for the payment year.
- For payment years from 2019 through 2024, QPs receive a lump sum incentive payment equal to 5 percent of their prior year's estimated aggregate payments for Part B covered professional services. Beginning in payment year 2026, QPs receive a differentially higher update under the PFS for the year than non-QPs.
- For payment years 2019 and 2020, eligible clinicians may become QPs only through participation in Medicare Advanced APMs.
- For payment years 2021 and later, eligible clinicians may become QPs through a combination of participation in Medicare Advanced APMs and Other Payer Advanced APMs (which we refer

to as the All-Payer Combination Option).

In the CY 2018 Quality Payment Program final rule (82 FR 53832 through 53895), we finalized clarifications, modifications, and additional details pertaining to Advanced APMs, QP and Partial QP determinations, Other Payer Advanced APMs, Determination of Other Payer Advanced APMs, Calculation of All-Payer Combination Option Threshold Scores and QP Determinations, and Physician-Focused Payment Models (PFPMs).

In the CY 2019 PFS final rule (83 FR 59915 through 59940), we finalized clarifications, modifications, and additional details pertaining to use of Certified Electronic Health Record Technology (CEHRT), MIPS-comparable quality measures, bearing financial risk for monetary losses, the QP Performance Period, Partial QP election to report to MIPS, Other Payer Advanced APM criteria, determination of Other Payer Advanced APMs, calculation of All-Payer Combination Option Threshold Scores and QP determinations under the All-Payer Combination Option.

In this final rule, we discuss policies pertaining to Advanced APMs and the All-Payer Combination Option.

b. Terms and Definitions

As we continue to develop the Quality Payment Program, we have identified the need to propose new definitions to go along with the previously defined terms. A list of the previously defined terms is available in the CY 2017 Quality Payment Program final rule (81 FR 77537 through 77540), the CY 2018 Quality Payment Program final rule (82 FR 53951 through 53952), and in the CY 2019 PFS final rule (83 FR 60075 through 60076), and reflected in our regulation at § 414.1305.

In the CY 2017 Quality Payment Program final rule, we defined the term ''Medical Home Model'' and ''Medicaid Medical Home Model.'' Since defining these terms in the CY 2017 Quality Payment Program final rule, we solicited comment on whether or not to establish a similar definition to describe payment arrangements similar to Medical Home Models and Medicaid Medical Home Models that are operated by other payers (82 FR 30180).

As discussed in the CY 2020 PFS proposed rule (84 FR 40731), we proposed to add the defined term ''Aligned Other Payer Medical Home Model'' to § 414.1305, to mean a payment arrangement (not including a Medicaid payment arrangement) operated by an other payer that formally partners with CMS in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU), and is determined by CMS to have the following characteristics:

- The other payer payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
- Empanelment of each patient to a primary clinician; and
- At least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; Risk-stratified care management; Coordination of care across the medical neighborhood; Patient and caregiver engagement; Shared decision-making; and/or Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

We are finalizing this proposal. For additional discussion related to this definition of Aligned Other Payer Medical Home Model, please see section III.K.4.e of this final rule.

c. Advanced APMs

(1) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77408), we finalized the criteria that define an Advanced APM based on the requirements set forth in sections 1833(z)(3)(C) and (D) of the Act. An Advanced APM is an APM that:

- Requires its participants to use certified EHR technology (CEHRT) (81 FR 77409 through 77414);
- Provides for payment for covered professional services based on quality measures comparable to measures under the quality performance category under MIPS (81 FR 77414 through 77418); and
- Either requires its participating APM Entities to bear financial risk for monetary losses that are in excess of a nominal amount, or is a Medical Home Model expanded under section 1115A(c) of the Act (81 FR 77418 through 77431). We refer to this criterion as the financial risk criterion.

In the CY 2018 Quality Payment Program final rule (82 FR 53832 through 53895), we finalized clarifications, modifications, and additional details pertaining to the Advanced APM criteria, Qualifying APM Participant (QP) and Partial QP determinations, the Other Payer Advanced APM criteria, Determination of Other Payer Advanced APMs, Calculation of All-Payer Combination Option Threshold Scores and QP Determinations, and we discussed Physician-Focused Payment Models (PFPMs).

In the CY 2019 PFS final rule (83 FR 59915 through 59938), we finalized the following:

Use of CEHRT:

- We revised § 414.1415(a)(i) to specify that an Advanced APM must require at least 75 percent of eligible clinicians in each APM Entity, or, for APMs in which hospitals are the APM Entities, each hospital, use CEHRT as defined at § 414.1305 to document and communicate clinical care with patients and other health care professionals.

MIPS-Comparable Quality Measures:

- We revised § 414.1415(b)(2) to clarify, effective January 1, 2020, that at least one of the quality measures upon which an Advanced APM bases payment must either be finalized on the MIPS final list of measures, as described in § 414.1330; endorsed by a consensus-based entity; or determined by CMS to be evidenced-based, reliable, and valid.
- We revised the requirement at § 414.1415(b)(3) that the quality measures upon which an Advanced APM bases payment must include at least one outcome measure (unless there are no available or applicable outcome measures included in the MIPS final quality measures list for the Advanced APM's first QP Performance Period) to provide, effective January 1, 2020, that at least one such outcome measure must either be finalized on the MIPS final list of measures as described in § 414.1330; endorsed by a consensus-based entity; or determined by CMS to be evidence-based, reliable, and valid.

Bearing Financial Risk for Monetary Losses:

- We revised § 414.1415(c)(3)(i)(A) to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for QP Performance Periods 2021 through 2024.

In this section of the final rule, we address policies regarding several aspects of the Advanced APM criterion on bearing financial risk for monetary losses—specifically our proposal to amend the definition of expected

expenditures, and our request for comment on whether certain items and services should be excluded from the capitation rate for our definition of full capitation arrangements.

(2) Bearing Financial Risk for Monetary Losses

(a) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77418), we divided the discussion of this criterion into two main topics: (1) What it means for an APM Entity to bear financial risk for monetary losses under an APM (which we refer to as either the generally applicable financial risk standard or Medical Home Model financial risk standard); and (2) what levels of risk we would consider to be in excess of a nominal amount (which we refer to as either the generally applicable nominal amount standard or the Medical Home Model nominal amount standard).

(b) Expected Expenditures

In the CY 2017 Quality Payment Program final rule (81 FR 77550), we established a definition of expected expenditures at § 414.1415(c)(5) to mean the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, ''expected expenditures'' means the episode target price. We established this definition of expected expenditures for the purposes of applying the Advanced APM financial risk criterion to determine whether an APM meets the generally applicable nominal amount standard.

In the CY 2017 Quality Payment Program proposed rule (81 FR 28305 through 28309), we proposed to measure three dimensions of risk under our generally applicable nominal amount standards: (1) Marginal risk, which refers to the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the APM; (2) minimum loss rate (MLR), which is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk; and (3) total potential risk, which refers to the maximum potential payment for which an APM Entity could be liable under the APM.

However, based on commenters' concerns regarding technical complexity, we did not finalize the marginal risk and MLR components of the generally applicable nominal amount standard under the Advanced APM criteria (81 FR 77427), but did finalize those additional elements of risk under the Other Payer Advanced APM criteria. We stated in the CY 2017 Quality Payment Program final rule (81 FR 77426) that it is not necessary to include the marginal risk and MLR components in the generally applicable nominal amount standard for Advanced APMs because we are committed to creating Advanced APMs with strong financial risk designs that incorporate risk adjustment, benchmark methodologies, sufficient stop-loss amounts, and sufficient marginal risk; and that all APMs involving financial risk that we operate now or in the future would meet or exceed the proposed marginal risk and MLR requirements. In the CY 2017 Quality Payment Program proposed rule (81 FR 28306), we explained that, to determine whether an APM satisfies the marginal risk component of the generally applicable nominal amount standard, we would examine the payment required under the APM as a percentage of the amount by which actual expenditures exceeded expected expenditures. We proposed that we would require this percentage to exceed a required marginal risk percentage of 30 percent regardless of the amount by which actual expenditures exceeded expected expenditures. We believed that any marginal risk below 30 percent could create scenarios in which the total risk could be very high, but the average or likely risk for an APM Entity would actually be very low (81 FR 28306).

Our rationale for proposing the marginal risk requirement was that the inclusion of the marginal risk requirement would contribute to maintaining a more than nominal level of average or likely risk under an Advanced APM. We did not finalize the marginal risk requirement under the Advanced APM criteria because, as noted above, we believed that all Advanced APMs that we operate now or would potentially operate in the future would meet or exceed the previously proposed marginal risk and MLR requirements, and we believed the total risk portion of the nominal amount standard alone was sufficient to ensure that the level of average or likely risk under an Advanced APM would actually be more than nominal for participants.

However, based on our experience to date, we became concerned that the total risk portion of the benchmark-based nominal amount standard as currently constructed may not always be sufficient to ensure that the level of average or likely risk under an Advanced APM is actually more than nominal for participants. This is because the benchmark-based nominal amount standard at § 414.1415(c)(3)(i)(B) is dependent upon the definition of expected expenditures codified at § 414.1415(c)(5), where expected expenditures are defined as the beneficiary expenditures for which an APM Entity is responsible under an APM, and for episode payment models, the episode target price.

In our experience implementing the Quality Payment Program and considering the diversity of model designs, we came to believe there is a need to amend the definition of expected expenditures to further ensure there are more-than-nominal levels of average or likely risk under an Advanced APM that would meet the generally applicable benchmark-based nominal amount standard. For instance, an APM could have a sufficient total risk to meet the benchmark-based nominal amount standard and a sharing rate that results in adequate marginal risk if actual expenditures exceed expected expenditures. However, in that same APM, the level of expected expenditures reflected in the APM's benchmark or episode target price could be set in a manner that would substantially reduce the amount of loss the APM Entity would reasonably expect to incur.

For an APM to meet the generally applicable benchmark-based nominal amount standard, we believe there should be not only the potential for financial losses based on expenditures in excess of the benchmark as provided in § 415.1415(c)(3)(i)(B) of our regulations, but also a meaningful possibility that an APM Entity might exceed the benchmark. If the benchmark is set in such a way that it is extremely unlikely that participants would exceed it, then there is little potential for participants to incur financial losses, and the amount of risk is essentially illusory.

Therefore, in the CY 2020 PFS proposed rule (84 FR 40731 through 40732), we proposed to amend the definition of expected expenditures at § 414.1415(c)(5). Specifically, we proposed to define expected expenditures for purposes of this section as the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the APM should not exceed the expected Medicare Parts A and B expenditures for a participant in the absence of the APM. If expected expenditures under the APM exceed the Medicare Parts A and B

expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for Advanced APM determinations.

In general, expected expenditures are expressed as a dollar amount, and may be derived for a particular APM from national, regional, APM Entity-specific, and/or practice-specific historical expenditures during a baseline period, or other comparable expenditures. However, in making our proposal, we recognized that expected expenditures under an APM often are risk-adjusted and trended forward, and may be adjusted to account for expenditure changes that are expected to occur as a result of APM participation. For the purpose of the definition of expected expenditures that we proposed, we would not consider risk adjustments to be excess expenditures when comparing expected expenditures under the APM to the costs that an APM Entity would be expected to incur in the absence of the APM.

We proposed the amendment to the definition of expected expenditures to allow us to ensure that there are more-than-nominal amounts of average or likely risk under an APM that meets the generally applicable benchmark-based nominal amount standard. We also believed that the proposed amended definition of expected expenditures, particularly the proposal to not consider excess expenditures when determining whether an APM meets the benchmark-based nominal amount standard, would provide a more appropriate basis for us to assess whether an APM Entity would bear more than a nominal amount of financial risk for participants under the generally applicable benchmark-based nominal amount standard.

We also proposed a similar amendment to the definition of expected expenditures for the Other Payer Advanced APM generally applicable nominal amount standard in section III.I.4.d.(2)(b)(i) of this final rule.

We sought comment on this proposal. The following is a summary of the comments we received and our responses.

Comment: A few commenters opposed the proposed amended definition of expected expenditures. These commenters were concerned that application of the proposed definition of expected expenditures could potentially cause some current Advanced APMs to no longer meet the generally applicable nominal amount standard beginning in CY 2020, and thus to no longer be Advanced APMs.

Response: It is possible that application of the amended definition could lead to a current Advanced APM no longer meeting the expected expenditure nominal amount standard at § 414.1415(c)(3)(i)(B), and potentially no longer being an Advanced APM if it does not meet the standard at § 414.1415(c)(3)(i)(A). However, all Advanced APMs for CY 2019 that satisfy the current generally applicable nominal amount standard by meeting the expected expenditure nominal amount standard at § 414.1415(c)(3)(i)(B) would continue to do so under the proposed amended definition of expected expenditures.

Comment: A few commenters supported the exclusion of risk adjustment when considering what constitutes excess expenditures.

Response: We thank the commenters for their support of our proposal and will not consider risk adjustments to be excess expenditures when comparing expected expenditures under the APM to the costs that an APM Entity would be expected to incur in the absence of the APM.

After considering the public comments received, we are finalizing our proposal to amend the definition of expected expenditures at § 414.1415(c)(5) without modification.

(c) Excluded Items and Services Under Full Capitation Arrangements

In the CY 2017 Quality Payment Program final rule (81 FR 74431), we finalized a capitation standard at § 414.1415(c)(6), which provides that a full capitation arrangement meets the Advanced APM financial risk criterion. We defined a capitation arrangement as a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services for which payment is made through the APM furnished to a population of beneficiaries, and no settlement is performed to reconcile or share losses incurred or savings earned by the APM Entity. We clarified that arrangements between CMS and Medicare Advantage Organizations under the Medicare Advantage program are not considered capitation arrangements for purposes of this definition.

In the CY 2019 PFS final rule (83 FR 59939), we made technical corrections to the Advanced APM financial risk capitation standard at § 414.1415(c)(6). These corrections clarified that our financial risk capitation standard applies only to full capitation arrangements where a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement or reconciliation is performed.

As we began to collect information on other payer payment arrangements for purposes of making Other Payer Advanced APM determinations, we noticed that some payment arrangements that are submitted as capitation arrangements consistent with § 414.1420(d)(7) include a list of services that have been excluded from the capitation rate, such as hospice care, organ transplants, and out-of-network emergency services. In reviewing these exclusion lists, we came to believe that it may be appropriate for CMS to allow certain capitation arrangements to be considered ''full'' capitation arrangements even if they categorically exclude certain items or services from payment through the capitation rate.

As such, in the CY 2020 PFS proposed rule (84 FR 40827), we solicited comments on what categories of items and services might be excluded from a capitation arrangement that would still be considered a full capitation arrangement. Specifically, we solicited comment on whether there are common industry practices to exclude certain categories of items and services from capitated payment rates and, if so, whether there are common principles or reasons for excluding those categories of services. We also sought comment on what percentage of the total cost of care such exclusions typically account for under what is intended to be a ''full'' global capitation arrangement. We also solicited comment on how non-Medicare payers define or prescribe certain categories of services that are excluded from global capitation payment arrangements.

We received a few comments on this topic as summarized below.

Comment: All commenters were supportive of excluding certain items and services from the definition of full capitation arrangements for the purposes of the advanced APM financial risk criterion. They asserted that the exclusion of certain services from the definition of full capitation arrangements for purposes of the Advanced APM financial risk criterion would provide the ability to tailor different APMs to meet the needs of different payers and provider types. The commenters also identified specific items and services such as hospice care, emergency care, or specific high cost pharmaceuticals.

Response: We will take these comments into consideration as we consider possible proposals in future rulemaking.

(3) Summary

In this section, we are finalizing the following policy:

• *Expected Expenditures:* We are finalizing as proposed an amendment to the definition of expected expenditures at § 414.1415(c)(5) to state that for the purposes of this section, for purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the APM should not exceed the expected Medicare Parts A and B expenditures for a participant in the absence of the APM. If expected expenditures under the APM exceed the Medicare Parts A and B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for Advanced APM determinations.

d. Qualifying APM Participant (QP) and Partial QP Determinations

(1) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77433 through 77450), we finalized policies relating to QP and Partial QP determinations. In the CY 2019 PFS final rule (83 FR 59923 through 59925), we finalized additional policies relating to QP determinations and the Partial QP election to report to MIPS.

(2) Group Determination

(a) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77439 through 77440), we finalized that QP determinations would generally be made at the APM Entity level, but for two exceptions in which we make the QP determination at the individual level: (1) Individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group; and (2) eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the APM Entity (81 FR 77439 through 77443). As a result, the QP determination for the APM Entity generally applies to all the individual eligible clinicians who are identified as part of the APM Entity participating in an Advanced APM. If the APM Entity's Threshold Score meets the relevant QP threshold, all individual eligible clinicians in that APM Entity would receive the same QP determination, applied to their NPIs, for the relevant payment year. The QP determination calculations are aggregated using data for all eligible clinicians participating in the APM Entity on a determination date during the QP Performance Period.

(b) Application of Partial QP Status

In the CY 2017 Quality Payment Program final rule (81 FR 77440), we stated that we would apply QP status at the NPI level instead of at the TIN/NPI level. We noted that an individual clinician identified by an NPI may have reassigned billing rights to multiple TINs, resulting in multiple TIN/NPI combinations being associated with one individual clinician (NPI). We also stated that if QP status was only applied to one of an individual clinician's multiple TIN/NPI combinations, an eligible clinician who is a QP for only one TIN/NPI combination might still have to report under MIPS for another TIN/NPI combination. Under that approach, the APM Incentive Payment would be based on only a fraction of the clinician's covered professional services instead of, as we believe is the most logical reading of the statute, all those services furnished by the individual clinician, as represented by an NPI. Therefore, we expressed our concern with applying QP status only to a specific TIN/NPI combination as it would not effectuate the goals of the APM incentive path of the Quality Payment Program to reward individual clinicians for their commitment to Advanced APM participation.

For Partial QPs, we currently apply Partial QP status at the NPI level across all TIN/NPI combinations as we have for QP status. However, in the CY 2020 PFS proposed rule (84 FR 40827 through 40828), we explained that for eligible clinicians who are Partial QPs, based on our experience implementing the Quality Payment Program and feedback from stakeholders, we believe it would be more appropriate to apply any exclusion from MIPS reporting requirements and payment adjustments only to TIN/NPI combinations affiliated with that TIN. Under our current policy, Partial QPs are excluded from the MIPS reporting requirements and payment adjustment based on an election made at the APM Entity or individual eligible clinician level, and this exclusion is currently applied at the NPI level across all of their TIN/NPI combinations. Partial QPs do not receive an APM Incentive Payment; rather, the APM Entity in which the Partial QPs participated is permitted to choose whether to be subject to the MIPS reporting requirements and payment adjustments. As such, while an eligible clinician who is a Partial QP might wish to be excluded from MIPS reporting requirements and payment adjustments with respect to the TIN/NPI combination that relates to the APM Entity in the Advanced APM through which they achieved Partial QP status, that same eligible clinician might wish to report to MIPS and receive a MIPS payment adjustment with respect to other TIN/NPI combinations (for example, because they anticipate receiving an upward MIPS payment adjustment).

Therefore, we proposed that beginning with the 2020 QP Performance Period, Partial QP status would apply only to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status, and to amend our regulation by adding § 414.1425(d)(5) to reflect this change. This means that any MIPS election for a Partial QP would only apply to the TIN/NPI combination through which Partial QP status is attained, so that an eligible clinician who is a Partial QP for only one TIN/NPI combination may still be a MIPS eligible clinician, and subject to the MIPS reporting requirements and payment adjustment, for other TIN/NPI combinations.

We received public comments on our proposal. We thank the commenters for the public comments on this proposal. After including our proposal in the CY 2020 PFS proposed rule (84 FR 40827 through 40828), we further investigated the system requirements to implement the proposed policy. Our current data systems apply Partial QP assignment to NPIs, rather than to TIN/NPI combinations, and we determined that we would not be able to modify our system to implement the proposed policy, if finalized, for the 2020 QP Performance Period. After taking into account our operational limitations, we are not finalizing the proposed policy. We will review and consider the public comments received, continue to seek stakeholder feedback and, if appropriate, proposed policies pertaining to Partial QPs in future rulemaking.

(3) QP Performance Period

(a) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77446 through 77447), we finalized for the timing of QP determinations that a QP Performance Period runs from January 1 through August 31 of the calendar year that is 2 years prior to the payment year. We finalized that during the QP Performance Period, we will make QP determinations at three separate snapshot dates (March 31, June 30, and August 31), each of which will be a final determination for the eligible clinicians

who are determined to be QPs. The QP Performance Period and the three separate QP determinations apply similarly for both the group of eligible clinicians on a Participation List and the individual eligible clinicians on an Affiliated Practitioner List.

(b) APM Entity Termination

In the CY 2017 Quality Payment Program final rule, we finalized at §§ 414.1425(c)(5) and 414.1425(d)(3) that an eligible clinician is not a QP or Partial QP for a year if the APM Entity group voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period (81 FR 77446 through 77447). We also finalized at §§ 414.1425(c)(6) and 414.1425(d)(4) that an eligible clinician is not a QP or Partial QP for a year if one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP or Partial QP payment amount threshold or QP or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities (81 FR 77446 through 77447). We finalized these policies in part to ensure that APM Entities and eligible clinicians who achieve QP or Partial QP status during a QP Performance Period actually assume a more than a nominal amount of financial risk, as is necessary for Advanced APMs, for at least the full QP performance period from January 1 through August 31, if not the entire performance year under the Advanced APM.

Currently, under the terms of some Advanced APMs, APM Entities can terminate their participation in the Advanced APM while bearing no financial risk after the end of the QP Performance Period for the year (August 31). Under our current regulation, an APM Entity's termination after that date would not affect the QP or Partial QP status of all eligible clinicians in the APM Entity. In the CY 2020 PFS proposed rule (84 FR 40828), we acknowledged that it may be appropriate for an Advanced APM to allow participating APM Entities to terminate without bearing financial risk for that performance period under the terms of the Advanced APM itself, including allowing such terminations to occur after the end of the QP Performance Period (August 31). However, we noted that allowing those eligible clinicians to retain their QP or Partial QP status without having borne financial risk under the Advanced APM through which they attained QP or Partial QP status is not aligned with the structure and principles of the Quality Payment Program, which is designed to reward those APM Entities and eligible clinicians for meaningfully assuming more than a nominal amount of financial risk, as required by the Advanced APM criteria. A critical aspect of Advanced APMs is that participants must bear more than a nominal amount of financial risk under the model. If an APM Entity terminates participation in the Advanced APM without financial accountability, the APM Entity has not yet borne more than a nominal amount of financial risk. As such, we do not believe it is appropriate for eligible clinicians in an APM Entity that terminates after QP determinations are made, but before bearing more than a nominal amount of financial risk, to retain any status as QPs or Partial QPs.

Therefore, regarding QP status, in the CY 2020 PFS proposed rule (84 FR 40827 through 40828), we proposed to revise our regulation at § 414.1425(c)(5) and to add § 414.1425(c)(5)(i) and (ii) to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a QP for a year if: (1) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; (2) or the APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs. In addition, we proposed to revise our regulation at § 414.1425(c)(6) and add §§ 414.1425(c)(6)(i) and (ii) to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a QP for a year if: (1) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities; or (2) one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities.

Regarding Partial QP status, in the CY 2020 PFS proposed rule (84 FR 40828), we also proposed to revise § 414.1425(d)(3) and add §§ 414.1425(d)(3)(i) and (ii), to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a Partial QP for a year if: (1) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or (2) the APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs. We also proposed to revise § 414.1425(d)(4) and add §§ 414.1425(d)(4)(i) and (ii), to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a Partial QP for a year if: (1) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities; or (2) one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities. We believe these amendments and additions account for the scenarios in which an APM Entity could terminate from an Advanced APM at a date on which the APM Entity would not incur any financial accountability under the terms of the Advanced APM.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters opposed our proposal. A few of these commenters agreed that QPs in APM Entities that terminated their

participation in an Advanced APM without bearing financial risk should not receive the APM Incentive Payment. These commenters expressed concern that there would be a very short window of time between the termination from the Advanced APM and the reporting deadlines required for reporting to MIPS such that there would not be enough time to prepare for MIPS reporting for that year.

Response: We have consistently maintained that participants in Advanced APMs may be considered MIPS eligible clinicians and that they may need to report to MIPS, depending on whether they attain QP or Partial QP status. Eligible clinicians who participate with one or more APM Entities in Advanced APMs are MIPS eligible clinicians unless they are excluded from MIPS based on QP or Partial QP status, or some other ground. As such, they are potentially subject to the MIPS reporting requirements and payment adjustment throughout the performance year. We encourage individual eligible clinicians who are Advanced APM participants to check their QP or Partial QP status throughout the year online, and to communicate with their APM Entities in case there are any changes at the APM Entity Level that may affect whether they will need to report to MIPS.

Comment: One commenter suggested that for involuntary terminations, of an APM Entity's participation in an Advanced APM, affected eligible clinicians should retain their QP or Partial QP status based on their significant investment and participation in the Advanced APM.

Response: We acknowledge that participation in Advanced APMs is a significant investment. However, we also recognize that opportunities exist to take advantage of the program. Whether termination is voluntary or involuntary, we have a duty to ensure that the benefits of QP or Partial QP status, including the APM Incentive Payment and any exemption from the MIPS reporting requirements and payment adjustment is based on fully meeting the elements of Advanced APM participation, including the requirement that an APM Entity in an Advanced APM is actually required to bear a more than nominal amount of financial risk during the relevant QP Performance Period.

We are finalizing our proposed policies without modification that an eligible clinician is not a QP or a Partial QP for the year through an APM Entity that voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity will not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs.

(4) Summary

In this section, we are taking the following actions on our proposed policies:

- *Application of Partial QP Status:* We are not finalizing our proposal that, beginning with the 2020 QP Performance Period, Partial QP status will apply only to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status.
- *APM Entity Termination:* We are finalizing without modification the proposal to revise our regulations at §§ 414.1425(c)(5) and (6) and (d)(3) and (4) to state that an eligible clinician is not a QP or a Partial QP for the year when an APM Entity terminates voluntarily or involuntarily from an Advanced APM at a date on which the APM Entity will not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs.

e. All-Payer Combination Option

(1) Overview

Section 1833(z)(2)(B)(ii) of the Act requires that beginning in payment year 2021, in addition to the Medicare Option, eligible clinicians may become QPs through the Combination All-Payer and Medicare Payment Threshold Option, which we refer to as the All-Payer Combination Option. In the CY 2017 Quality Payment Program final rule (81 FR 77459), we finalized our overall approach to the All-Payer Combination Option. The Medicare Option focuses on participation in Advanced APMs, and we make QP determinations under this option based on Medicare Part B covered professional services attributable to services furnished through an APM Entity. The All-Payer Combination Option does not replace or supersede the Medicare Option; instead, it will allow eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through payment arrangements offered by payers other than Medicare that CMS has determined meet the criteria to be Other Payer Advanced APMs. We finalized that beginning in payment year 2021, we will conduct QP determinations sequentially so that the Medicare Option is applied before the All-Payer Combination Option (81 FR 77438). The All-Payer Combination Option encourages eligible clinicians to participate in payment arrangements that satisfy the Other Payer Advanced APM criteria with payers other than Medicare. It also encourages sustained participation in Advanced APMs across multiple payers.

We finalized that the QP determinations under the All-Payer Combination Option are based on payment amounts or patient counts as illustrated in Tables 36 and 37, and Figures 1 and 2 of the CY 2017 Quality Payment Program final rule (81 FR 77460 through 77461), presented in this final rule as Tables 64A and 64B and Figures 2 and 3. We also finalized that, in making QP determinations with respect to an eligible clinician, we will use the Threshold Score (that is, based on payment amount or patient count) that is most advantageous to the eligible clinician toward achieving QP status, or if QP status is not achieved, Partial QP status, for the year (81 FR 77475).

TABLE 64A: QP Payment Amount Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Payment Amount Threshold					
Medicare Minimum	N/A	N/A	25%	25%	25%
Total			50%	50%	75%
Partial QP Payment Amount Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			40%	40%	50%

TABLE 64B: QP Patient Count Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			35%	35%	50%
Partial QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	10%	10%	10%
Total			25%	25%	35%

FIGURE 2: QP Determination Tree, Payment Years 2021-2022

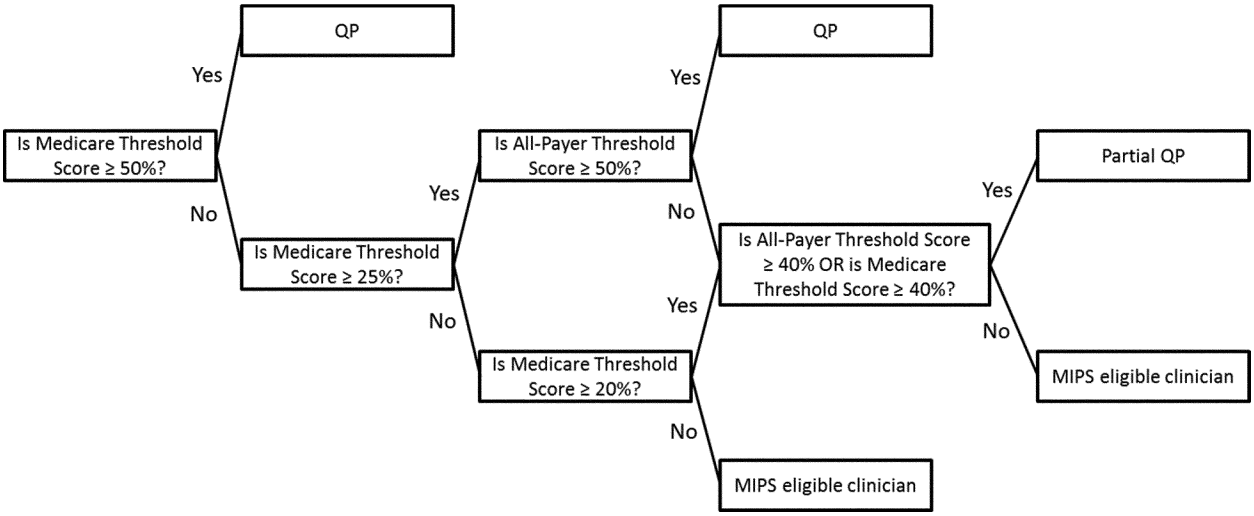
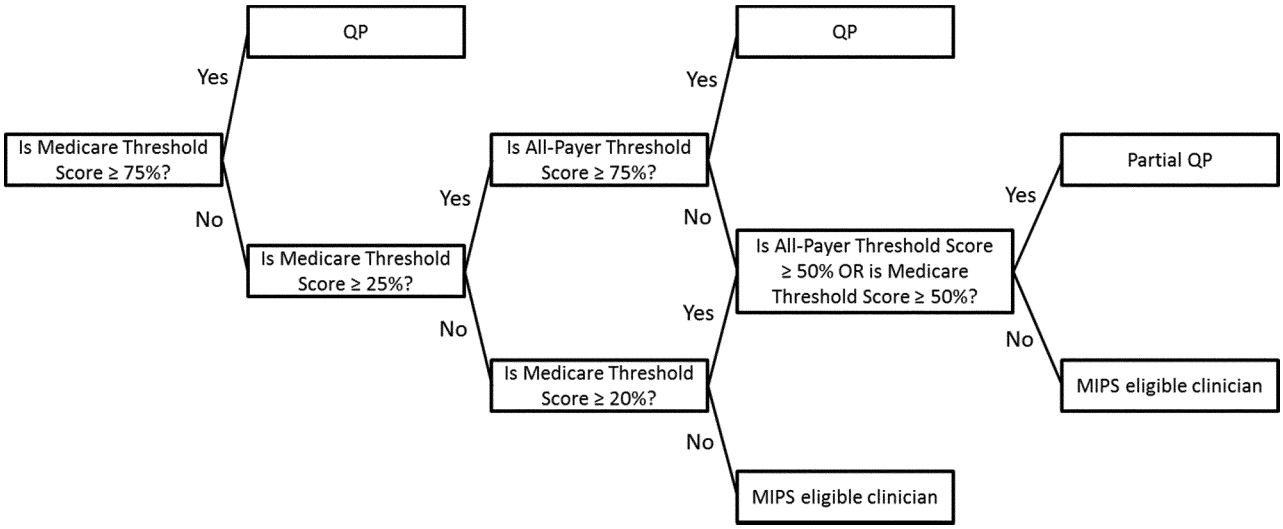


FIGURE 3: QP Determination Tree, Payment Years 2023 and Later



Unlike the Medicare Option where we have access to all of the information necessary to determine whether an APM meets the criteria to be an Advanced APM, we cannot determine whether payment arrangements offered by other payers meet the criteria to be an Other Payer Advanced APM without receiving information about the payment arrangements from an external source. Similarly, we do not have the necessary payment amount and patient count information to determine under the All-Payer Combination Option whether an eligible clinician meets the payment amount or patient count threshold to be a QP without receiving certain information from an external source.

In the CY 2018 Quality Payment Program final rule (82 FR 53844 through 53890), we established additional policies to implement the All-Payer Combination Option and finalized certain modifications to our previously finalized policies. A detailed summary of those policies can be found at 82 FR 53874 through 53876 and 53890 through 53891.

In the CY 2019 PFS final rule (83 FR 59926 through 59938), we finalized the following:

Other Payer Advanced APM Criteria

- We changed the CEHRT use criterion so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, the other payer arrangement must require at least 75 percent of participating eligible clinicians in each participating APM Entity group, or each hospital if hospitals are the APM Entities, use CEHRT to document and communicate clinical care.
- We allowed payers and eligible clinicians to submit evidence as part of their request for an Other Payer Advanced APM determination that CEHRT is used by the requisite percentage of eligible clinicians participating in the payment arrangement (50 percent for 2019, and 75 percent for 2020 and beyond) to document and communicate clinical care; and specified that we will use such evidence to demonstrate the level of CEHRT use, whether or not CEHRT use is explicitly required under the terms of the payment arrangement.
- We amended § 414.1420(c)(2), effective January 1, 2020, to provide that at least one of the quality measures used in the payment arrangement in paragraph (c)(1) of this regulation must be:

++ Finalized on the MIPS final list of measures, as described in § 414.1330;

++ Endorsed by a consensus-based entity; or

++ Determined by CMS to be evidenced-based, reliable, and valid.

- We revised § 414.1420(c)(3) to require that, effective January 1, 2020, unless there is no applicable outcome measure on the MIPS quality measure list, that to be an Other Payer Advanced APM, an other payer arrangement must use an outcome measure, that must be:

++ Finalized on the MIPS final list of measures, as described in § 414.1330;

++ Endorsed by a consensus-based entity; or

++ Determined by CMS to be evidenced-based, reliable, and valid.

- We also revised our regulation at § 414.1420(c)(3)(i) to provide that, for payment arrangements determined to be Other Payer Advanced APMs for the 2019 performance year that did not include an outcome measure that is evidence-based, reliable, and valid, and that are resubmitted for an Other Payer Advanced APM determination for the 2020 performance year (whether for a single year, or for a multi-year determination as finalized in CY 2019 PFS final rule (83 FR 55931 through 55932), we would continue to apply the previous requirements for purposes of those determinations. This revision also applies to payment arrangements in existence prior to the 2020 performance year that are submitted for determination to be Other Payer Advanced APMs for the 2020 performance year and later.
- We revised § 414.1420(d)(3)(i) to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM Entities for QP Performance Periods 2021 through 2024.

Determination of Other Payer Advanced APMs

- We finalized details regarding the Payer Initiated Process for Remaining Other Payers. To the extent possible, we aligned the Payer Initiated Process for Remaining Other Payers with the previously finalized Payer Initiated Process for Medicaid, Medicare Health Plans, and CMS Multi-Payer Models.
- We eliminated the Payer Initiated Process that is specifically for CMS Multi-Payer Models. These payers will be able to submit their arrangements through the Payer Initiated Process for Remaining Other Payers as finalized in the CY 2019 PFS final rule (82 FR 59933 through 59935), or through the Medicaid or Medicare Health Plan

payment arrangement submission processes, and no longer need a special pathway.

Calculation of All-Payer Combination Option Threshold Scores and QP Determinations

- We added a third alternative to allow requests for QP determinations at the TIN level in instances where all clinicians who reassigned billing rights under the TIN participate in a single APM Entity. We modified our regulation at § 414.1440(d) by adding a third alternative to allow QP determinations at the TIN level in instances where all clinicians who have reassigned billing under the TIN participate in a single APM Entity, as well as to assess QP status at the most advantageous level for each eligible clinician.
- We clarified that, in making QP determinations using the All-Payer Combination Option, eligible clinicians may meet the minimum Medicare threshold using one method, and the All-Payer threshold using the same or a different method. We codified this clarification by amending § 414.1440(d)(1).
- We extended the weighting methodology that is used to ensure that an eligible clinician does not receive a lower score on the Medicare portion of their all-payer calculation under the All-Payer Combination Option than the Medicare Threshold Score they received at the APM Entity level in order to apply a similar policy to the proposed TIN level Medicare Threshold Scores.

In this section of the final rule, we are finalizing our proposed definition of the term Aligned Other Payer Medical Home Model. We are also finalizing our proposals regarding bearing financial risk for monetary losses, specifically the Medicaid Medical Home Model financial risk standard and our proposed amendment to the definition of expected expenditures. We also discuss our request for comment on whether certain items and services could be excluded from the capitation rate consistent with our definition of full capitation arrangements.

(2) Aligned Other Payer Medical Home Models

(a) Definition

As we explained when finalizing the definitions of Medical Home Model and Medicaid Medical Home Model in the CY 2017 Quality Payment Program final rule, MACRA does not define ''medical homes,'' but sections 1848(q)(5)(C)(i), 1833(z)(2)(B)(iii)(II)(cc)(BB), 1833(z)(2)(C)(iii)(II)(cc)(BB), and 1833(z)(3)(D)(ii)(II) of the Act make medical homes an instrumental piece of the law (81 FR 77403). The terms Medical Home Model and Medicaid Medical Home Model are limited to Medicare and Medicaid payment arrangements, respectively, and do not include other payer payment arrangements.

As we discuss in section III.I.4.b. of this final rule, in the CY 2020 PFS proposed rule (84 FR 40832), we proposed to amend § 414.1305 to add the defined term ''Aligned Other Payer Medical Home Model'', which would mean an aligned other payer payment arrangement (not including a Medicaid payment arrangement) operated by an other payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation with CMS, such as a memorandum of understanding (MOU), and is determined by CMS to have the following characteristics:

- The other payer payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
- Empanelment of each patient to a primary clinician; and
- At least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood; patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

The proposed definition of Aligned Other Payer Medical Home Model includes the same characteristics as the definitions of Medical Home Model and Medicaid Medical Home Model, but it applies to other payer payment arrangements. In the CY 2020 PFS proposed rule (84 FR 40832), we explained that we believe that structuring this definition in this manner is appropriate because we recognize that there may be medical homes that are operated by other payers that may be appropriately considered medical home models under the All-Payer Combination Option.

We proposed to exclude Medicaid payment arrangements from this definition of Aligned Other Payer Medical Home Model because we have previously defined the term Medicaid Medical Home Model at § 414.1305 and we believe it is important to distinguish Medicaid payment arrangements from other payment arrangements, given the requirements in sections 1833(z)(2)(B)(ii)(I)(bb) and 1833(z)(3)(B)(ii)(I)(bb) of the Act requiring us to consider whether there is a medical home or alternative payment model under the Title XIX state plan in each state when making QP determinations using the All-Payer Combination Option.

For purposes of the Aligned Other Payer Medical Home Model definition, for an arrangement to be aligned, we explained that we mean through a written expression of alignment and cooperation with CMS, such as an MOU. CMS Multi-Payer Models require alignment across the different payers, and a written expression reflects the fact that each arrangement has been reviewed by CMS and CMS has determined that the other payer payment arrangement is aligned with a CMS Multi-Payer Model that is a Medical Home Model. We proposed to limit this Aligned Other Payer Medical Home Model definition to other payer payment arrangements that are aligned with CMS Multi-Payer Models that are Medical Home Models because we can be assured that the structure of these arrangements is similar to the Medical Home Models and Medicaid Medical Home Models for which we have already made a similar determination. Based on our experience to date, we anticipate that participants in these arrangements may generally be more limited in their ability to bear financial risk than other entities because they may be smaller and predominantly include primary care practitioners, whose revenues are a smaller fraction of the patients' total cost of care than those of other eligible clinicians. At the same time, we do not believe that participants in all medical homes, regardless of payer, face the same limitations on their ability to bear financial risk. We explained that we believe that some participants may have different organizational or financial circumstances that allow them to bear greater such risk. We believe that applying the proposed Aligned Other Payer Medical Home Model definition to all other payer payment arrangements

would create potential new opportunities for gaming in commercial settings where we do not have control over the design of such models. However, we believe that payment arrangements that have been aligned and are similar to a Medicaid Home Model, where we have already put in place policies to control against gaming, would be similarly constrained.

In addition, we have acquired additional understanding of some other payer payment arrangements after one year of experience with the Payer Initiated Process, which included some arrangements that are aligned with CMS Multi-Payer Models that are Medical Home Models.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposed definition of the term Aligned Other Payer Medical Home Model.

Response: We appreciate the support for adding the defined term Aligned Other Payer Medical Home Model.

Comment: Some commenters expressed concern that the proposed definition of Aligned Other Payer Medical Home Models would include only those other payer payment arrangements that meet the definition as proposed, requiring alignment with CMS Multi-Payer Models, and not including other payer payment arrangements that are not aligned with a CMS Multi-Payer Model. These commenters recommend that the definition be broadened to include any other payer payment arrangement that would not be formally partnering with a CMS Multi-Payer Model, but would otherwise meet the proposed definition. These commenters stated that CMS is being too prescriptive, and limiting the definition would unnecessarily limit opportunities for participation by eligible clinicians in other payer payment arrangements that would have all of the characteristics of medical home models. Some of these same commenters stated that, while they understood CMS' concern with potential gaming related to payment arrangements that have lower nominal risk thresholds, they believe CMS is already collecting sufficient information to allow for monitoring of other payer payment arrangements such that limiting the definition to only include other payer arrangements that are aligned with CMS Multi-Payer Models is not necessary. One commenter stated that CMS has generally attempted to align Advanced APM and Other Advanced APM policies, and asserted that approach should carry over to inclusion of all commercial payment arrangements that meet the Medical Home Model definition.

Response: We continue to be concerned about the potential for gaming associated with payment arrangements where we do not have any control over the design. We necessarily rely on a limited set of self-reported information, and as a result, we have a limited capability to monitor for, or respond effectively to, potential gaming. We also believe our cautious approach is appropriate given that the All-Payer Combination Option has only been available since the 2019 QP Performance Period and we are still gathering additional information and experience. We acknowledge that limiting the definition of Aligned Other Payer Medical Home Model to only include other payer payment arrangements that meet the proposed definition, including alignment with a CMS Multi-Payer Model, may result in some other payer payment arrangements not being considered an Aligned Other Payer Medical Home Model even though they may be structurally similar to Medical Home Models and Medicaid Medical Home Models. However, as we discussed in the CY 2020 PFS proposed rule (84 FR 40833), we continue to believe that finalizing the definition as proposed is the best approach for expanding innovation while ensuring program integrity.

After considering public comments, we are finalizing without modification our proposal to amend § 414.1305 to define the term ''Aligned Other Payer Medical Home Model''.

(b) Other Payer Advanced APM Criteria for Aligned Other Payer Medical Home Models

As defined in § 414.1305, an Other Payer Advanced APM is an other payer arrangement that meets the Other Payer Advanced APM criteria set forth in § 414.1420. Accordingly, in the CY 2020 PFS proposed rule (84 FR 40833), we proposed that the CEHRT criterion codified in § 414.1420(b) and the use of quality measures criterion codified in § 414.1420(c) will apply to any Aligned Other Payer Medical Home Model for which we will make an Other Payer Advanced APM determination. Further, we proposed to revise § 414.1420(d)(8) to require Aligned Other Payer Medical Home Models to comply with the 50 eligible clinician limit to align with the requirements that apply to Medical Home Models and Medicaid Medical Home Models.

Regarding the applicable financial risk and nominal amount standards, consistent with the financial risk and nominal amount standards applicable to Medical Home Models and Medicaid Medical Home Models, we proposed that the Aligned Other Payer Medical Home Model financial risk and nominal amount standards will be the same as the Medicaid Medical Home Model financial risk and nominal amount standards. We proposed corresponding amendments to § 414.1420(d)(2) and (4) so that those sections would reflect the Medicaid Medical Home Model and Aligned Other Payer Medical Home Model financial risk standard, and Medicaid Medical Home Model and Aligned Other Payer Medical Home Model nominal amount standard, respectively. We proposed this policy consistent with our principle of aligning the Advanced APM criteria and Other Payer Advanced APM criteria to the extent feasible and appropriate, as well as our continued belief that organization size is a proxy for potential risk-bearing capacity.

We did not receive any public comments on our proposal that the CEHRT criterion in § 414.1420(b) and the use of quality measures criterion in § 414.1420(c) will apply to any Aligned Other Payer Medical Home Model for which we will make an Other Payer Advanced APM determination. We discuss public comments regarding our proposal to apply the 50 eligible clinician limit to Aligned Other Payer Medical Home Models in section III.K.4.e.(3)(b) of this final rule.

We are finalizing without modification our proposal that the CEHRT criterion codified in § 414.1420(b) and the use of quality measures criterion codified in § 414.1420(c) will apply to any Aligned Other Payer Medical Home Model for which we will make an Other Payer Advanced APM determination.

(c) Determination of Aligned Other Payer Medical Home Model and Other Payer Advanced APM Status

In the CY 2020 PFS proposed rule (84 FR 40833), we proposed that payers may submit other payer arrangements for CMS determination as Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, through the Payer Initiated Process, to be effective January 1, 2020, for applications for the 2021 QP Performance Period. In the CY 2019 PFS final rule, we finalized a process for Remaining Other Payers to submit other payer arrangements for CMS determination of Other Payer Advanced APM status (83 FR 59934 through 59935). Other payers will be required to submit their other payer arrangements

for CMS determination as Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, using this Remaining Other Payer process.

We also proposed that APM Entities and eligible clinicians can submit other payer arrangements for CMS to determine whether they are Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, through the Eligible Clinician Initiated Process.

We received no public comments on these proposals. We are finalizing our proposal without modification that payers may submit other payer arrangements for CMS determination as Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, through the Payer Initiated Process. This policy will be effective January 1, 2020, beginning with applications submitted for the 2021 QP Performance Period. Other payers will submit their other payer arrangements for CMS determination as Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, using this Remaining Other Payer process. We are also finalizing our proposal without modification that APM Entities and eligible clinicians can submit other payer arrangements for CMS to determine whether they are Aligned Other Payer Medical Home Models and Other Payer Advanced APMs, as applicable, through the Eligible Clinician Initiated Process.

(3) Bearing Financial Risk for Monetary Losses

(a) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77466), we divided the discussion of this criterion into two main topics: (1) What it means for an APM Entity to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures under a payment arrangement (which we refer to as either the generally applicable financial risk standard or Medicaid Medical Home Model financial risk standard); and (2) what levels of risk we would consider to be in excess of a nominal amount (which we refer to as either the generally applicable nominal amount standard or the Medicaid Medical Home Model nominal amount standard).

In the CY 2017 Quality Payment Program final rule, we finalized that for a Medicaid Medical Home Model to be an Other Payer Advanced APM, if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures, the Medicaid Medical Home Model must:

- Withhold payment for services in the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians;
- Require direct payment by the APM Entity to the Medicaid program; or
- Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

We based this standard on our belief that Medicaid Medical Home Models are unique types of Medicaid APMs because they are identified and treated differently under the statute. We believe it is appropriate to establish a unique standard for bearing financial risk that reflects these statutory differences and remains consistent with the statutory scheme, which is to provide incentives for participation by eligible clinicians in Advanced APMs (81 FR 77467 through 77468).

In addition, to be an Other Payer Advanced APM, a Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes or foregoes under the Medicaid Medical Home Model must be at least:

- For QP Performance Period 2019, 3 percent of the APM Entity's total revenue under the payer.
- For QP Performance Period 2020, 4 percent of the APM Entity's total revenue under the payer.
- For QP Performance Period 2021 and later, 5 percent of the APM Entity's total revenue under the payer.

(b) Aligned Other Payer Medical Home Model Financial Risk and Nominal Amount Standards

Neither the current Medical Home Model financial risk and nominal amount standards nor the Medicaid Medical Home Model financial risk and nominal amount standards apply to similar arrangements with other payers for purposes of Other Payer Advanced APM determinations. Consistent with the proposal we are finalizing in this rule to define the term, Aligned Other Payer Medical Home Model. In the CY 2020 PFS proposed rule (84 FR 40834), we proposed to amend § 414.1420(d)(2) and (d)(4) of our regulations to conform the financial risk and nominal amount standards for Aligned Other Payer Medical Home Models with the existing Medicaid Medical Home Model financial risk and nominal amount standards. Recognizing the similar characteristics of these ''medical home'' other payer payment arrangements, we believe that the same financial risk and nominal amount standards should be applied to Aligned Other Payer Medical Home Models as to Medicaid Medical Home Models.

Further, we proposed a corresponding amendment to § 414.1420(d)(2)(ii) to state that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, an Aligned Other Payer Medical Home Model must require the direct payment by the APM Entity to the payer. This amendment would further conform the requirements for Aligned Other Payer Medical Home Models with the current requirements for Medicaid Medical Home Models.

We explained that we believe that if we applied the Medicaid Medical Home Model financial risk and nominal amount standards to all other payer arrangements that would meet the Aligned Other Payer Medical Home Model definition, but for the arrangements' not being aligned with a CMS Multi-Payer Model that is a Medical Home Model, we might create gaming opportunities whereby other payers might develop arrangements that appear to be medical homes solely to take advantage of the unique nominal amount standard. This would be of particular concern because we have less insight into the nature of arrangements not aligned with CMS Multi-Payer Models.

In addition, as the 50 eligible clinician limit as codified in §§ 414.1415(c)(7) and 414.1420(d)(8) currently applies to Medical Home Models and Medicaid Medical Home Models, respectively, we correspondingly proposed that the 50 eligible clinician limit apply to Aligned Other Payer Medical Home Models by amending § 414.1420(d)(8).

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: A few commenters supported our proposed amendment to our regulations to conform the financial risk and nominal amount standards for Aligned Other Payer Medical Home Models with those for Medicaid Medical Home Models.

Response: We appreciate the commenters' support for our proposal.

Comment: A few commenters supported our proposal to make corresponding revisions to § 414.1420(d)(2)(ii) to add that an Aligned Other Payer Medical Home Model must require the direct payment by the APM Entity to the payer, aligning with the current requirement for Medicaid Medical Home Models.

Response: We appreciate the commenters' support for our proposal.

Comment: Two commenters opposed our proposal to require Aligned Other Payer Medical Home Models to comply with the 50 eligible clinician limit to align with the requirements that apply to Medical Home Models and Medicaid Medical Home Models. These commenters stated that the application of the 50 eligible clinician limit to Aligned Other Payer Medical Home Models is an arbitrary cap that would unnecessarily limit the adoption of such payment arrangements by excluding certain entities and clinicians who would benefit from participating in an Aligned Other Payer Medical Home Model. Specifically, the commenters expressed concern that certain large specialty groups would be unable to participate in Aligned Other Payer Medical Home Models if the 50 eligible clinician limit were finalized.

Response: As a general principle, we align policies pertaining to the Advanced APM criteria and the Other Payer Advanced APM criteria to the extent feasible and appropriate. We continue to believe that alignment of the requirements that apply to Medical Home Models, Medicaid Medical Home Models, and Aligned Other Payer Medical Home Models, including the 50 eligible clinician limit, is appropriate.

After considering public comments, we are finalizing our proposal, without modification, to amend § 414.1420(d)(2) and (4) to conform the financial risk and nominal amount standards for Aligned Other Payer Medical Home Models with the existing Medicaid Medical Home Model financial risk and nominal amount standards for Medicaid Medical Home Models as proposed. We are also finalizing without modification our proposal that the 50 eligible clinician limit apply to Aligned Other Payer Medical Home Models by amending § 414.1420(d)(8).

(b) Generally Applicable Other Payer Advanced APM Nominal Amount Standard

(i) Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77471), we finalized at § 414.1420(d)(3)(ii) that except for risk arrangements described under the Medicaid Medical Home Model Standard, for a payment arrangement to meet the nominal amount standard, the specific level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures and total potential risk must be at least 4 percent of the expected expenditures. Furthermore, we finalized that a payment arrangement must require APM Entities to bear financial risk for at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement. Section 414.1420(d)(6) provides that, for purposes of this section, expected expenditures is defined as the Other Payer Advanced APM benchmark or, for episode payment models, as the episode target price.

(ii) Marginal Risk

As we stated in the 2017 Quality Payment Program final rule (81 FR 77470), to determine that a payment arrangement satisfies the marginal risk portion of the nominal amount standard, we would examine the payment required under the payment arrangement as a percentage of the amount by which actual expenditures exceeded expected expenditures. Specifically, for marginal risk we finalized that for a payment arrangement to meet the nominal amount standard, the specific level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures. We also stated that the rate of marginal risk could vary with the amount of losses.

To date, we have applied the marginal risk requirement as requiring that a payment arrangement must exceed the marginal risk rate of 30 percent at all levels of total losses even as the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, consistent with § 414.1420(d)(5)(i). For example, certain other payer arrangements where the marginal risk met or exceeded 30 percent at lower levels of losses in excess of expected expenditures, but fell below 30 percent at higher levels of losses, would not meet the marginal risk requirement of the generally applicable nominal amount standard.

In general, this approach has worked well and served its intended purpose of ensuring only other payer arrangements with strong financial risk components are determined to be Other Payer Advanced APMs. At the same time, this policy has necessitated that we determine that certain other payer arrangements are not Other Payer Advanced APMs even though they include strong financial risk components and well exceed the 30 percent marginal risk requirement at the most common levels of losses in excess of expected expenditures, and employ marginal risk rates below 30 percent only at much higher levels of losses. We do not believe these other payer arrangements include marginal risk rates below 30 percent to avoid subjecting participants to more than nominal amounts of risk. Rather, we believe that these other payer arrangements employ the lower marginal risk rates at higher levels of losses in order to protect participants from potentially catastrophic losses and undue financial burden that might arise because of market factors likely outside their control.

Therefore, in the CY 2020 PFS proposed rule (84 FR 40834), we proposed to amend § 414.1420(d)(5)(i) to provide that in event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we would use the average marginal risk rate across all possible levels of actual expenditures for comparison to the marginal risk rate specified in paragraph (d)(3)(ii) of this section, with exceptions for large losses and small losses as described in paragraphs (d)(5)(ii) and (d)(5)(iii) of this section.

We proposed that we would calculate the average marginal risk rate in two steps. An example of such a calculation is presented in Table 65. This example uses a model that relies on a Total Cost of Care (TCOC) benchmark. This methodology for the calculating average marginal risk rate can also be applied to other types of other payer payment arrangements. In this example, we first take the sum of the marginal risk for each percent above the Total Cost of Care (TCOC) benchmark to determine the participant losses. For example, at 3 percent add 50 percent (amount for 1 percent above benchmark) plus 50 percent (amount for 2 percent above benchmark) plus 50 percent (amount for 3 percent above benchmark), which equals 1.50 percent. Second, we divide the participant losses by the percentage above the benchmark (in our example, 1.50 percent divided by 3) to get average marginal risk. The average marginal risk rate remains above 30 percent at all levels of potential losses up to the point where the participant would be responsible for losses equal to the total potential risk requirement of 3 percent. We note that this example presents the calculation only up to the point where the total potential risk requirement is met.

TABLE 65: Example Average Marginal Risk Calculation

Performance (% above TCOC Benchmark)	Marginal Risk	Participant Losses	Average marginal risk
1%	50%	0.50%	50%
2%	50%	1.00%	50%
3%	50%	1.50%	50%
4%	25%	1.75%	44%
5%	25%	2.00%	40%
6%	25%	2.25%	38%
7%	25%	2.50%	36%
8%	25%	2.75%	34%
9%	25%	3.00%	33%

As we discussed in the CY 2020 PFS proposed rule (84 FR 40835), with this proposed amendment, significant and meaningful financial risk would continue to be required for Other Payer Advanced APMs because the average marginal risk rate would need to be at least 30 percent. At the same time, the proposed amendment would allow us to recognize that significant and meaningful risk can be present even where there is wide variation in the application of marginal risk rates, allowing for continued innovation in the marketplace. This proposed policy is intended to ensure that all Other Payer Advanced APMs include marginal risk of at least 30 percent up to the point that the participant owes 3 percent of losses, which is the intended effect of the current marginal risk standard, while providing flexibility to avoid excluding certain payment arrangements that have strong financial risk designs. When considering average marginal risk in the context of total risk, as we propose to do for Other Payer Advanced APM determinations, certain risk arrangements can create meaningful and significant risk-based incentives for performance and at the same time ensure that the payment arrangement has strong financial risk components.

We note that in making this change we would not lower the standard for the applicable marginal risk rate, but rather allow for new flexibility as to how it can be met. In the CY 2020 PFS proposed rule, we clarified that the amendment as proposed would not change the allowance for large losses provision as described in paragraph (d)(5)(ii) of § 414.1420, so that when calculating the average marginal risk rate, we may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by an amount sufficient to require the APM Entity to make financial risk payments under the payment arrangement greater than or equal to the total risk requirements. We also clarified that the proposal would not change the exception for small losses described in paragraph (d)(5)(iii).

We received comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported our proposal, and no commenters opposed our proposal. Two of these commenters stated that the proposal would provide greater flexibility in the design of other payer payment arrangements, and therefore, would encourage other payers to seek Other Payer Advanced APM determinations for their payment arrangements.

Response: We appreciate the support for our proposal.

After considering public comments, we are finalizing our proposal, without modification, to amend § 414.1420(d)(5)(i) to provide that in event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the average marginal risk rate across all possible levels of actual expenditures will be used for comparison to the marginal risk rate specified in paragraph (d)(3)(ii) of this section, while retaining the current exceptions for large losses and small losses as described in paragraphs (d)(5)(ii) and (d)(5)(iii) of this section.

(iii) Expected Expenditures

In the CY 2017 Quality Payment Program final rule (81 FR 77551), we established the definition of ''expected expenditures'' at § 414.1420(d)(6) to mean the Other Payer APM benchmark, except for episode payment models, for which it is defined as the episode target price. We also finalized at § 414.1420(d)(3)(ii) that, except for arrangements assessed under the Medicaid Medical Home Model financial risk and nominal amount standards, in order to meet the Other Payer Advanced APM nominal amount standard, a payment arrangement's level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures and the total potential risk must be at least 4 percent (81 FR 77471).

In the CY 2017 Quality Payment Program proposed rule (81 FR 28332), we proposed to measure three dimensions of risk under our generally applicable nominal amount standards: (1) Marginal risk, which refers to the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the APM; (2) minimum loss rate (MLR), which is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk; and (3) total potential risk, which refers to the maximum potential payment for which an APM Entity could be liable under the APM. However, based on commenters' concerns regarding technical complexity, we finalized only the marginal risk and MLR requirements.

In the CY 2017 Quality Payment Program proposed rule (81 FR 28333), we explained that, to determine whether an APM satisfies the marginal risk portion of the nominal risk standard, we would examine the payment required under the APM as a percentage of the amount by which actual expenditures exceeded expected expenditures. We proposed to require that this percentage exceed a required marginal risk percentage of 30 percent regardless of the amount by which actual expenditures exceeded expected expenditures.

Our rationale for proposing the marginal risk requirement was that the inclusion of a marginal risk requirement would be intended to focus on maintaining a more than nominal level of likely risk under an Advanced APM

or an Other Payer Advanced APM. However, even with a marginal risk requirement, as there is under the Other Payer Advanced APM criteria, in the CY 2020 PFS proposed rule (84 FR 40837), we explained that we believe there is a need to amend the definition of expected expenditures to ensure there are more than nominal levels of average or likely risk under Other Payer Advanced APMs that meet the generally applicable benchmark-based nominal amount standard. Even with the current marginal risk requirement, we believe a more rigorous definition of expected expenditures is needed to avoid situations where the level of expected expenditures would be set in a manner that reduces the losses a participant might incur. For the same general reasons, we made a similar proposal to revise our definition of expected expenditures under the Advanced APM criteria in the CY 2020 PFS proposed rule (84 FR 40825). We also believe it is important that our definition of expected expenditures is consistent across both the Advanced APM and Other Payer Advanced APM criteria. We generally try to align the Advanced APM and Other Payer Advanced APM criteria to the extent feasible and appropriate.

We made this parallel proposal for the Other Payer Advanced APM criteria to similarly account for scenarios where a payment arrangement can have a sufficient total risk potential to meet our standard, and a sharing rate that results in adequate marginal risk if actual expenditures exceed expected expenditures, but where the level of expected expenditures reflected in the payment arrangement's benchmark or episode target price could be set in a way that substantially reduces the amount of loss a participant in the payment arrangement would reasonably expect to incur.

For a payment arrangement to meet the generally applicable benchmark-based nominal amount standard, we believe there should be not only the potential for financial losses based on expenditures in excess of the benchmark as provided in § 414.1420(d)(6), but also some meaningful likelihood that a participant might exceed the benchmark. If the benchmark is set in such a way that it is extremely unlikely that participants will exceed it, then there is little potential for participants to incur financial losses, and the amount of risk is essentially illusory.

Therefore, we proposed to amend the definition of expected expenditures in § 414.1420(d)(6). Specifically, we would continue to define expected expenditures, for the purposes of this section, as the Other Payer APM benchmark. For episode payment arrangements, expected expenditures would continue to mean the episode target price. However, for purposes of assessing financial risk for Other Payer Advanced APM determinations, the expected expenditures under the payment arrangement should not exceed the expenditures for a participant in the absence of the payment arrangement. The amended regulation would specify that if expected expenditures (that is, benchmarks) under the payment arrangement exceed the expenditures that the participant will be expected to incur in the absence of the payment arrangement, such excess expenditures are not considered when CMS assesses financial risk under the payment arrangement for Other Payer Advanced APM determinations.

We believe that this change would prevent the expected expenditures under the other payer payment arrangement being set in a manner that substantially reduces the amount of losses a participant may face while otherwise satisfying this Other Payer Advanced APM criterion.

We clarify that, in general, expected expenditures are expressed as a dollar amount, and may be derived from national, regional, APM Entity-specific, and/or practice-specific historical expenditures during a baseline period, or other comparable expenditures. However, we recognize expected expenditures under a payment arrangement are often risk-adjusted and trended forward, and may be adjusted to account for expenditure changes that are expected to occur as a result of participation in the payment arrangement. For the purpose of this definition of expected expenditures, we will not consider risk adjustments to be excess expenditures when comparing to the costs that an APM Entity will be expected to incur in the absence of the payment arrangement.

We believe that this amendment would allow us to ensure that there are more-than-nominal amounts of average or likely risk under an other payer payment arrangement that meets the generally applicable benchmark-based nominal amount standard. We believe that the amended definition of expected expenditures, particularly by our not considering excess expenditures, will provide a more definite basis for us to assess whether an APM Entity will bear more than a nominal amount of financial risk for participants under the generally applicable benchmark-based nominal amount standard.

We received public comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Several commenters opposed this proposal. A few of these commenters asserted that the proposal would add significant administrative burden to other payers because other payers would have to carry out significant analytical work to demonstrate compliance with the requirement. A few of these commenters also stated this additional effort would discourage other payers from developing other payer payment arrangements that may be Other Payer Advanced APMs. In addition, a few of these commenters stated that the proposal does not clearly state how CMS would either calculate or assess whether expected expenditures under the other payer payment arrangement exceed the expenditures that the participant will be expected to incur, or whether the other payer would be required to assess whether expected expenditures under the other payer payment arrangement exceed the expenditures that the participant will be expected to incur. One commenter stated the language in the proposal is confusing and does not explain how the expenditures that would be expected to occur in the absence of the arrangement will be calculated. Another commenter noted that the proposal does not provide enough detail on how the assessment would be conducted and stated the requirement would require ''difference-in-difference'' evaluations, which require robust evaluations of claims data. Furthermore, some commenters stated that the proposed change would result in fewer payment arrangements qualifying as Other Payer Advanced APMs.

Response: In proposing this amendment, we did not intend to place an administrative burden on payers and do not expect payers to undertake an additional analysis of claims data to demonstrate compliance. As part of our Other Payer Advanced APM monitoring and program integrity activities, we would expect payers submitting payment arrangements for Other Payer Advanced APM determinations to understand that they may be subject to random or targeted monitoring as part of participation in Quality Payment Program in the form of a request for a simple analysis provided by the payer demonstrating that the expected expenditures under the payment arrangement should not exceed the expenditures for a participants in the absence of the payment arrangement. At the time of submissions of other

payment arrangements from either payers or eligible clinicians, no additional analysis would be required. In addition, we are not requiring that any payer conduct any ''difference-in-difference'' evaluation to comply with this amendment. We are notifying other payers that they should take this requirement into account when they design new payment arrangements that they intend to satisfy the financial risk criterion by way of the benchmark-based nominal amount standard.

We acknowledge that there may be instances where, even if no additional analysis is required, this policy may lead to a payer not to make a submission of their payment arrangement for Other Payer Advanced APM determinations. However, we believe that this policy monitoring is important to the integrity of the program, and that any such impact on submissions will be minimal.

After considering public comments, we are finalizing our proposal to amend the definition of expected expenditures at § 414.1420(d)(6) without modification. We clarify that demonstrating compliance with this requirement should require only a minimal amount of analysis, if any, on the part of the payer or clinicians.

(iv) Excluded Items and Services Under Full Capitation Arrangements

In the CY 2017 Quality Payment Program final rule (81 FR 77551), we finalized a capitation standard at § 414.1420(d)(7) which provides that a capitation arrangement meets the Other Payer Advanced APM financial risk criterion. For purposes of § 414.1420(d)(3), we defined a capitation arrangement as a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services for which payment is made under the APM for all items and services for which payment is made through the APM furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity. We clarified that arrangements made directly between CMS and Medicare Advantage Organizations under the Medicare Advantage program are not considered capitation arrangements for purposes of § 414.1420(d)(7).

In the CY 2019 PFS final rule (83 FR 59939), we made technical corrections to the Advanced APM financial risk capitation standard at § 414.1420(d)(7). These corrections clarified that our financial risk capitation standard applies only to full capitation arrangements where a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement or reconciliation is performed.

As we have begun to collect information on other payer payment arrangements for purposes of making Other Payer Advanced APM determinations, we have noticed that some payment arrangements that are submitted for CMS to determine as capitation arrangements consistent with § 414.1420(d)(7) include a list of services that have been excluded from the capitation rate, such as hospice care, organ transplants, or out-of-network emergency room services. In reviewing these exclusion lists, we believe that it may be appropriate for capitation arrangements to be considered ''full'' capitation arrangements even if they categorically exclude certain services from payment through the capitation rate. Therefore, in the CY 2020 PFS proposed rule (84 FR 40826), we solicited comment on how other payers define or determine what, if any, exclusions are reasonable in a given capitation arrangement. Specifically, we solicited comment on whether there are common industry practices to exclude certain categories of items and services from capitated payment rates and, if so, whether there are common principles or reasons for excluding those categories of services. In addition, we solicited comment on why such items or services are excluded.

We also solicited comment on how non-Medicare payers define or prescribe certain categories of services that are excluded with regard to global capitation payment arrangements. We also solicited comment on whether we should consider a capitation arrangement to be a full capitation arrangement even though it excludes certain categories of services from the capitation rate.

We received public comments responding to our solicitation for information. We appreciate the comments submitted and will take them into consideration for any potential future rulemaking on this issue. The comments that we received in response to this solicitation for information were applicable to both Advanced APMs and Other Payer Advanced APMs. For our responses to these comments, please see section III.K.4.c. of this final rule.

(4) Summary

In this section, we are finalizing the following policies:

- *Aligned Other Payer Medical Home Model:* We are finalizing our proposal to define the term Aligned Other Payer Medical Home Model as proposed. In addition, we are finalizing without modification our proposals that the CEHRT criterion and the use of quality measures criterion will apply to any Aligned Other Payer Medical Home Model for which we will make an Other Payer Advanced APM determination. We are also finalizing our proposal without modification to conform the financial risk and nominal amount standards for Aligned Other Payer Medical Home Models to the existing standards for Medicaid Medical Home Model financial risk and nominal amount standards, including the 50 eligible clinician limit.
- *Marginal Risk:* We are finalizing without modification our proposal that when the marginal risk rate in a payment arrangement varies depending on the amount by which actual/expenditures exceed expected expenditures, we will use the average marginal risk rate across all possible levels of actual expenditures for comparison to the marginal risk rate requirement, with exceptions for large losses and small losses as provided in § 414.1420(d)(5) without modification.
- *Expected Expenditures:* We are finalizing our proposal without modification to amend the definition of expected expenditures at § 414.1420(d)(6) to provide that, for assessing financial risk for Other Payer Advanced APM determinations for episode payment arrangements, the expected expenditures (episode target price) under the payment arrangement should not exceed the expenditures for a participant in the absence of the payment arrangement.

5. Quality Payment Program Technical Revisions

In the CY 2020 PFS proposed rule (84 FR 40837), we proposed certain technical revisions to our regulations to correct several technical errors and to reconcile the text of several of our regulations with the final policies we adopted through notice and comment rulemaking.

We proposed a technical revision to § 414.1405(f) of our regulations to specify that the exception for the application of the MIPS payment adjustment factors to model-specific payments is applicable starting in the 2019 MIPS payment year, not just for the 2019 MIPS payment year. This revision would align the regulation text with our final policy as stated in the preamble of the CY 2019 PFS final rule with comment period (83 FR 59887 through 59888) which makes clear that the exception begins with the 2019

MIPS payment year and continues in subsequent years.

We also proposed technical revisions to Table 59 of the CY 2019 PFS final rule with comment period (83 FR 59935) to correct two dates. Specifically we proposed to change the date for Medicare Health Plans: Guidance made available to ECs, then Submission Period Opens; it is currently listed as September 2020, and we proposed to change that date to August 2020. Similarly, we proposed to change the date for Remaining Other Payers: Guidance made available to ECs, then Submission Period Opens; it is currently listed as September 2020, and we proposed to change that to August 2020. These changes align with what was originally finalized in the CY 2018 Quality Payment Program final rule with comment period (82 FR 53864) which stated that the dates were to be August 2020, and which we did not propose or intend to change in the CY 2019 PFS final rule. Table 66 is included as the corrected Table 59 from the CY 2019 PFS final rule.

TABLE 66: Proposed Other Payer Advanced APM Determination Process for Medicaid, Medicare Health Plans, and Remaining Other Payers for QP Performance Period 2020 (Corrected "Table 59" from the CY 2020 PFS proposed rule)

	Payer Initiated Process	Date	Eligible Clinician (EC) Initiated Process*	Date
Medicaid	Guidance sent to states, then Submission Period Opens	January 2019	Guidance made available to ECs, then Submission Period Opens	September 2019
	Submission Period Closes	April 2019	Submission Period Closes	November 2019
	CMS contacts states and posts Other Payer Advanced APM List	September 2019	CMS contacts ECs and states and posts Other Payer Advanced APM List	December 2019
Medicare Health Plans	Guidance made available to Medicare Health Plans, then Submission Period Opens	April 2019	Guidance made available to ECs, then Submission Period Opens	August 2020
	Submission Period Closes	June 2019	Submission Period Closes	November 2020
	CMS contacts Medicare Health Plans and posts Other Payer Advanced APM List	September 2019	CMS contacts ECs and Medicare Health Plans and posts Other Payer Advanced APM List	December 2020
Remaining Other Payers	Guidance made available to Remaining Other Payers, then Submission Period Opens	January 2019	Guidance made available to ECs, then Submission Period Opens	August 2020
	Submission Period Closes	June 2019	Submission Period Closes	November 2020
	CMS contacts Remaining Other Payers and posts Other Payer Advanced APM List	September 2019	CMS contacts ECs and Remaining Other Payers and posts Other Payer Advanced APM List	December 2020

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

We also proposed technical revisions to §§ 414.1415(c)(6) and 414.1420(d)(7) to correct the internal citation. The current citation, 42 U.S.C. 422, is incorrect. It should instead be 42 CFR part 422. We also proposed technical revisions to § 414.1420(d)(5). We clarify that ''APM'' in § 414.1420(d)(5) should be ''other payer payment arrangement.'' In the CY 2019 PFS final rule, we finalized deleting § 414.1420(d)(3)(ii)(B) and consolidating § 414.1420(d)(3)(ii)(A) into § 414.1420(d)(3)(ii), but that change was not applied to the regulation. We proposed to revise the regulation accordingly. Relatedly, we proposed to amend § 414.1420(d)(5)(i), (ii), and (iii) to state in ''paragraph (d)(3)(ii)'' of this section instead of ''paragraph (d)(3)(ii)(A)'' of this section. We also proposed to clarify that ''Other Payer Advanced APM'' in § 414.1420(d)(5)(ii) should be ''other payer payment arrangement,'' as the marginal risk rate requirements are applied to any other payer payment arrangement that CMS assesses against the Other Payer Advanced APM criteria. These revisions are technical in nature and do not change any substantive policies for the Quality Payment Program.

We did not receive any comments on these proposed technical revisions.

We are finalizing these technical revisions as proposed.

IV. Physician Self-Referral Law: Annual Update to the List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to an entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act and § 411.351 of our regulations specify that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Annual Update to the Code List

1. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS Level II publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§ 411.355(h)).

The definition of DHS at § 411.351 excludes services for which payment is made by Medicare as part of a composite rate (unless the services are specifically identified as DHS and are themselves payable through a composite rate, such as home health and inpatient and outpatient hospital services). Effective January 1, 2011, EPO and dialysis-related drugs furnished in or by an ESRD facility (except drugs for which there are no injectable equivalents or other forms of administration), have been reimbursed under a composite rate known as the ESRD prospective payment system (ESRD PPS) (75 FR 49030). Accordingly, EPO and any dialysis-related drugs that are paid for under ESRD PPS are not DHS and are not listed among the drugs that could qualify for the exception at § 411.355(g) for EPO and other dialysis-related drugs furnished by an ESRD facility.

ESRD-related oral-only drugs, which are drugs or biologicals with no injectable equivalents or other forms of administration other than an oral form, were scheduled to be paid under ESRD PPS beginning January 1, 2014 (75 FR 49044). However, there have been several delays of the implementation of payment of these drugs under ESRD PPS. On December 19, 2014, section 204 of the Stephen Beck, Jr., Achieving a Better Life Experience Act of 2014 (ABLE) (Pub. L. 113–295) was enacted and delayed the inclusion of these oral-only drugs under the ESRD PPS until 2025. Until that time, such drugs furnished in or by an ESRD facility are not paid as part of a composite rate and thus, are DHS.

The Code List was last updated in Tables 28 and 29 of the CY 2019 PFS final rule (83 FR 59718).

2. Response to Comments

We received no comments relating to the Code List that became effective January 1, 2019.

3. Revisions Effective for CY 2020

The updated, comprehensive Code List effective January 1, 2020, is available on our website at *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html.*

Additions and deletions to the Code List conform it to the most recent publications of CPT and HCPCS Level II and to changes in Medicare coverage policy and payment status.

Tables 67 and 68 identify the additions and deletions, respectively, to the comprehensive Code List that become effective January 1, 2020. Tables 67 and 68 also identify the additions and deletions to the list of codes used to identify the items and services that may qualify for the exception in § 411.355(g) (regarding dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

TABLE 67: Additions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES
{No additions}
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES
90912 Bfb training 1st 15 min
90913 Bfb training ea addl 15 min
97129 Ther ivntj 1st 15 min
97130 Ther ivntj ea addl 15 min
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
0558T Ct scan f/biomchn ct alys
74221 X-ray xm esophagus 2cntrst
74248 X-ray sm int f-thru std
74251 X-ray xm sm int 2cntrst std
74270 X-ray xm colon 1cntrst std
74280 X-ray xm colon 2cntrst std
78429 Myocrd img pet 1 std w/ct
78430 Myocrd img pet rst/strs w/ct
78431 Myocrd img pet rst & strs ct
78432 Myocrd img pet 2rtracer
78433 Myocrd img pet 2rtracer ct
78434 Aqmbf pet rest & rx stress
93356 Myocrd strain img spckl trck
RADIATION THERAPY SERVICES AND SUPPLIES
A9590 Iodine i-131 iobenguane 1mci
64625 Rf abltj nrv nrvtg si jt
78830 Rp loclzj tum spect w/ct 1
78831 Rp loclzj tum spect 2 areas
78832 Rp loclzj tum spect w/ct 2
78835 Rp quan meas single area
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS
{No additions}
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES
90694 Vacc acc aIIV4 no prsrv 0.5ml im

[1]CPT codes and descriptions only are copyright 2019 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 68: Deletions from the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES
0357T Cryopreservation oocyte(s)
0020U Rx test prsmv ur w/def conf
0028U Cyp2d6 gene cpy nmr cmn vrnt
0057U Onc sld org neo mrna 51 gene
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES
90911 Biofeedback peri/uro/rectal
95831 Limb muscle testing manual
95832 Hand muscle testing manual
95833 Body muscle testing manual
95834 Body muscle testing manual
G0460 Autologous PRP for ulcers
G0515 Cognitive skills development
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES
74241 X-ray exam upper gi tract
74245 X-ray exam upper gi tract
74247 Contrst x-ray uppr gi tract
74249 Contrst x-ray uppr gi tract
78205 Liver imaging (3D)
78206 Liver image (3d) with flow
78320 Bone imaging (3D)
78607 Brain imaging (3D)
78647 Cerebrospinal fluid scan
78710 Kidney imaging (3D)
78805 Abscess imaging ltd area
78806 Abscess imaging whole body
78807 Nuclear localization/abscess
93965 Extremity study
RADIATION THERAPY SERVICES AND SUPPLIES
{No deletions}
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS
{No deletions}
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES
{No deletions}

[1]CPT codes and descriptions only are copyright 2019 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

V. Interim Final Rule With Comment Period [CMS–1715–IFC]

A. Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine (HCPCS Codes G2082 and G2083)

On March 5, 2009, the U.S. Food and Drug Administration (FDA) approved Spravato™ (esketamine) nasal spray, used in conjunction with an oral antidepressant, for treatment of depression in adults who have tried other antidepressant medicines but have not benefited from them (treatment-resistant depression (TRD)).[120] Because of the risk of serious adverse outcomes resulting from sedation and dissociation caused by Spravato administration, and the potential for abuse and misuse of the product, it is only available through a restricted distribution system under a Risk Evaluation and Mitigation Strategy (REMS). A REMS is a drug safety program that the FDA can require for certain medications with serious safety

[120] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

concerns to help ensure the benefit of the medication outweigh its risks.[121]

Patients with major depression disorder who, despite trying at least two antidepressant treatments given at adequate doses for an adequate duration in the current episode, have not responded to treatment are considered to have TRD.[122] TRD is especially relevant for Medicare beneficiaries. Depression in the elderly is associated with suicide more than at any other age; adults 65 or older constitute 16 percent of all suicide deaths. The decrease in average life expectancy for those with depressive illness, including Medicare beneficiaries, is 7 to 11 years. Depression is a major predictor of the onset of stroke, diabetes, and heart disease; it raises patients' risk of developing coronary heart disease and the risk of dying from a heart attack nearly threefold.[123] There has also been a longstanding need for additional effective treatment for TRD, a serious and life-threatening condition.[124]

A treatment session of esketamine consists of instructed nasal self-administration by the patient, followed by a period of post-administration observation of the patient under direct supervision of a health care professional. Esketamine is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist. It is a nasal spray supplied as an aqueous solution of esketamine hydrochloride in a vial with a nasal spray device. This is the first FDA approval of esketamine for any use.[125] Each device delivers two sprays containing a total of 28 mg of esketamine. Patients would require either two (2) devices (for a 56mg dose) or three (3) devices (for an 84 mg dose) per treatment.

After reviewing the Spravato Prescribing Information, Medication Guide, and REMS requirements, we have concluded that effective and appropriate treatment of TRD with esketamine requires discrete services of a medical professional, meaning those that may furnish and report E/M services under the PFS, both during an overall course of treatment and at the time the drug is administered.[126] Because of the risk of serious adverse outcomes resulting from sedation and dissociation caused by Spravato administration, and the potential for abuse and misuse of the product: The product is only available through a restricted distribution system under a REMS; [127] patients must be monitored by a health care provider for at least 2 hours after receiving their Spravato dose; the prescriber and patient must both sign a Patient Enrollment Form; and the product will only be administered in a certified medical office where the health care provider can monitor the patient.[128] Further information regarding certification of medical offices is available at *www.SPRAVATOrems.com* or 1–855–382–6022.

Because this newly available treatment regimen addresses a particular and urgent need for people with TRD, including Medicare beneficiaries, we recognize that it is in the public interest to ensure appropriate patients have access to this potentially life-saving treatment. We recognize, however, that the services and resources involved in furnishing this treatment are not adequately reflected in existing coding and payment under the PFS, or otherwise under Medicare Part B. Given the FDA approval conditions/requirements including that the drug is only available as an integral component of a physicians' service, the absence of existing HCPCS coding that would adequately describe the service with the provision of the product, and our understanding based on review of the Spravato Prescribing Information, Medication Guide, and REMS requirements, we do not believe the Medicare beneficiaries in the greatest medical need of this treatment would be likely to have access to it until such time that Medicare coding and payment are updated. Medicare coding and payment policies are generally adopted through annual updates to the PFS. Unless we adopt coding and payment changes for this treatment beginning January 1, 2020, we believe that the next practicable alternative would be either standalone rulemaking or PFS rulemaking for 2021. Both of these alternatives would risk the lives of Medicare beneficiaries with TRD for several months to over a year.

Therefore, to facilitate prompt beneficiary access to the new, potentially life-saving treatment for TRD using esketamine, we are creating two new HCPCS G codes, G2082 and G2083, effective January 1, 2020 on an interim final basis. For CY 2020, we are establishing RVUs for these services that reflect the relative resource costs associated with the evaluation and management (E/M), observation and provision of the self-administered esketamine product using HCPCS G codes. We note that we have historically established coding and payment on an interim final basis for truly new services when it is in the public interest to do so. Like most other truly new services, we expect diffusion of this kind of treatment into the market will take place over several years, even though we expect some people to benefit immediately. Consequently, the expected impact on other PFS services is negligible for 2020, and we will consider the public comments we receive on this interim final policy as we consider finalizing coding or payment rules for this treatment beginning in 2021. The HCPCS G-codes are described as follows:

- HCPCS code G2082: *Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.*
- HCPCS code G2083: *Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation.*

In developing the interim final values for these codes, we used a building block methodology that sums the values associated with several codes. For the overall E/M and observation elements of the services, we are incorporating the work RVUs, work time and direct PE inputs associated with a level two office/outpatient visit for an established patient, CPT code 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other*

[121] *https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems.*

[122] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

[123] *https://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=105&bc=AAAQAAAAAAAA&.*

[124] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

[125] Ibid.

[126] *https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=211243.*

[127] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

[128] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family), which has a work RVU of 0.48 and a total work time of 16 minutes, which is based on a pre-service evaluation time of 2 minutes, an intraservice time of 10 minutes, and a postservice time of 4 minutes. We are also incorporating CPT codes 99415 (*Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service))* and 99416 (*Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service))* in which neither code has a work RVU, but includes direct PE inputs reflecting the prolonged time for clinical staff under the direct supervision of the billing practitioner.

Additionally, to account for the cost of the provision of the self-administered esketamine as a direct PE input, we are incorporating the wholesale acquisition cost (WAC) data from the most recent available quarter. For HCPCS code G2082, we are using a price of $590.02 for the supply input that describes 56 mg (supply code SH109) and for HCPCS code G2083, we are using a price of $885.02 for the supply input describing 84 mg of esketamine (supply code SH110).

We note that we are valuing these two HCPCS codes, in part, on the basis of a level 2 established patient office/outpatient E/M visit; consequently, for purposes of relevant Medicare conditions of payment, reporting these codes is similar to reporting a level 2 office/outpatient E/M visit code. In addition to seeking comment on the interim final values we are establishing for HCPCS codes G2082 and G2083, we also seek comment on the assigned work RVUs, work times, and direct PE inputs.

Under circumstances where the health care professional supervising the self-administration and observation does not also provide the esketamine product, the provider cannot report HCPCS codes G2082 or G2083. Rather, the visit and the extended observation (by either the billing professional or clinical staff) could be reported using the existing E/M codes that describe the visit and the prolonged service of the professional or the clinical staff. CMS will monitor claims data to safeguard against duplicative billing for these services and items.

Historically, supply input prices are updated on a code by code basis and periodically through annual notice and comment rulemaking. The prices, including for a variety of pharmaceutical products, are not routinely updated like Part B drugs paid under the ASP methodologies. For the supply inputs for the esketamine product, used in developing rates for HCPCS codes G2082 and G2083, we are using the most recent available quarter of WAC data for 2020 pricing, but we anticipate using either data that is reported for determining payments under section 1847A of the Act (such as ASP) or compendia pricing information (such as WAC) in future years and expect to address this issue in further rulemaking. We seek comments on how to best establish input prices for the esketamine product, as well as other potential self-administered drugs that necessitate concurrent medical services, under PFS ratesetting in future years.

We note that there is a 60-day public comment period following publication of this interim final rule for the public to comment on these interim final amendments to our regulations. We refer readers to the **ADDRESSES** section of the final rule for instructions on submitting public comments. Comments are due by the ''Comment date'' specified in the **DATES** section of this rule.

B. Waiver of Proposed Rulemaking for Provisions

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. Section 553(b)(B) of the APA provides for exceptions from the notice and comment requirements; in cases in which these exceptions apply, section 1871(b)(2)(C) of the Act provides for exceptions from the notice and 60-day comment period requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest.

We find that there is good cause to waive the notice and comment requirements under sections 553(b)(B) of the APA and section 1871(b)(2)(C) due to the urgent need of some Medicare beneficiaries for effective treatment for TRD, a serious and life-threatening condition. The U.S. Food and Drug Administration (FDA) approved Spravato (esketamine) nasal spray on March 5, 2019, used in conjunction with an oral antidepressant, for treatment of adults who have tried other antidepressant medications but have not benefited from them. Because of the treatment's unique method of delivery, specifically the necessary inclusion of a self-administered drug product as part of a uniquely identifiable service of a medical professional (as required through a restricted distribution system under a Risk Evaluation and Mitigation Strategy (REMS),[129] existing Medicare coding and payment policies would not permit appropriate payment for these services. Consequently, Medicare beneficiaries' access to this treatment would be impeded without Medicare coding and payment policy changes established in this final rule with comment period. Given the longstanding need for additional effective treatments for patients with TRD and the potential risk to the lives of the Medicare beneficiaries with TRD, we believe it is in the public interest to adopt these interim final policies to ensure access by making available appropriate payment to physicians and other practitioners for provision of this service as soon as practicable, and that the lack of an appropriate payment mechanism would jeopardize or significantly delay access to this treatment regimen. We find that it would be impracticable and contrary to the public interest to undergo notice and comment procedures before finalizing these payment policies on an interim basis. We also find that delaying implementation of these policies is unnecessary because the impact on other PFS services for 2020 is negligible and the practical alternative for this treatment is no payment under Medicare Part B. In either case, payments for 2021 and beyond would be informed by public comments.

Therefore, we find good cause to waive the notice of proposed rulemaking as provided under section

[129] *https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified.*

1871(b)(2)(C) of the Act and section 533(b)(B) of the APA and to issue this interim final rule with an opportunity for public comment. We are providing a 60-day public comment period as specified in the **DATES** section of this document.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. chapter 35), we are required to publish a 30-day notice in the **Federal Register** and solicit public comment before a ''collection of information'' requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

Our August 14, 2019 (84 FR 40482) proposed rule solicited public comment on each of the required issues under section 3506(c)(2)(A) of the PRA for the following information collection requirements. We received PRA-related comments pertaining to the Open Payments Program and Quality Payment Program. A summary of the comments and our response are set out below, under sections V.B.5. and V.B.7.c.(3)(b).

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2018 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 69 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 69: National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Billing and Posting Clerks	43-3021	19.00	19.00	38.00
Bookkeeping, Accounting, and Auditing Clerks	43-3031	22.46	22.46	44.92
Chief Executive	11-1011	96.22	96.22	192.44
Compliance Officer	13-1041	41.85	41.85	83.70
Computer Systems Analysts	15-1121	45.01	45.01	90.02
Health Diagnosing and Treating Practitioners	29-1000	49.02	49.02	98.04
Licensed Practical Nurse (LPN)	29-2061	22.62	22.62	45.24
Medical Secretary	43-6013	17.83	17.83	35.66
Physicians	29-1060	101.43	101.43	202.86
Practice Administrator (Medical and Health Services Managers)	11-9111	54.68	54.68	109.36

As indicated, we adjusted our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Information Collection Requirements (ICRs)

1. ICRs Regarding Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs) (§§ 414.800 through 414.806)

As described in section II.G. of this final rule, section 2005 of the SUPPORT for Patients and Communities Act establishes a new Medicare Part B benefit for OUD treatment services furnished by OTPs for episodes of care beginning on or after January 1, 2020. In this final rule we are adopting our proposals to use the payment methodology in section 1847A of the Act, which is based on Average Sales Price (ASP), to set the payment rates for the ''incident to'' drugs and ASP-based payment to set the payment rates for the oral product categories, when we receive manufacturers' voluntarily-submitted ASP data for these drugs.

The burden consists of the time/cost for manufacturers of oral opioid agonist or antagonist treatment medications (that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of OUD) to voluntarily prepare and submit their ASP data to CMS.

The burden for such reporting is currently approved by OMB under control number 0938–0921 (CMS–10110) and will remain unchanged (13 hours per response, 4 responses per year, 180 respondents, and 9,360 total hours) since our currently approved burden already accounts for the voluntary reporting of ASP data. We estimate that there are approximately 15 manufacturers of oral drugs used for treatment of opioid use disorder (OUD). We believe that approximately 10 of the 15 manufacturers already report ASP data to CMS for other drugs, and thus up to 5 manufacturers may newly report ASP data to CMS. However, we note that some of these new respondents may have subsidiary or similar relationships with manufacturers that already report ASP data and may be able to submit their data with a current respondent. While the policies we are adopting in

this CY 2020 PFS final rule may slightly increase the number of respondents, our 180 respondent estimate historically fluctuates over time as new Part B drug manufacturers are added while others leave or consolidate. The annual fluctuation in respondents in the past has typically been +/- 5 to 10 manufacturers per year; over the past few years, the annual fluctuation has sometimes been greater, ranging from −13 to +11, but over that same period the overall average of the annual fluctuation is near zero. As a result, the potential slight increase in respondents associated with voluntary reporting for oral drugs used in the treatment of OUD, remains unchanged from the currently approved burden estimate of 180 respondents. In addition, we believe that additional voluntary reporting for oral drugs used for treatment of OUD by those manufacturers that currently report ASP data to CMS for other drugs will impose minimal additional burden. Consequently, we are not making any changes under the aforementioned control number. However, we will continue to monitor the number of respondents to account for various factors such as a change in the number of voluntary submissions from oral OUD drug manufacturers, as well as other issues that may not be related to the voluntary reporting for oral drugs used in OTPs, such as manufacturer consolidations, and new Part B drug and biological manufacturers. We will revise the burden estimate as needed.

We received no comments in relation to our proposed burden estimates.

2. ICRs Regarding the Ground Ambulance Data Collection System

Section 1834(l)(17)(A) of the Act requires that the Secretary develop a ground ambulance data collection system that collects cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services and suppliers of ground ambulance services (ground ambulance organizations). Section 1834(l)(17)(I) of the Act states that the PRA does not apply to the collection of information required under section 1834(l)(17) of the Act. Accordingly, we did not set out in the proposed rule the burden of the collection of information under the data collection system, and we are similarly not setting out that burden in this final rule. Please refer to section VII.F.2. of this final rule for a discussion of the impacts associated with the ground ambulance data collection system.

3. ICRs Regarding Intensive Cardiac Rehabilitation (§ 410.49)

Section 410.49(b)(1)(vii) and (viii) of this final rule will expand the covered conditions to chronic heart failure and add other cardiac conditions as specified through the national coverage determination (NCD) process. We do not anticipate the need to use the NCD process to add additional covered conditions in the near future. In the unlikely event an NCD request is submitted, it will be covered by OMB control number 0938–0776 (CMS–R–290), which will not expire until February 29, 2020. We are not making any changes under that control number since this rule does not impose changes to the currently approved submission process or burden.

We did not receive public comments on the ICRs for intensive cardiac rehabilitation.

4. ICRs Regarding the Medicare Shared Savings Program (42 CFR part 425)

Section 1899(e) of the Act provides that chapter 35 of title 44 of the U.S. Code, which includes such provisions as the PRA, shall not apply to the Shared Savings Program. Accordingly, we are not setting out burden under the authority of the PRA. Please refer to section VII.F.6. of this final rule for a discussion of the impacts associated with the changes to the Shared Savings Program quality reporting requirements included in this final rule.

5. ICRs Regarding the Open Payments Program

Section III.F. of this rule: (1) Expands the definition of ''covered recipient,'' (2) modifies ''nature of payment'' categories, and (3) standardizes data on reported covered drugs, devices, biologicals, or medical supplies.

Expanding the Definition of ''Covered Recipient'' (§§ 403.902, 403.904, and 403.908): This rule expands the definition of a ''covered recipient'' in accordance with the SUPPORT Act to include physician assistants, nurse practitioners, clinical nurse specialists, nurse anesthetists, and certified nurse midwifes. The definition currently includes certain physicians and teaching hospitals. Section 6111(c) of the SUPPORT Act provides that chapter 35 of title 44 of the U.S. Code, which includes such provisions as the PRA, shall not apply to the changes to the definition of a covered recipient included in the SUPPORT Act. In this regard we are not setting out burden under the authority of the PRA. Such estimates can be found in the RIA under section VII.F.7. of this final rule.

Modification of the ''Nature of Payment'' Categories (§§ 403.902 and 403.904): The following changes will be submitted to OMB for approval under control number 0938–1237 (CMS–10495). Subject to renewal, the control number is currently set to expire on March 31, 2021. It was last approved on March 21, 2018, and remains active.

The changes will modify the ''nature of payment'' categories and provide more options for applicable manufacturers and GPOs to capture the nature of the payment made to the covered recipient. To accommodate this change, we project that reporting entities will need to update their system to incorporate the additional categories. We estimate, based on the trends in the number of entities that report every year, that there are 1,600 reporting entities and estimate, using the number of records that these entities report as a proxy for size of the entity. The total number of entities that report fluctuates year to year but has been close to 1,600 for the last two program years. We also estimate that 38 percent (or 611 entities) are small, 29 percent (or 457 entities) are medium, and 33 percent (or 532 entities) are large. We also estimate that 25 percent of reporting entities (400) will need to make minor, one-time updates to their data collection processes because they expect to report a transaction with one of the new categories. Among the 400 entities, we estimate it will take between 5 and 30 hours per entity depending on the size of the entity (with large companies requiring more time) at $44.92/hr for support staff. For all of these entities, we estimate a subtotal of 5,895 hours [(30 hr for a large entity × 133 entities) + (10 hr for a medium entity × 114 entities) + (5 hr for a small entity × 153 entities)] at a cost of $264,804 (5,895 hr × $44.92/hr).

We also expect that all entities will need to make minor, one-time adjustments to their submission processes. For each entity we estimate that this will take 2 to 5 hours at $44.92/hr (with larger entities requiring more time) for support staff and 1 hour at $83.70/hr for compliance officers. For all entities, we estimate a subtotal of 7,767 hours [(5 hr for support staff at a large entity × 532 entities) + (5 hr for support staff at a medium entity × 457 entities) + (2 hr for support staff at a small entity × 611 entities) + (1 hr for compliance officer at each entity regardless of size × 1,600 entities)] at a cost of $410,941 [(2,660 hr for support staff at large entities × $44.92/hr) + (2,285 hr for support staff at medium entities × $44.92/hr) + (1,222 hr for support staff at small entities × $44.92/

hr) + (1,600 hr for compliance officers across all entities × $83.70/hr)].

In aggregate, we estimate a one-time burden of 13,662 hours (5,895 hr + 7,767 hr) at a cost of $675,745 ($264,804 + $410,941) to implement. After these adjustments are made, we do not anticipate any ongoing added burden beyond what is currently approved under the aforementioned control number. We are maintaining these burden estimates as we believe they are representative of the array of potential burden associated with these changes.

TABLE 70—BURDEN TO MODIFY NATURE OF PAYMENT CATEGORIES

Description	Hours	Cost
Burden to update collection processes for entities that expect to report a transaction with a new Nature of Payment category	5,895	$264,804
Burden to update submission processes and systems to account for the new Nature of Payment categories	7,767	410,941
Total	13,662	$675,745

Standardizing Data Reporting for Covered Drugs, Devices, Biologicals, or Medical Supplies (§§ 403.902 and 403.904): The following changes will be submitted to OMB for approval under control number 0938–1237 (CMS–10495). Subject to renewal, the control number is currently set to expire on March 31, 2021. It was last approved on March 21, 2018, and remains active.

Applicable manufacturers and GPOs will need to accommodate the reporting of device identifiers. The following estimates may vary because the information collection system changes that are needed will vary since some entities may already be capturing this information in their systems while others may not.

We estimate, based on an analysis of currently available data, that approximately 850 entities (approximately 53 percent of an assumed 1,600) will need to report at least one record with a device identifier and that 450 of those entities do not already collect the device identifier. For this analysis we assumed that 38 percent (172 = 450 × 0.38) of the entities will be small, 29 percent (128 = 450 × 0.29) will be medium, and 33 percent (150 = 450 × 0.33) will be large. We differentiate because we assume that larger companies will incur more burden to make the changes needed to begin reporting device identifiers because they have more complex systems and potentially more records to report. The number of submitted records will not change, but this rule will add a new data element that may need to be reported along with some or all of an entity's records. The precise tasks will vary by entity, but may include developing processes for gathering device identifier information or systems for collecting the data.

For the 450 entities that will be required to start collecting device identifiers, we estimate that this task will take between 20 and 100 hours for support staff depending on the size of the company (with larger companies requiring more time) at $44.92/hr. For all entities, we estimate a subtotal of 24,840 hours [(100 hr for a large entity × 150 entities) + (50 hr for a medium entity × 128 entities) + (20 hr for a small entity × 172 entities)] at a cost of $1,115,813 [(15,000 hr for support staff at a large entity × $44.92/hr) + (6,400 hr for support staff at a medium entity × $44.92/hr) + (3,440 hr for support staff at a small entity × $44.92/hr)].

For the 850 entities that we expect will be required to begin reporting a device identifier, we estimate that this would take support staff between 10 and 40 hours per entity (with larger companies requiring more time) at $44.92/hr and 2 hours at $83.70/hr for compliance officers. For all entities, we estimate a subtotal of 21,100 hours [(40 hr for support staff at a large entity × 282 entities) + (20 hr for support staff at a medium entity × 244 entities) + (10 hr for support staff at a small entity × 324 entities) + (2 hr for compliance officers at every entity regardless of size × 850 entities)] at a cost of $1,013,740 [(11,280 hr for support staff at large entities × $44.92/hr) + (4,880 for support staff at medium entities × $44.92/hr) + (3,240 for support staff at small entities × $44.92/hr) + (1,700 hr for compliance officers across all entities regardless of size × $83.70/hr)].

We also assume that the remaining 750 entities not planning to submit a device identifier will have a small amount of burden associated with updating their submission processes. We estimate that this will take support staff between 2 and 10 hours per entity (with larger entities requiring more time) at $44.92/hr and 2 hours for compliance officers at $83.70/hr. For all entities, we estimate a subtotal of 5,637 hours [(10 hr for support staff at a large entity × 249 entities) + (5 hr for support staff at a medium entity × 215 entities) + (2 hr for support staff at a small entity × 286 entities) + (750 hr for compliance officers at all entities regardless of size × 2 hr)] at a cost of $311,384 [(2,490 hr for support staff at large entities × $44.92/hr) + (1,075 hr for support staff at medium entities × $44.92/hr) + (572 hr for support staff at small entities × $44.92/hr) + (1,500 hr for compliance officers at all entities regardless of size × $83.70/hr)].

In aggregate, we estimate a one-time burden of 51,577 hours (24,840 hr + 21,100 hr + 5,637 hr) at a cost of $2,440,937 ($1,115,813 + $1,013,740 + $311,384) to implement. After these adjustments are made, we do not anticipate there being any ongoing added burden beyond what is currently approved under the aforementioned control number. We are maintaining these burden estimates as we believe they are representative of the array of potential burden associated with these changes.

TABLE 71—BURDEN FOR CHANGES TO STANDARDIZE DATA ON REPORTED COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES

Description	Hours	Cost
First year data collection burden for entities that do not currently collect a device identifier	24,840	$1,115,813
First year submission burden for all entities that will be required to report a device identifier	21,100	1,013,740
One time submission process and system updates for entities not reporting a device identifier	5,637	311,384

TABLE 71—BURDEN FOR CHANGES TO STANDARDIZE DATA ON REPORTED COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES—Continued

Description	Hours	Cost
Total	51,577	$2,440,937

Comment: One commenter requested that CMS consider the potential additional burden on reporting entities based on the expanded definition of covered recipients.

Response: We recognize that there is an increased data reporting requirement associated with implementation of these statutory requirements, but the expanded definition is required by statute. The estimated burden of Open Payments program is outlined under OMB control number 0938–1237. Section VII.F.7.a. of this final rule provides an estimate of the anticipated regulatory impact, although section 6111(c) of the SUPPORT Act states that chapter 35 of title 44 of the U.S. Code, which includes such provisions as the PRA, shall not apply to the changes to the definition of a covered recipient. As implementation plans are made, we will work to provide guidance, technical assistance, and operational efficiencies to help reduce the potential burden as much as possible.

Comment: One commenter further stated that they believe the burden estimate to add DI information to the Open Payment dataset is greater than CMS assumed. The commenter would like to provide input to CMS on the implementation of this requirement.

Response: When making this burden estimate, we took into account all of the current reporting entities and the array of demographics. We divided the group into several smaller categories based on entity size and made assumptions about the effort needed to make system and process changes. We assume that our estimates for each category will be low for some entities, but high for others. As we work through implementing these changes, we hope stakeholders will continue to provide feedback during working sessions to ensure our data collection system is easy to use and provides clear information.

6. ICRs Regarding Medicare Enrollment of Opioid Treatment Programs

The following discusses the burden estimates we proposed regarding the enrollment of OTP programs.

As mentioned in section III.H. of this final rule, OTP providers will be required to enroll in Medicare via the paper or internet-based version of the Form CMS–855B (or its successor application) and any applicable supplement, pay the application fee, submit fingerprints, and complete a provider agreement.

Based on SAMHSA statistics and our internal data, we generally estimated that: (1) There are about 1,700 certified and accredited OTPs eligible for Medicare enrollment; and (2) 200 OTPs would become certified by SAMHSA in the next 3 years (or roughly 67 per year), bringing the total amount of OTPs eligible to enroll to approximately 1,900 over the next 3 years.

Form Completion (§ 424.67(b)): We estimated that it would take each OTP an average of 3 hours to obtain and furnish the information on the Form CMS–855B (OMB control number: 0938–0685) and a new supplement thereto designed to capture information unique to OTPs. Per our experience, we believe that the OTP's medical secretary would be responsible for securing and reporting data on the Form CMS–855B and new accompanying OTP supplement. We estimated that this task would take approximately 2.5 hours; of this amount, roughly 30 minutes would involve completion of the data on the supplement, though this timeframe could be higher or lower depending upon the number of individuals whom the OTP must list. Additionally, the form would be reviewed and signed by a health diagnosing and treating practitioner of the OTP, a process we estimated would take 30 minutes. We project a first-year burden of 5,301 hours (1,767 entities × 3 hr) at a cost of $244,146 (1,767 entities × ((2.5 hr × $35.66/hr) + (0.5 hr × $98.04/hr)), a second-year burden of 201 hours (67 entities × 3 hr) at a cost of $9,257 (67 entities × ((2.5 hr × $35.66/hr) + (0.5 hr × $98.04/hr)), and a third-year burden of 198 hours (66 entities × 3 hr) at a cost of $9,119 (66 entities × ((2.5 hr × $35.66/hr) + (0.5 hr × $98.04/hr)). In aggregate, we estimated a burden of 5,700 hours (5,301 hr + 201 hr + 198 hr) at a cost of $262,522 ($244,146 + $9,257 + $9,119). When averaged over the typical 3-year OMB approval period, we estimate an annual burden of 1,900 hours (5,700 hr/3) at a cost of $87,507 ($262,522/3).

A copy of the draft OTP supplement was made available online, and we welcomed public comment on: (1) Its contents; (2) the usefulness of the data to be captured thereon; and (3) the anticipated burden of completion. We received no comment and are finalizing the supplement as well as our burden estimates as proposed.

Fingerprinting (§ 424.518): In this rule, OTPs will be subject to high categorical risk level screening under § 424.518, which requires the submission of a set of fingerprints for a national background check (via FBI Applicant Fingerprint Card FD–258) from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the OTP. Since the burden is currently approved by OMB as a common form (FD–258) under control number 1110–0046, we are not setting out such burden. However, an analysis of the impact of this requirement can be found in the RIA section of this rule.

Application Fee (§ 424.514): As already discussed in this rule, each OTP will be required to pay an application fee at the time of enrollment. The application fee does not meet the definition of a ''collection of information'' (5 CFR 1320.3(c)) and, as such, is not subject to the requirements of the PRA. Although we are not setting out such burden under this PRA section, the cost is scored under section VII.F.8. of the RIA.

Provider Agreement (§ 424.67(b)(7)): OTPs will also have to complete a provider agreement in order to enroll in Medicare. The burden for reporting and completing the Provider Agreement Form CMS–1561 and –1561A (OMB control number 0938–0832) was based on SAMHSA statistics. We estimate that there are about 1,700 already certified and accredited OTPs eligible for Medicare enrollment initially; approximately 200 OTPs would become certified by SAMHSA in the next 3 years (or roughly 67 per year). We anticipate that it would take the OPT 5 minutes at $192.44/hr for a Chief Executive to review and sign the CMS–1561 or CMS–1561A, and an additional 5 minutes at $35.66/hr for a Medical Secretary to file the document when fully executed.

In aggregate, we estimate a 3-year burden of 317 hours ([1,767 OPTs for year 1 + 67 OTPs for year 2 + 67 OTPs for year 3] × 10 min/60) at a cost of $36,154 ([317 hr/2 respondents ×

$192.44/hr] + [317 hr/2 respondents × $35.66/hr]). This results, roughly, in a Year 1 burden of 295 hours at a cost of $33,623, a Year 2 burden of 11 hours at a cost of $1,272, and a Year 3 burden of 11 hours at a cost of $1,254. Over the course of OMB's typical 3-year approval period, we estimate an average annual burden of 106 hours (317 hr/3 years) at a cost of $12,051 ($36,154/3 years).

Total: Table 72 summarizes our foregoing burden estimates.

TABLE 72: Combined Burden Related to Enrollment of OTPs (Completion of CMS-855B and CMS-1561/-1561A)

	Year 1	Year 2	Year 3	Total	Average Annual Burden
CMS-855B Time (Hours)	5,301	201	198	5,700	1,900
CMS-1561/-1561A Time (Hours)	295	11	11	317	106
TOTAL	**5,596**	**212**	**209**	**6,017**	**2,006**
CMS-855B Cost ($)	244,146	9,257	9,119	262,522	87,507
CMS-1561/-1561A Cost ($)	33,623	1,272	1,254	36,154	12,051
TOTAL	**277,769**	**10,529**	**10,373**	**298,676**	**99,558**

We received no comments on our proposed requirements and burden estimates and are therefore finalizing them without change. The requirement and burden estimates will be submitted to OMB for approval under control number 0938–0685 (Form CMS–855B; ''Medicare Enrollment Application: Clinics/Group Practices and Certain Other Suppliers'') and 0938–0832 (Form CMS–1561/-1561A; ''Health Insurance Benefit Agreement'').

7. The Quality Payment Program (42 CFR Part 414 and Section III.K. of This Final Rule)

a. Background

(1) ICRs Associated With MIPS and Advanced APMs

The Quality Payment Program is comprised of a series of ICRs associated with MIPS and Advanced APMs.

The ICRs reflect this final rule's policies, as well as policies in the CY 2017 and 2018 Quality Payment Program final rules (81 FR 77008 and 82 FR 53568, respectively), and the CY 2019 PFS final rule (83 FR 59452).

(2) Summary of Quality Payment Program Changes: MIPS

(a) Summary of Changes to our Currently Approved Burden Estimates

As discussed in more detail in section VI.B.7, the MIPS ICRs consist of: Registration for virtual groups; qualified registry self-nomination applications; and QCDR self-nomination applications; CAHPS survey vendor applications; Quality Payment Program Identity Management Application Process; quality performance category data submission by Medicare Part B claims collection type, QCDR and MIPS CQM collection type, eCQM collection type, and CMS web interface submission type; CAHPS for MIPS survey beneficiary participation; group registration for CMS web interface; group registration for CAHPS for MIPS survey; call for quality measures; reweighting applications for Promoting Interoperability and other performance categories; Promoting Interoperability performance category data submission; call for Promoting Interoperability measures; improvement activities performance category data submission; nomination of improvement activities; and opt-out of Physician Compare for voluntary participants.

Two MIPS ICRs show changes in burden due to finalized policies: QCDR self-nomination applications and Call for Quality Measures. For the QCDR self-nomination applications ICR, we have decreased our estimate of the number of QCDR measures QCDRs will submit for approval from 9 to 2 (-7 measures) due to the finalized proposal to require measure testing prior to submission for approval. We have also increased our estimate of the time required to submit a QCDR measure by 1.5 hours due to the requirement for QCDRs to link their QCDR measures as feasible to at least one cost measure, improvement activity, or MIPS Value Pathways starting with the 2021 self-nomination period (+1 hour); and the requirement for QCDR measure stewards to submit measure testing data as part of the self-nomination process for each QCDR measure (+0.5 hours). The net effect of these changes is a reduction in burden per QCDR to self-nominate from 12 hours to 8 hours (-4 hours). For the Call for Quality Measures, we have increased our estimate of the time required to nominate a quality measure for consideration by 1 hour due to the requirement that MIPS quality measure stewards link their MIPS quality measures to existing and related cost measures and improvement activities and provide rationale for the linkage.

The remaining changes to our currently approved burden estimates are adjustments to reflect better understanding of the impacts of policies finalized in previous rules, as well as the use of updated data sources available at the time of publication of this final rule.

We are not making any changes to the following ICRs: Registration for virtual groups, CAHPS survey vendor applications, Quality Payment Program Identity Management Application Process, CAHPS for MIPS survey beneficiary participation, and group registration for CAHPS for MIPS survey. See section VI.B.7.n. of this final rule for a summary of the ICRs, the overall burden estimates, and a summary of the assumption and data changes affecting each ICR.

The accuracy of our estimates of the total burden for data submission under the quality, Promoting Interoperability, and improvement activities performance categories may be impacted due to two primary reasons. First, we anticipate the number of QPs to increase because of total expected growth in Advanced APM participation as new models that are Advanced APMs for which we do not yet have enrollment data become available for participation. The additional QPs will be excluded from MIPS and likely not report. Second, it is difficult to predict what eligible clinicians who may report voluntarily

will do in the 2020 MIPS performance period compared to the 2018 MIPS performance period, and therefore, the actual number of participants and how they elect to submit data may be different than our estimates. However, we believe our estimates are the most appropriate given the available data.

The revised requirements and burden estimates for all Quality Payment Program ICRs (except for CAHPS for MIPS and virtual groups election) will be submitted to OMB for approval under control number 0938–1314 (CMS–10621). The CAHPS for MIPS Survey is approved under OMB control number 0938–1222 (CMS–10450). The Virtual Groups Election is approved under OMB control number 0938–1343 (CMS–10652).

(b) Summary of Changes to Burden Estimates Provided in the CY 2020 PFS Proposed Rule

In the CY 2020 PFS proposed rule (84 FR 40838 through 40881), we used respondent data from the 2017 MIPS performance period for the quality, Promoting Interoperability, and improvement activities performance categories with the sole exception of 104 CMS Web Interface respondents, which was based on the number of groups who submitted data for the quality performance category via the CMS Web Interface for the 2018 MIPS performance period. For this final rule, we have updated our respondent estimates for each of these performance categories with data from the 2018 MIPS performance period.

Our participation estimates are reflected in Tables 78, 79 and 80 for the quality performance category, Table 96 for the Promoting Interoperability performance category, and Table 101 for the improvement activities performance category.

(3) Summary of Quality Payment Program Changes: Advanced APMs

As discussed in more detail in sections VI.B.7. of this final rule, ICRs for Advanced APMs consist of: Partial Qualifying APM Participant (QP) election; Other Payer Advanced APM identification: Payer Initiated and Eligible Clinician Initiated Processes; and submission of data for All-Payer QP determinations under the All-Payer Combination Option.

For these ICRs, the changes to currently approved burden estimates are adjustments based on updated projections for the 2020 MIPS performance period. We are not making any changes to our per-respondent burden estimates and have not made any changes or adjustments to the burden estimates provided in the CY 2020 PFS proposed rule. We are also not making any changes to the Other Payer Advanced APM identification: Eligible Clinician Initiated Process ICR.

(4) Framework for Understanding the Burden of MIPS Data Submission

Because of the wide range of information collection requirements under MIPS, Table 73 presents a framework for understanding how the organizations permitted or required to submit data on behalf of clinicians vary across the types of data, and whether the clinician is a MIPS eligible clinician or other eligible clinician voluntarily submitting data, MIPS APM participant, or an Advanced APM participant. As shown in the first row of Table 73, MIPS eligible clinicians that are not in MIPS APMs and other clinicians voluntarily submitting data will submit data either as individuals, groups, or virtual groups for the quality, Promoting Interoperability, and improvement activities performance categories. Note that virtual groups are subject to the same data submission requirements as groups, and therefore, we will refer only to groups for the remainder of this section unless otherwise noted. Because MIPS eligible clinicians are not required to submit any additional information for assessment under the cost performance category, the administrative claims data used for the cost performance category is not represented in Table 73.

For MIPS eligible clinicians participating in MIPS APMs, the organizations submitting data on behalf of MIPS eligible clinicians will vary between performance categories and, in some instances, between MIPS APMs. For the 2020 MIPS performance period, the quality data submitted by MIPS APM participants reporting through the CMS Web Interface on behalf of their participant MIPS eligible clinicians will fulfill any MIPS submission requirements for the quality performance category. For other MIPS APMs, the quality data submitted by APM Entities on behalf of their participant MIPS eligible clinicians will fulfill any MIPS submission requirements for the quality performance category if that data is available to be scored. However, as finalized in section III.K.3.c.(5)(c)(i)(A) of this rule, beginning in the 2020 MIPS performance period, MIPS eligible clinicians participating in MIPS APMs whose APM quality data is not available for MIPS may elect to report MIPS quality measures at either the APM entity, individual, or TIN-level in a manner similar to our established policy for the Promoting Interoperability performance category under the APM scoring standard for purposes of the MIPS quality performance category. If we determine there are not sufficient measures applicable and available, we will assign performance category weights as specified in § 414.1370(h)(5).

For the Promoting Interoperability performance category, group TINs may submit data on behalf of eligible clinicians in MIPS APMs, or eligible clinicians in MIPS APMs may submit data individually. For the improvement activities performance category, we will assume no reporting burden for MIPS APM participants. In the CY 2017 Quality Payment Program final rule, we described that for MIPS APMs, we compare the requirements of the specific MIPS APM with the list of activities in the Improvement Activities Inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians (81 FR 77185). Although the policy allows for the submission of additional improvement activities if a MIPS APM receives less than the maximum improvement activities performance category score, to date all MIPS APM have qualified for the maximum improvement activities score. Therefore, we assume that no additional submission will be needed.

Advanced APM participants who are determined to be Partial QPs may incur additional burden if they elect to participate in MIPS, which is discussed in more detail in the CY 2018 Quality Payment Program final rule (82 FR 53841 through 53844), but other than the election to participate in MIPS, we do not have data to estimate that burden.

BILLING CODE 4120–01–P

TABLE 73: Clinicians or Organizations Submitting MIPS Data on Behalf of Clinicians, by Type of Data and Category of Clinician*

Category of Clinician	Type of Data Submitted			
	Quality Performance Category	Promoting Interoperability Performance Category	Improvement Activities Performance Category	Other Data Submitted on Behalf of MIPS Eligible Clinicians
MIPS Eligible Clinicians (not in MIPS APMs) and Other Eligible Clinicians Voluntarily Submitting MIPS Data [a]	As virtual group, group, or individual clinicians	As virtual group, group, or individual clinicians. Clinicians who are hospital-based, ambulatory surgical center-based, non-patient facing, physician assistants, nurse practitioners, clinician nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals are automatically eligible for a zero percent weighting for the Promoting Interoperability performance category. Clinicians who submit an application and are approved for significant hardship or other exceptions are also eligible for a zero percent weighting.	As virtual group, group, or individual clinicians	Groups electing to use a CMS-approved survey vendor to administer CAHPS must register. Groups electing to submit via CMS Web Interface for the first time must register. Virtual groups must register via email.
MIPS Eligible Clinicians Participating in MIPS APMs that report via Web Interface	ACOs submit to the CMS Web Interface and CAHPS for ACOs on behalf of their participating MIPS eligible clinicians. If the ACO does not submit quality data, MIPS eligible clinicians participating in MIPS APMs may elect to report individually or at the TIN-level.[e] [Submissions by the ACO are not included in	Each MIPS eligible clinician in the APM Entity reports data for the Promoting Interoperability performance category through either group TIN or individual reporting. [Burden estimates for this final rule assume group TIN-level reporting].[c]	CMS will assign the improvement activities performance category score to each APM Entity group based on the activities involved in participation in the MIPS APM.[d] [The burden estimates for this final rule assume no improvement activity reporting burden for APM participants because we assume the MIPS	APM Entities will make Partial QP election for participating MIPS eligible clinicians.

Category of Clinician	Type of Data Submitted			
	Quality Performance Category	**Promoting Interoperability Performance Category**	**Improvement Activities Performance Category**	**Other Data Submitted on Behalf of MIPS Eligible Clinicians**
	burden estimates for this final rule because quality data submission to fulfill requirements of the Shared Savings Program and for purposes of testing and evaluating the Next Generation ACO Model are not subject to the PRA].[b]		APM model provides a maximum improvement activity performance category score.]	
MIPS Eligible Clinicians Participating in Other MIPS APMs	APM Entities submit to MIPS on behalf of their participating MIPS eligible clinicians; however if the quality data is not available to MIPS in time for scoring, MIPS eligible clinicians participating in MIPS APMs may elect to report individually or at the TIN-level.[e] [Submissions made by APM Entities to MIPS on behalf of their participating MIPS eligible clinicians are not included in burden estimates for this final rule because quality data submission for purposes of testing and evaluating Innovation Center models tested under section	Each MIPS eligible clinician in the APM Entity reports data for the Promoting Interoperability performance category through either group TIN or individual reporting. [The burden estimates for this final rule assume group TIN-level reporting].	CMS will assign the same improvement activities performance category score to each APM Entity based on the activities involved in participation in the MIPS APM. [The burden estimates for this final rule assume no improvement activities performance category reporting burden for APM participants because we assume the MIPS APM model provides a maximum improvement activity score.]	APM Entities will make Partial QP election for participating eligible clinicians.

Category of Clinician	Type of Data Submitted			
	Quality Performance Category	Promoting Interoperability Performance Category	Improvement Activities Performance Category	Other Data Submitted on Behalf of MIPS Eligible Clinicians
	1115A of the Act (or section 3021 of the Affordable Care Act) are not subject to the PRA.]			

* Because the cost performance category relies on administrative claims data, MIPS eligible clinicians are not required to provide any additional information, and therefore, the cost performance category is not represented in this table.

a Virtual group participation is limited to MIPS eligible clinicians, specifically, solo practitioners and groups consisting of 10 eligible clinicians or fewer.

b Sections 1899 and 1115A of the Act (42 U.S.C. 1395jjj and 42 U.S.C. 1315a, respectively) state that the Shared Savings Program and the testing, evaluation, and expansion of Innovation Center models are not subject to the PRA.

c Both group TIN and individual clinician Promoting Interoperability data will be accepted. If both group TIN and individual scores are available for the same APM Entity, CMS will use the higher score for each TIN/NPI. The TIN/NPI scores are then aggregated for purposes of calculating the APM Entity score.

d APM Entities participating in MIPS APMs receive an improvement activities performance category score of at least 50 percent.(42 CFR 414.1380) and do not need to submit improvement activities data unless the CMS-assigned improvement activities scores are below the maximum improvement activities score.

e Both group TIN and individual clinician quality data will be accepted. If both group TIN and individual scores are available for the same APM Entity, CMS will use the higher score for each TIN/NPI. We would then use the highest individual or TIN-level score attributable to each MIPS eligible clinician in an APM Entity in order to determine the APM Entity score based on the average of the highest scores for each MIPS eligible clinician in the APM Entity.

BILLING CODE 4120–01–C

The policies finalized in the CY 2017 and CY 2018 Quality Payment Program final rules, and the CY 2019 PFS final rule and continued in this final rule create some additional data collection requirements not listed in Table 73. These additional data collections, some of which were previously approved by OMB under the control numbers 0938–1314 (Quality Payment Program, CMS–10621) and 0938–1222 (CAHPS for MIPS, CMS–10450), are as follows:

Additional ICRs Related to MIPS Third-Party Intermediaries

- Self-nomination of new and returning QCDRs (81 FR 77507 through 77508, 82 FR 53906 through 53908, and 83 FR 59998 through 60000) (OMB 0938–1314).
- Self-nomination of new and returning registries (81 FR 77507 through 77508, 82 FR 53906 through 53908, and 83 FR 59997 through 59998) (OMB 0938–1314).
- Approval process for new and returning CAHPS for MIPS survey vendors (82 FR 53908) (OMB 0938–1222).

Additional ICRs Related to the Data Submission and the Quality Performance Category

- CAHPS for MIPS survey completion by beneficiaries (81 FR 77509, 82 FR 53916 through 53917, and 83 FR 60008 through 60009) (OMB 0938–1222).
- Quality Payment Program Identity Management Application Process (82 FR 53914 and 83 FR 60003 through 60004) (OMB 0938–1314).

Additional ICRs Related to the Promoting Interoperability Performance Category

- Reweighting Applications for Promoting Interoperability and other performance categories (82 FR 53918 and 83 FR 60011 through 60012) (OMB 0938–1314).

Additional ICRs Related to Call for New MIPS Measures and Activities

- Nomination of improvement activities (82 FR 53922 and 83 FR 60017 through 60018) (OMB 0938–1314).
- Call for new Promoting Interoperability measures (83 FR 60014 through 60015) (OMB 0938–1314).
- Call for new quality measures (83 FR 60010 through 60011) (OMB 0938–1314).

Additional ICRs Related to MIPS

- Opt out of performance data display on Physician Compare for voluntary reporters under MIPS (82 FR 53924 through 53925 and 83 FR 60022) (OMB 0938–1314).

Additional ICRs Related to APMs

- Partial QP Election (81 FR 77512 through 77513, 82 FR 53922 through 53923, and 83 FR 60018 through 60019) (OMB 0938–1314).
- Other Payer Advanced APM determinations: Payer Initiated Process (82 FR 53923 through 53924 and 83 FR 60019 through 60020) (OMB 0938–1314).
- Other Payer Advanced APM determinations: Eligible Clinician Initiated Process (82 FR 53924 and 83 FR 60020) (OMB 0938–1314).
- Submission of Data for All-Payer QP Determinations (83 FR 60021) (OMB 0938–1314).

b. ICRs Regarding the Virtual Group Election (§ 414.1315)

This rule is not finalizing any new or revised collection of information requirements or burden related to the virtual group election. The virtual group election requirements and burden are currently approved by OMB under

control number 0938–1343 (CMS–10652). Consequently, we are not making any virtual group election changes under that control number.

c. ICRs Regarding Third-Party Intermediaries (§ 414.1400)

(1) Background

Under MIPS, the quality, Promoting Interoperability, and improvement activities performance category data may be submitted via relevant third-party intermediaries, such as qualified registries, QCDRs, and health IT vendors. Data on the CAHPS for MIPS survey, which counts as either one quality performance category measure, or towards an improvement activity, can be submitted via CMS-approved survey vendors. Entities seeking approval to submit data on behalf of clinicians as a qualified registry, QCDR, or survey vendor must complete a self-nominate process annually. The processes for self-nomination for entities seeking approval as qualified registries and QCDRs are similar with the exception that QCDRs have the option to nominate QCDR measures for approval for the reporting of quality performance category data. Therefore, differences between QCDRs and qualified registry self-nomination are associated with the preparation of QCDR measures for approval.

The burden associated with qualified registry self-nomination, QCDR self-nomination and measure submission, and the CAHPS for MIPS survey vendor applications follow: [130]

(2) Qualified Registry Self-Nomination Applications

The requirements and burden associated with qualified registries and their self-nomination will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As explained below, this rule will both adjust the number of self-nomination applications based on current data and revise the number of self-nomination applications due to policies promulgated in the CY 2019 final rule regarding the definition of a QCDR (83 FR 59895) and minimum participation requirements (83 FR 59897) which are effective beginning in the 2020 MIPS performance period. The adjustment will decrease our total burden estimates while keeping our burden per response estimates unchanged. We are not making any changes to the self-nomination process.

We refer readers to § 414.1400(a)(2) and (c)(1) which state that qualified registries interested in submitting MIPS data to us on behalf of MIPS eligible clinicians, groups, or virtual groups need to complete a self-nomination process to be considered for approval to do so.

In the CY 2018 Quality Payment Program final rule (82 FR 53815) and as stated in § 414.1400(c)(1), previously approved qualified registries in good standing (that is, that are not on probation or disqualified) 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. In the same rule, we stated that qualified registries in good standing that would like to make minimal changes to their previously approved self-nomination application from the previous year, may submit these changes, and attest to no other changes from their previously approved qualified registry application for CMS review during the self-nomination period (82 FR 53815). The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period beginning with the 2020 MIPS performance period (83 FR 59906).

For this final rule, we have adjusted the number of self-nominating applicants from 150 to 153 based on the number of applications received during the 2020 self-nomination period, an increase of 3 from the currently approved estimate of 150 (83 FR 59997 through 59998). This is a decrease of 137 from the estimate of 290 provided in the CY 2020 PFS proposed rule due to availability of more recent data. This estimate reflects impacts of revisions to both the definition of a QCDR and minimum participation requirements for entities seeking approval as a QCDR which were previously finalized in the CY 2019 PFS final rule (83 FR 59895 through 59897) that may or may not have resulted in some entities seeking approval as a qualified registry rather than a QCDR.

The burden associated with the qualified registry self-nomination process varies depending on the number of existing qualified registries that elect to use the simplified self-nomination process in lieu of the full self-nomination process as described in the CY 2018 Quality Payment Program final rule (82 FR 53815). The Quality Payment Program Self-Nomination Form is submitted electronically using a web-based tool. We will be submitting a revised version of the form for approval under OMB control number 0938–1314 (CMS–10621).

As described in the CY 2017 Quality Payment Program final rule, the full self-nomination process requires the submission of basic information, a description of the process the qualified registry will use for completion of a randomized audit of a subset of data prior to submission, and the provision of a data validation plan along with the results of the executed data validation plan by May 31 of the year following the performance period (81 FR 77383 through 77384). As shown in Table 75, we estimate that the staff involved in the qualified registry self-nomination process will be mainly computer systems analysts or their equivalent, who have an adjusted labor rate of $90.02/hr. Consistent with the CY 2019 PFS final rule (83 FR 59998), we estimate that the time associated with the self-nomination process ranges from a minimum of 0.5 hours (for the simplified self-nomination process) to 3 hours (for the full self-nomination process) per qualified registry. For the 2019 MIPS performance period, 135 qualified registries were approved to submit data out of the total 141 (96 percent) which submitted nomination forms. For our minimum burden estimate, we assume a similar percentage of the 153 qualified registries that submitted nomination forms in CY 2019 for the 2020 MIPS performance period will be approved and will nominate using the simplified process in CY 2020; this results in a total of 147 (153 × 96 percent) simplified self-nomination applications received. When considering this rule's adjusted number of nomination applications (153), we estimate that the annual burden will range from 91.5 hours ([147 simplified self-nominations × 0.5 hr] + [6 full self-nominations × 3 hr]) to 459 hours (153 qualified registries × 3 hr) at a cost ranging from $8,237 (91.5 hr × $90.02/hr) to $41,319 (459 hr × $90.02/hr), respectively (see Table 75).

As shown in Table 74, compared to the currently approved minimum estimates of 97.5 hours and $8,777 and the maximum estimates of 450 hours and $40,509, the increase in the number of respondents will adjust our total burden estimates by −6 hours and −$540 [(6 registries × 0.5 hr × $90.02/hr) + (−3 registries × 3 hr × $90.02/hr)] and +9 hours and +$810 (3 registries × 3 hr × $90.02/hr). Although we are adjusting our total burden estimates based on more current data, the burden per response would remain unchanged. The reason for the decrease in minimum burden despite an increase in number of qualified registries, is the change in number of simplified and full self-nominations. In the CY 2019 PFS final rule, we estimate 141 simplified self-

[130] As stated in the CY 2019 PFS final rule (83 FR 53998), health IT vendors are not included in the burden estimates for MIPS.

nominations and 9 full self-nominations; for this final rule, we estimate 147 simplified self-nominations and 6 full self-nominations.

TABLE 74: Change in Estimated Burden for Qualified Registry Self-Nomination

	Minimum Burden	Maximum Burden
Total Annual Hours for Qualified Registries in CY 2019 Final Rule (a)	97.5	450
Total Annual Hours for Qualified Registries in CY 2020 Final Rule (b)	91.5	459
Difference (c) = (b)-(a)	**-6**	**+9**
Total Annual Cost for Qualified Registries in CY 2019 Final Rule (d)	$8,777	$40,509
Total Annual Cost for Qualified Registries in CY 2020 Final Rule (e)	$8,237	$41,319
Difference (f) = (e)-(d)	**$-540**	**+$810**

As finalized in the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at (83 FR 60088) and in § 414.1400(a)(2), qualified registries may submit data for any of the three MIPS performance categories quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability. In section III.K.3.g.(4)(a)(i) of this rule, we are finalizing changes to § 414.1400(a)(2) to state that beginning with the 2023 payment year (2021 performance period), qualified registries must be able to submit data for all of the MIPS performance categories identified in the regulation. We are also finalizing to amend § 414.1400(a)(2)(iii) to state that a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(*4*) or (*5*) or § 414.1380(c)(2)(i)(C)(*1*) through (*7*) or (*9*). As part of the current self-nomination process, qualified registries are already required to attest to the MIPS quality measures, performance categories, improvement activities, and/or Promoting Interoperability measures and objectives supported. As part of this policy, we are requiring qualified registries to attest to the ability to submit data for all three of these performance categories at time of self-nomination. As finalized in the CY 2017 Quality Payment Program final rule, qualified registries are required to provide feedback on all of the MIPS performance categories at least 4 times a year (81 FR 77367 through 77386). In section III.K.3.g.(4)(a)(ii), we are finalizing, beginning with the 2023 MIPS payment year, to require qualified registries to provide the following as a part of the performance feedback given at least 4 times (to the extent feasible) a year: Feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the qualified registry. Further, qualified registries will be required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year, and if not, provide sufficient rationale as to why they do not believe they would be able to meet this requirement. Because we are not requiring qualified registries to provide performance feedback to their clinicians and groups at a greater frequency than what has previously been required combined with qualified registries only being required to provide feedback using data they are already collecting, we do not believe this finalized policy creates enough additional burden for qualified registries to elect to discontinue participation in the Quality Payment Program. Therefore, we are not adjusting our estimates for the number of qualified registries that will self-nominate in the 2021 performance period or future years as a result of this requirement; if reliable information becomes available indicating this assumption is incorrect, we will adjust our assumptions and respondent estimates at that time. Because qualified registries will only be required to provide performance feedback to clinicians and not to CMS, and because qualified registries are already required to attest to the performance categories they support, we anticipate minimal changes to the self-nomination process as a result of these requirements and assume there will be minimal impact on the time required to complete either the simplified or full self-nomination process.

We are also finalizing in section III.K.3.g.(2) of this final rule and at § 414.1400(a)(4) to establish that a condition of approval is for the third party intermediary to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan. Because of the uncertain, but low frequency (less than 10 per year historically) with which third party intermediaries have elected to discontinue services during a performance period, we are unable to estimate the total burden associated with development of CMS approved transition plans. However, we anticipate the time involved in developing a transition plan and disseminating it to their contracted MIPS eligible clinicians is likely to be no more than 10 hours.

Qualified registries must comply with requirements on the submission of MIPS data to CMS. The burden associated with qualified registry submission requirements will be the time and effort associated with calculating quality measure results from the data submitted to the qualified registry by its participants and submitting these results, the numerator and denominator data on quality measures, the Promoting Interoperability performance category, and improvement activities data to us on behalf of their participants. We expect that the time needed for a qualified registry to accomplish these tasks will vary along with the number of MIPS eligible clinicians submitting data to the qualified registry and the number of applicable measures. However, we believe that qualified registries already perform many of these activities for their participants. Therefore, we believe the estimates discussed earlier and shown in Table 75

represents the upper bound for qualified registry burden, with the potential for less additional MIPS burden if the qualified registry already provides similar data submission services.

Based on these assumptions, we estimate the total annual burden associated with a qualified registry self-nominating to be considered for approval.

TABLE 75: Estimated Burden for Qualified Registry Self-Nomination

	Minimum Burden	Maximum Burden
# of Qualified Registry Simplified Self-Nomination Applications submitted (a)	147	0
# of Qualified Registry Full Self-Nomination Applications submitted (b)	6	153
Total Applications	**153**	**153**
Total Annual Hours Per Qualified Registry for Simplified Process (c)	0.5	0.5
Total Annual Hours Per Qualified Registry for Full Process (d)	3	3
Total Annual Hours (e) = (a)*(c)+(b)*(d)	**91.5**	**459**
Cost Per Simplified Process Per Registry (@ computer systems analyst's labor rate of $90.02/hr.) (f)	$45.01	$45.01
Cost Per Full Process Per Registry (@ computer systems analyst's labor rate of $90.02/hr.) (g)	$270.06	$270.06
Total Annual Cost (h) = (a)*(f)+(b)*(g)	**$8,237**	**$41,319**

Both the minimum and maximum burdens shown in Table 75 reflect adjustments to the number of respondents (from 150 to 153) due to availability of more recent data (+3 respondents). For purposes of calculating total burden associated with this final rule as shown in Table 116 only the maximum burden is being submitted to OMB for their review and approval.

We received no public comments related to the burden estimates for qualified registry self-nomination. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40848 through 40849) due to availability of updated data.

(3) QCDR Self-Nomination Applications

(a) Self-Nomination Process

The requirements and burden associated with QCDRs and the self-nomination process will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As explained below, this rule will adjust the number of self-nomination applications submitted by QCDRs seeking approval to submit data from 200 to 76 based on data from the CY 2019 nomination period for the 2020 MIPS performance period. This estimate reflects impacts of revisions to both the definition of a QCDR and minimum participation requirements for entities seeking approval as a QCDR which were previously finalized in the CY 2019 PFS final rule (83 FR 59895 through 59897) that may or may not have resulted in some entities seeking approval as a qualified registry rather than a QCDR. This rule will also update the number of QCDR measures submitted for consideration by each QCDR seeking to self-nominate (from 9 to 2), as well as the time required to submit information (from 1 hour to 2.5 hours) for each QCDR measure due to policies being finalized. In addition, our per response estimates for the simplified and full self-nomination processes will decrease from 9.5 hours to 5.5 hours and from 12 hours to 8 hours, respectively due strictly to our adjustment to the average number of QCDR measures submitted for approval by each QCDR based on availability of more recent data. These changes will decrease our minimum total burden estimate (from 2,025 hours to 418 hours) and increase our maximum total burden estimate (from 2,400 hours to 608 hours).

We refer readers to § 414.1400(a)(2) and (b)(1) which state that QCDRs interested in submitting MIPS data to us on behalf of a MIPS eligible clinician, group, or virtual group will need to complete a self-nomination process to be considered for approval to do so.

In the CY 2018 Quality Payment Program final rule and § 414.1400(b)(1), previously approved QCDRs in good standing (that are not on probation or disqualified) that wish to self-nominate using the simplified process can attest, in whole or in part, that their previously approved form is still accurate and applicable (82 FR 53808). Existing QCDRs in good standing that would like to make minimal changes to their previously approved self-nomination application from the previous year, may submit these changes, and attest to no other changes from their previously approved QCDR application, for CMS review during the current self-nomination period, from September 1 to November 1 (82 FR 53808). The self-nomination period is from July 1 to September 1 of the calendar year prior to the applicable performance period beginning in the 2020 MIPS performance period (83 FR 59898).

The burden associated with QCDR self-nomination will vary depending on the number of existing QCDRs that will elect to use the simplified self-nomination process in lieu of the full self-nomination process as described in the CY 2018 Quality Payment Program final rule (82 FR 53808 through 53813). The OPP Self-Nomination Form is submitted electronically using a web-based tool. We will be submitting a revised version of the form for approval under OMB control number 0938–1314 (CMS–10621).

For this final rule, we have adjusted the number of QCDRs self-nominating for approval to submit data from 200 to 76 based on the number of applications received during the CY 2019 self-nomination period for the 2020 MIPS performance period, a decrease of 124 from the currently approved estimate of 150 (83 FR 59997 through 59998). This is a decrease of 15 from the estimate of 91 provided in the CY 2020 PFS proposed rule due to availability of more recent data. Given this decrease, for our minimum burden estimate we will assume each of the 76 QCDRs will be approved for the 2020 MIPS performance period and will self-nominate using the simplified process during the CY 2020 nomination period. This estimate reflects impacts of revisions to both the definition of a QCDR and minimum participation requirements for entities seeking approval as a QCDR which were previously finalized in the CY 2019 PFS final rule (83 FR 59895 through 59897) that may or may not have resulted in

some entities seeking approval as a qualified registry rather than a QCDR. We were unable to change our estimates in the CY 2019 PFS final rule to reflect these policies because we had neither the data to support a change nor any notifications of intent by previously approved QCDRs indicating they would no longer self-nominate as a QCDR (83 FR 59999). As a result, we are making the necessary adjustments to our respondent estimates in this final rule.

Based on previously finalized policies in the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at § 414.1400(a)(2) (83 FR 60088), the current policy is that all third party intermediaries may submit data for any of the three MIPS performance categories quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability. In section III.K.3.g.(3)(a)(i) of this rule, we are finalizing changes to § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year (2021 performance period), QCDRs must be able to submit data for all of the MIPS performance categories identified in the regulation. We are also finalizing to amend § 414.1400(a)(2)(iii) to state that for the Promoting Interoperability performance category, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(*A*)(*4*) or (5) or § 414.1380(c)(2)(i)(*C*)(*1*) through (*7*) or (*9*). As finalized in the CY 2018 Quality Payment Program final rule, QCDRs are required to provide feedback on all of the MIPS performance categories that the QCDR reports at least 4 times a year (82 FR 53812). In section III.K.3.g.(3)(a)(iii) we are finalizing, beginning with the 2023 MIPS payment year, to require that QCDRs provide the following as a part of the performance feedback given at least 4 times a year: Feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure (MIPS quality measure and/or QCDR measure) within the QCDR. We also understand that QCDRs can only provide feedback on data they have collected on their clinicians and groups, and realize the comparison would be limited to that data and not reflect the larger sample of those that have submitted on the measure for MIPS, which the QCDR does not have access to. Further, we are also finalizing, beginning with the 2023 MIPS payment year, to require QCDRs to attest during the self-nomination process that they can provide performance feedback at least 4 times a year, and if not, provide sufficient rationale as to why they do not believe they will be able to meet this requirement. We do not believe these proposals create enough additional burden for QCDRs to elect to discontinue participation in the Quality Payment Program because we are not requiring QCDRs to provide performance feedback to their clinicians and groups at a greater frequency than what has previously been required and because QCDRs will only be required to provide feedback using data they are already collecting. Therefore, we are not adjusting our estimates for the number of QCDRs that will self-nominate in the 2021 performance period or future years as a result of these finalized policies; if reliable information becomes available indicating this assumption is incorrect, we will adjust our assumptions and respondent estimates at that time. As part of the self-nomination process, QCDRs are already required to attest to the MIPS quality measures, performance categories, improvement activities, and Promoting Interoperability measures and objectives supported and will not be required to provide performance feedback to CMS. Therefore, we anticipate no additional steps being added to the self-nomination process as a result of these finalized policies and assume there will be no impact on the time required to complete either the simplified or full self-nomination process.

In the CY 2020 PFS proposed rule, we increased our per-respondent burden estimate for completing the full self-nomination process by 15 minutes (0.25 hours) due to the proposal to require QCDRs to describe the quality improvement services they will provide as part of their self-nomination (84 FR 40851). Due to this proposal not being finalized, we have decreased our burden estimate from the CY 2020 PFS proposed rule by 0.25 hours.

We estimate that the self-nomination process for QCDRs to submit on behalf of MIPS eligible clinicians or groups for MIPS will involve approximately 3 hours per QCDR to submit information required at the time of self-nomination as described in the CY 2017 Quality Payment Program final rule including basic information about the QCDR, describing the process it will use for completion of a randomized audit of a subset of data prior to submission, providing a data validation plan, and providing results of the executed data validation plan by May 31 of the year following the performance period (81 FR 77383 through 77384). However, for the simplified self-nomination process, we estimate 0.5 hours per QCDR to submit this information.

We are also finalizing in section III.K.3.g.(2) of this final rule and at § 414.1400(a)(4) to establish that a condition of approval is for the third party intermediary to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan. Because of the uncertain, but low frequency (less than 10 per year historically) with which third party intermediaries have elected to discontinue services during a performance period, we are unable to estimate the total burden associated with development of CMS approved transition plans. However, we anticipate the time involved in developing a transition plan and disseminating it to contracted MIPS eligible clinicians is likely to be no more than 10 hours.

(b) QCDR Measure Requirements

As promulgated in the CY 2017 and CY 2018 Quality Payment Plan final rules (81 FR 77366 through 77374 and 82 FR 53812 through 53813), QCDRs calculate their measure results and also must possess benchmarking capabilities (for QCDR measures) that compare the quality of care a MIPS eligible clinician provides with other MIPS eligible clinicians performing the same quality measures. For QCDR measures, the QCDR must provide to us, if available, data from years prior (for example, 2017 data for the 2019 MIPS performance period) before the start of the performance period. In addition, the QCDR must provide to us, if available, the entire distribution of the measure's performance broken down by deciles. As an alternative to supplying this information to us, the QCDR may post this information on their website prior to the start of the performance period, to the extent permitted by applicable privacy laws. The time it takes to perform these functions may vary depending on the sophistication of the entity, but we estimate that a QCDR will spend an additional 1 hour performing these activities per measure.

As discussed in section III.K.3.g.(3)(c)(i)(B)(cc), we are finalizing that in order for a QCDR measure to be considered for use in the program beginning with the 2021 performance period and future years, all QCDR measures submitted for self-nomination

must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System, as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures. Beginning with the 2021 performance period and future years, we are finalizing in section III.K.3.g.(3)(c)(i)(B)(dd) of this final rule, to also require QCDRs to collect data on the potential QCDR measure, appropriate to the measure type, as defined in the CMS Blueprint for the CMS Measures Management System, prior to self-nomination. We estimate the time necessary to submit measure testing data as part of the self-nomination process will average approximately 0.5 hours per measure, understanding that this estimate may be either high or low depending on the type of measure and the quantity of data being submitted. We discuss additional impacts of this proposal in section VII.C.10.(f) of this rule's RIA.

In section III.K.3.g.(3)(c)(i)(A)(bb) of this rule, we are finalizing to amend § 414.1400 to state that CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. Because the choice to license a QCDR measure is an elective business decision made by individual QCDRs and we lack insight into both the specific terms and frequency of agreements made between entities, we are not accounting for QCDR measure licensing costs as part of our burden estimate. However, if information regarding the number of licensing agreements and the approximate cost per agreement becomes available, we may adjust our assumptions and burden estimates at that time.

In section III.K.3.g.(3)(c)(i)(B)(ee) of this rule, we are finalizing, beginning with the 2020 performance period, that after the self-nomination period closes each year, we will review newly self-nominated and previously approved QCDR measures based on considerations as described in the CY 2019 PFS final rule (83 FR 59900 through 59902). In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. The QCDR could do so by harmonizing its measure with, or significantly differentiating its measure from, other similar QCDR measures. QCDR measure harmonization may require two or more QCDRs to work collaboratively to develop one cohesive QCDR measure that is representative of their similar yet, individual measures. We are unable to account for measure harmonization costs as part of our burden estimate, as the process and outcomes of measure harmonization will likely vary substantially depending on a number of factors, including: Extent of duplication with other measures, number of QCDRs involved in harmonizing toward a single measure, and number of measures being harmonized among the same QCDRs. We intend to identify only those QCDR measures which are duplicative to such an extent as to assume harmonization will not be overly burdensome, however, because the harmonization process will occur between QCDRs without our involvement, we are unable to predict or quantify the associated effort.

As discussed in section III.K.3.g.(3)(c)(i)(B)(bb) of this final rule, beginning with the 2021 performance period and future years, we are finalizing that QCDRs are required to link their QCDR measures as feasible to at least one of the following, at the time of self-nomination: (1) Cost measures (as found in section III.K.3.c.(2) of this final rule); (2) improvement activities (as found in Appendix 2: Improvement Activities Tables); or (3) CMS developed MIPS Value Pathways (as described in section III.K.3.a. of this final rule). We estimate that a QCDR will spend an additional 1 hour performing these activities per measure, on average.

We are also finalizing to formalize factors we would take into consideration for approving and rejecting QCDR measures for the MIPS program beginning with the 2022 MIPS payment year (2020 performance period). With regard to approving QCDR measures, we are finalizing the following: (a) 2-year QCDR measure approval process, and (b) participation plan for existing QCDR measures that have failed to reach benchmarking thresholds. As discussed in section III.K.3.g.(3)(c)(ii)(B) of this rule, we are finalizing to implement, beginning with the 2021 performance period, 2-year QCDR measure approvals (at our discretion) for QCDR measures that attain approval status by meeting the QCDR measure considerations and requirements described in section III.K.3.g.(3)(c). The 2-year approvals will be subject to the following conditions whereby the multi-year approval will no longer apply if the QCDR measure is identified as: Topped out; duplicative of a new, more robust measure; reflects an outdated clinical guideline; requires measure harmonization, or if the QCDR self-nominating the measure is no longer in good standing. We believe this could result in reduced burden for QCDRs as they would not necessarily be required to submit every measure for approval annually. However, because we are unable to predict which previously approved QCDR measures will be removed or retained in future years, we are likewise unable to predict the total number of measures that will be submitted for approval and the resulting impact on future burden. We anticipate that the number of QCDR measures submitted in the 2021 performance period will reflect the impact of this policy; at that time we will update our assumptions and burden estimates accordingly.

We estimate that on average, each QCDR will submit information for 2 QCDR measures, for a total burden of 2 hours per QCDR (1 hr per measure × 2 measures). Based on the number of measures nominated during the CY 2019 nomination period for the 2020 MIPS performance period (790, or approximately 10.4 measures per QCDR) as well as an analysis of currently approved QCDR measures which indicates less than 10 percent of current measures have completed testing, we believe each QCDR is likely to submit 1 previously approved QCDR measure for approval during the CY 2020 nomination period. We also believe the finalized policy requiring measure testing will result in additional measures undergoing testing than in previous years and therefore estimate each QCDR will submit 1 additional measure for approval during the CY 2020 nomination period, for a total of 2 measures per QCDR. Finally, we believe the finalized changes in requirements for QCDR measure submission and for QCDRs to harmonize measures we identify as duplicative discussed earlier in this section will result in a reduction in the number of QCDR measures submitted for approval in future years. However, we are unable to quantify the impact these changes will have on the number of measures QCDRs will submit for approval beyond the impacts previously discussed. As information becomes available in future years, we will revisit our assumptions to better reflect the impact of these requirements on QCDRs and the quantity of measures

being submitted for consideration annually. When combined with our previously stated assumption regarding our inability to predict which QCDR measures will maintain approval in future years, we believe the estimate of 2 measures per QCDR to be appropriate.

Beginning with the 2021 performance period, we are finalizing in section III.K.3.g.(3)(c)(iii) of this rule that in instances where an existing QCDR measure has been in MIPS for 2 years, and has failed to reach benchmarking thresholds due to low adoption, where a QCDR believes the low-reported QCDR measure is still important and relevant to a specialist's practice, that the QCDR may develop and submit to a QCDR measure participation plan, to be submitted as part of their self-nomination. Because we are unable to predict the frequency with which existing QCDR measures will meet the finalized criteria for allowing QCDRs to submit a measure participation plan or the likelihood of QCDRs electing to submit a plan, we are unable to estimate the total associated burden. However, we anticipate the time involved in developing a measure participation plan is likely to average between 1 and 2 hours, depending on the QCDR and the level of detail they choose to include. In future performance periods we may reassess availability of the number of QCDR measure participation plans submitted by QCDRs and estimate the associated burden, if possible. In aggregate, we estimate a QCDR will require 2.5 hours per QCDR measure, an increase of 1.5 hours from the currently approved estimate of 1 hour (83 FR 59999). As discussed earlier in this section, we estimate each QCDR will submit 2 QCDR measures for approval, on average. Therefore, we estimate each QCDR will require 5 hours (2 measures × 2.5 hr per measure) to submit QCDR measures for approval, independent of the selection of the simplified or full self-nomination process.

We are finalizing in section III.K.3.g.3(c)(i)(A)(bb)(BB) of this final rule, to amend § 414.1400 to add paragraph (b)(3)(iv)(I) to state that we would give greater consideration to measures for which QCDRs: (a) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development. We are also finalizing in section III.K.3.g.3(c)(i)(A)(bb)(CC) of this final rule and § 414.1400 to add paragraph (b)(3)(iv)(J), to state that, beginning with the 2020 performance period, we place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. Those that do not meet this requirement, may not continue to be approved. Lastly, we are finalizing in section III.K.3.g.3(c)(i)(B)(aa) of this final rule, beginning with the 2020 performance period, to change both of the below listed considerations into requirements and add § 414.1400(b)(3)(v) to include the following for QCDR measure requirements for approval: Measures that are beyond the measure concept phase of development; and measures that address significant variation in performance. Because these proposals do not impact the amount of information QCDRs are required to submit for the nomination of a QCDR measure, we are not finalizing any additional changes to our burden estimate as result of these policies. We also do not believe these policies are likely to result in any additional change in the number of measures submitted per QCDR beyond the impacts previously discussed.

In the CY 2019 PFS final rule, the burden associated with self-nomination of a QCDR was estimated to range from a minimum of 9.5 hours (0.5 hours to submit information for simplified self-nomination process and 9 hours for submission of QCDR measures) to a maximum of 12 hours (3 hours for the full self-nomination process and 9 hours for the submission of QCDR measures) (83 FR 59999). For this rule, we are finalizing to increase the burden associated with self-nomination to a minimum of 5.5 hours (0.5 hours to submit information for the simplified self-nomination process and 5 hours for the submission of QCDR measures) to a maximum of 8 hours (3 hours to submit information for the full self-nomination process and 5 hours for the submission of QCDR measures) to account for our revised estimate of the average number of QCDR measures submitted for consideration per QCDR, as well as the revised estimate of burden per QCDR measure.

We assume that the staff involved in the QCDR self-nomination process will continue to be computer systems analysts or their equivalent, who have an average labor rate of $90.02/hr. Considering that the time per QCDR associated with the self-nomination process ranges from a minimum of 5.5 hours to a maximum of 8 hours, we estimate that the annual burden will range from 418 hours (76 QCDRs × 5.5 hr) to 608 hours (76 QCDRs × 8 hr) at a cost ranging from $37,628 (418 hr × $90.02/hr) and $54,732 (608 hr × $90.02/hr), respectively (*see* Table 76).

Based on the assumptions previously discussed, we provide an estimate of the total annual burden associated with a QCDR self-nominating to be considered ''qualified'' to submit quality measures results and numerator and denominator data on MIPS eligible clinicians.

TABLE 76: Estimated Burden for QCDR Self-Nomination and QCDR Measure Submission

	Minimum	Maximum
# of QCDR Simplified Self-Nomination Applications submitted (a)	76	0
# of QCDR Full Self-Nomination Applications submitted (b)	0	76
Total Applications	**76**	**76**
Total Annual Hours Per QCDR for Simplified Process (c)		
Total Annual Hours Per QCDR for Full Process (d)	5.5	5.5
Total Annual Hours (e) = (a)*(c) + (b)*(d)	8	8
Cost Per Simplified Process Per QCDR (@ computer systems analyst's labor rate of $90.02/hr) (f)	**418**	**608**
Cost Per Full Process Per QCDR (@ computer systems analyst's labor rate of $90.02/hr) (g)	$495.11	$495.11
Total Annual Cost (h) = (a)*(f)+(b)*(g)	$720.16	$720.16
	$37,628	**$54,732**

Both the minimum and maximum burden shown in Table 76 reflect adjustments to the number of respondents due to availability of more recent data, as well as changes resulting from policies finalized in the CY 2019 PFS final rule regarding the definition and minimum participation requirements for entities seeking approval as QCDRs which will be effective beginning with the 2020 MIPS performance period. For purposes of calculating total burden associated with the final rule as shown in Table 116, only the maximum burden is used.

Independent of the change to our per response time estimate, the decrease in the number of respondents (from 200 to 76) results in an adjustment of between −1,303 hours [(−74 QCDRs × 9.5 hr) + (−50 QCDRs × 12 hr)] at a cost of −$117,297 (−1,303 hr × $90.02) and −1,488 hours (−124 QCDRs × 12 hr) at a cost of −$133,950 (−1,488 hr × $90.02/hr). Accounting for the adjustment in the number of QCDRs, the change in time per QCDR to self-nominate results in an change of between −304 hours (76 QCDRs × −4 hr) at a cost of −$27,366 (−304 hr × $90.02/hr) and −304 hours (76 QCDRs × −4 hr) at a cost of −$27,366 (−304 hr × $90.02/hr). As shown in Table 77, when these two adjustments are combined, the net impact ranges between −1,607 hours (−1,304 hr −304 hr) at a cost of −$144,663 (−$117,297 −$27,366) and −1,792 hours (−1,488 hr −304 hr) at a cost of −$161,316 (−$133,950 −$27,366).

TABLE 77: Change in Estimated Burden for QCDR Self-Nomination and QCDR Measure Submission

	Minimum Burden	Maximum Burden
Total Annual Hours for QCDRs in CY 2019 Final Rule (a)	2,025	2,400
Total Annual Hours for QCDRs in CY 2020 Final Rule (b)	418	608
Difference (c) = (b)-(a)	**-1,607**	**-1,792**
Total Annual Cost for QCDRs in CY 2019 Final Rule (d)	$182,291	$216,048
Total Annual Cost for QCDRs in CY 2020 Final Rule (e)	$37,628	$54,732
Difference (f) = (e)-(d)	**-$144,663**	**-$161,316**

QCDRs must comply with requirements on the submission of MIPS data to CMS. The burden associated with the QCDR submission requirements will be the time and effort associated with calculating quality measure results from the data submitted to the QCDR by its participants and submitting these results, the numerator and denominator data on quality measures, the Promoting Interoperability performance category, and improvement activities data to us on behalf of their participants. We expect that the time needed for a QCDR to accomplish these tasks will vary along with the number of MIPS eligible clinicians submitting data to the QCDR and the number of applicable measures. However, we believe that QCDRs already perform many of these activities for their participants. As stated in section III.K.3.g.(3)(a)(i), based on our review of existing 2019 QCDRs through the 2019 QCDR Qualified Posting, approximately 92 QCDRs, or about 72 percent of the QCDRs currently participating in the program are able to submit data for these three performance categories. In addition, through our review of previous qualified postings for the 2018 and 2017 MIPS performance periods, we have observed that in 2018, 73 percent (approximately 110 QCDRs) and in 2017, 73 percent (approximately 83 QCDRs) have been able to submit data for all three of the quality, Promoting Interoperability, and improvement activity performance categories. Given this, we believe it is reasonable that all QCDRs have the capacity to submit data for the improvement activities and Promoting Interoperability performance categories and are not making any further changes to our burden estimates. Therefore, we believe the 608 hour estimate noted in this section represents the upper bound of QCDR burden, with the potential for less additional MIPS burden if the QCDR already provides similar data submission services.

The following is a summary of the public comments received on the Quality Payment Program ICRs regarding the burden estimates for QCDR self-nomination.

Comment: A few commenters believe that the scope of proposals in the proposed rule increases cost and burden to the point where some third-party intermediaries may end their participation in MIPS. One commenter stated that several provisions would additionally require it to alter business plans, missions, and customer service priorities while another commenter cited their belief that CMS is attempting to shift costs and burden of administering the MIPS program onto specialty societies that create measures and operate QCDRs.

Response: We believe that our policies are intended to standardize and raise the bar on the services and the quality of the third party intermediaries we have in the MIPS program. Similar to years past, the standards and requirements of QCDRs are higher when compared to that of qualified registries, as we expect QCDRs to have extensive experience in quality reporting, quality measure development, and clinical expertise to not just facilitate reporting, but to also help address measurement gaps found within the program. We believe that QCDRs and qualified registries should further clinician goals of quality improvement by providing meaningful information and services. While we estimate increases in the burden for self-nomination, the burden per QCDR measure submitted for approval, and the costs associated with developing measures and meeting requirements for approval as a QCDR or registry, we believe that the increased cost and burden are significantly outweighed by the positive impact of the policies for MIPS eligible clinicians. We discuss the financial impact of these proposals beyond reporting burden further in section VII.F.10.f. of the RIA.

Comment: One commenter believes that the ''true costs'' associated with a QCDR application, whether using the simplified or full application, must reflect more than the actual time to input the data required. The commenter further cited costs such as creating and maintaining registries and QCDR

measures, recruitment of clinicians to develop quality improvement initiatives, hiring staff to support and develop content and services identified by these clinicians, and technology solutions necessary to support the quality improvement services.

Response: We recognize there are additional costs and administrative burdens on respondents associated with self-nominating as a QCDR or submitting a QCDR measure beyond the reporting burden estimated in the Collection of Information section of this policy which only accounts for the time required for record keeping, reporting, and third-party disclosures associated with the policy. We discuss the financial impact of these proposals beyond reporting burden further in section VII.F.10.f. of the RIA. We understand that some respondents may require additional time above the 0.5 hours we estimate for the simplified self-nomination process and the 3 hours for the full self-nomination process, but given that we do not include the costs to maintain registries or create measures and quality improvement services in our burden estimate, we believe this estimate is a reasonable average across all respondents based on our review of the nomination process, the information required to complete the nomination form, and the criteria required to self-nominate as a QCDR.

After consideration of public comments, we are making no changes to our estimates as a result of public comments received, however we have decreased our per-respondent burden estimate for completing the full self-nomination form by 0.25 hours due to the decision not to finalize the proposal to require QCDR to engage in activities that will foster improvement in the quality of care. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40850 through 40854) due to availability of updated data.

(4) CAHPS for MIPS Survey Vendor

This rule is not finalizing any new or revised collection of information requirements or burden related to CMS-approved CAHPS for MIPS survey vendors. The requirements and burden are currently approved by OMB under control number 0938–1222 (CMS–10450). Consequently, we are not making any MIPS survey vendor changes under that control number.

d. ICRs Regarding Quality Data Submission (§§ 414.1325 and 414.1335)

(1) Background

As explained below, this rule will adjust the number of respondents based on current data. The adjustment will increase our total burden estimates while keeping our ''per response'' estimates unchanged. We are not revising any requirements regarding the number of measures to be submitted or the manner in which they may be submitted.

Under our current policies, two groups of clinicians must submit quality data under MIPS: Those who submit as MIPS eligible clinicians and those who opt to submit data voluntarily but are not subject to MIPS payment adjustments.

Clinicians are ineligible for MIPS if they are newly enrolled to Medicare; are QPs; are partial QPs who elect to not participate in MIPS; are not one of the clinician types included in the definition for MIPS eligible clinician; or do not exceed the low-volume threshold as an individual or as a group.

To determine which QPs should be excluded from MIPS, we used the QP List for the 2019 predictive file that contains current participation in Advanced APMs as of January 15, 2019, that could be connected into our respondent data and are the best estimate of future expected QPs. From this data, we calculated the QP determinations as described in the Qualifying APM Participant definition at § 414.1305 for the 2020 QP performance period. We assumed that all partial QPs will participate in MIPS data collections. Due to data limitations, we could not identify specific clinicians who have not yet enrolled in APMs, but who may become QPs in the future 2020 Medicare QP Performance Period (and therefore will no longer need to submit data to MIPS); hence, our model may underestimate or overestimate the number of respondents.

Using participation data from the 2018 MIPS performance period combined with the estimate of QPs for the 2020 performance period, we estimate a total of 780,605 clinicians will submit quality data as individuals or groups in the 2020 MIPS performance period, a decrease of 183,641 clinicians when compared to our estimate of 964,246 clinicians in the CY 2019 PFS final rule (83 FR 60002).

In the CY 2017 Quality Payment Program final rule, we assumed that any clinician that submits quality data codes to us for the Medicare Part B claims collection type is intending to do so for the Quality Payment Program to ensure that we fully accounted for any burden that may have resulted from our policies (81 FR 77501 through 77504); we continued using this assumption in both the CY 2018 Quality Payment Program final rule and the CY 2019 PFS final rule. In the CY 2019 PFS final rule, we finalized limiting the Medicare Part B claims collection type to small practices beginning with the 2021 MIPS payment year and allowing clinicians in small practices to report Medicare Part B claims as a group or as individuals (83 FR 59752). However, we also elected to continue using the assumption that all clinicians (except QPs) who submitted data via the Medicare Part B claims collection type in the 2018 MIPS performance period would continue to do so for MIPS to avoid overstating the impact of the change as we lacked the data to accurately estimate both the number of clinicians who would be impacted by the finalized policies and the potential behavioral response of those clinicians who would be required to switch to another collection type (83 FR 60001). For this final rule, beginning with the 2020 MIPS performance period, we assume only clinicians in small practices who submitted quality data via Medicare Part B claims in the 2018 MIPS performance period will continue to do so for the 2020 MIPS performance period. Further, we assume that clinicians in other practices (not small practices) who meet at least one of the following criteria will not need to find an alternate collection type for submitting quality performance category data for the Quality Payment Program for the 2020 MIPS performance period: (1) Facility-based; (2) submitted quality data via Medicare Part B claims and at least one other collection type; or (3) were previously scored as part of a group. Finally, we assume clinicians in other practices (not small practices) who meet all of the following criteria will submit via the MIPS CQM collection type for the 2020 MIPS performance period because the Medicare Part B claims collection type will no longer be available as an option for collecting and reporting quality data: (1) Scored as individuals; (2) not facility-based; and (3) submitted quality data only via the Medicare Part B claims collection type in the 2018 MIPS performance period. Because we do not have data to accurately predict what collection type each affected clinician would use to collect and report quality data, we assume that the affected clinicians will select the MIPS CQM collection type because, when compared to Medicare Part B claims, we believe this is the next most accessible and least burdensome

alternative. Our assumptions result in a 103,103 decrease in the estimated number of clinicians who will submit quality data via Medicare Part B claims and a 12,931 increase in the number of clinicians who will submit via the QCDR/MIPS CQM collection type, as shown in Table 78.

We assume that 100 percent of APM Entities in MIPS APMs will submit quality data to CMS as required under their models. Consistent with assumptions used in the CY 2019 PFS final rule (83 FR 60000 through 60001), we include all quality data voluntarily submitted by MIPS APM participants made at the individual or TIN-level in our respondent estimates. Therefore, we are not finalizing any adjustments to our respondent estimates as a result of the policies discussed in section III.K.3.c.(5)(c)(i)(A) of this final rule, which allows MIPS eligible clinicians participating in MIPS APMs to elect to report MIPS quality measures at either the individual or TIN-level under the APM scoring standard beginning in the 2020 MIPS performance period. To estimate who will be a MIPS APM participant in the 2020 MIPS performance period, we used the latest QP List for the first snapshot data of the 2019 QP performance period. This file was selected to better reflect the expected increase in the number of MIPS APMs in future years compared to previous APM eligibility files. If a MIPS eligible clinician is determined to not be scored as a MIPS APM, then their reporting assumption is based on their reporting for the CY 2018 MIPS performance period. For clinicians who participated in an APM in 2018, were not in an APM in 2019, and did not report MIPS quality data in 2018, we assume they will elect to report to MIPS via the MIPS CQM collection type, similar to our previously stated assumption regarding clinicians who are required to use an alternate reporting option.

Our burden estimates for the quality performance category do not include the burden for the quality data that APM Entities submit to fulfill the requirements of their APMs. The burden is excluded as sections 1899(e) and 1115A(d)(3) of the Act (42 U.S.C. 1395jjj(e) and 1315a(d)(3), respectively) state that the Shared Savings Program and the testing, evaluation, and expansion of Innovation Center models tested under section 1115A of the Act (or section 3021 of the Affordable Care Act) are not subject to the PRA.[131] Tables 78, 79 and 80 explain our revised estimates of the number of organizations (including groups, virtual groups, and individual MIPS eligible clinicians) submitting data on behalf of clinicians segregated by collection type.

Table 78 provides our estimated counts of clinicians that will submit quality performance category data as MIPS individual clinicians or groups in the 2020 MIPS performance period based on data from the 2018 MIPS performance period.

For the 2020 MIPS performance period, respondents will have the option to submit quality performance category data via Medicare Part B claims, direct, and log in and upload submission types, and CMS Web Interface. We estimate the burden for collecting data via collection type: Claims, QCDR and MIPS CQMs, eCQMs, and the CMS Web Interface. We believe that, while estimating burden by submission type may be better aligned with the way clinicians participate with the Quality Payment Program, it is more important to reduce confusion and enable greater transparency by maintain consistency with previous rulemaking.

For an individual, group, or third-party to submit MIPS quality, improvement activities, or Promoting Interoperability performance category data using either the log in and upload or the log in and attest submission type or to access feedback reports, the submitter must have a CMS Enterprise Portal user account. Once the user account is created using the Identity Management Application Process, registration is not required again for future years.

Table 78 shows that in the 2020 MIPS performance period, an estimated 94,846 clinicians will submit data as individuals for the Medicare Part B claims collection type; 391,430 clinicians will submit data as individuals or as part of groups for the MIPS CQM or QCDR collection types; 247,856 clinicians will submit data as individuals or as part of groups via eCQM collection types; and 46,473 clinicians will submit as part of groups via the CMS Web Interface. In the CY 2020 PFS proposed rule, we estimated 109,951 clinicians will submit data as individuals for the Medicare Part B claims collection type; 359,621 clinicians will submit data as individuals or as part of groups for the MIPS CQM or QCDR collection types; 247,329 clinicians will submit data as individuals or as part of groups via eCQM collection types; and 116,342 clinicians will submit as part of groups via the CMS Web Interface (84 FR 40856). Our updated estimates reflect the availability of more recent data.

Table 78 provides estimates of the number of clinicians to collect quality measures data via each collection type, regardless of whether they decide to submit as individual clinicians or as part of groups. Because our burden estimates for quality data submission assume that burden is reduced when clinicians elect to submit as part of a group, we also separately estimate the expected number of clinicians to submit as individuals or part of groups.

TABLE 78—ESTIMATED NUMBER OF CLINICIANS SUBMITTING QUALITY PERFORMANCE CATEGORY DATA BY COLLECTION TYPE

	Medicare Part B claims	QCDR/ MIPS CQM	eCQM	CMS web interface	Total
Number of clinicians to collect data by collection type (as individual clinicians or groups) in 2020 MIPS performance period (excludes QPs) (a)	94,846	391,430	247,856	46,473	780,605
* Number of clinicians to collect data by collection type (as individual clinicians or groups) in 2019 MIPS performance period (excludes QPs) (b)	257,260	324,693	243,062	139,231	964,246
Difference (c) = (a) − (b)	−162,414	+66,737	+4,794	−92,758	−183,641

* Currently approved by OMB under control number 0938–1314 (CMS–10621).

[131] Our estimates do reflect the burden on MIPS APM participants of submitting Promoting Interoperability performance category data, which is outside the requirements of their APMs.

In the CY 2018 Quality Payment Program final rule (82 FR 53625 through 53626), beginning with the 2019 MIPS performance period, we allowed MIPS eligible clinicians to submit data for multiple collection types for a single performance category. Therefore, with the exception of clinicians not in small practices who previously submitted quality data via Medicare Part B claims, we captured the burden of any eligible clinician that may have historically collected via multiple collection types, as we assume they will continue to collect via multiple collection types and that our MIPS scoring methodology will take the highest score where the same measure is submitted via multiple collection types. Hence, the estimated numbers of individual clinicians and groups to collect via the various collection types are not mutually exclusive and reflect the occurrence of individual clinicians or groups that collected data via multiple collection types during the 2018 MIPS performance period.

Table 79 uses methods similar to those described to estimate the number of clinicians that will submit data as individual clinicians via each collection type in the 2020 MIPS performance period. We estimate that approximately 94,846 clinicians will submit data as individuals using the Medicare Part B claims collection type; approximately 100,269 clinicians will submit data as individuals using MIPS CQMs or QCDR collection types; and approximately 38,935 clinicians will submit data as individuals using eCQMs collection type. In the CY 2020 PFS proposed rule, we estimated that 109,951 clinicians will submit data as individuals using the Medicare Part B claims collection type; approximately 106,039 clinicians will submit data as individuals using MIPS CQMs or QCDR collection types; and approximately 47,455 clinicians will submit data as individuals using eCQMs collection type (84 FR 40856 through 40857). Our updated estimates reflect the availability of more recent data.

TABLE 79—ESTIMATED NUMBER OF CLINICIANS SUBMITTING QUALITY PERFORMANCE CATEGORY DATA AS INDIVIDUALS BY COLLECTION TYPE

	Medicare Part B claims	QCDR/ MIPS CQM	eCQM	CMS web interface	Total
Number of Clinicians to submit data as individuals in 2020 MIPS Performance Period (excludes QPs) (a)	95,846	100,269	38,935	0	234,050
* Number of Clinicians to submit data as individuals in 2019 MIPS Performance Period (excludes QPs) (b)	257,260	71,439	47,557	0	376,256
Difference (c) = (a) − (b)	−162,414	+28,830	−8,622	0	−142,206

* Currently approved by OMB under control number 0938–1314 (CMS–10621).

Consistent with the policy finalized in the CY 2018 Quality Payment Program final rule that for MIPS eligible clinicians who collect measures via Medicare Part B claims, MIPS CQM, eCQM, or QCDR collection types and submit more than the required number of measures (82 FR 53735 through 54736), we will score the clinician on the required measures with the highest assigned measure achievement points and thus, the same clinician may be counted as a respondent for more than one collection type. Therefore, our columns in Table 79 are not mutually exclusive.

Table 80 provides our estimated counts of groups or virtual groups that will submit quality data on behalf of clinicians for each collection type in the 2020 MIPS performance period and reflects our assumption that the formation of virtual groups will reduce burden. With the previously discussed exceptions regarding groups who experienced a change in APM participation status between the 2018 and 2019 MIPS performance periods, we assume that groups that submitted quality data as groups in the 2018 MIPS performance period will continue to submit quality data either as groups or virtual groups for the same collection types as they did as a group or TIN within a virtual group for the 2020 MIPS performance period. Specifically, we estimate that 10,949 groups and virtual groups will submit data for the QCDR or MIPS CQM collection types on behalf of 291,161 clinicians; 4,398 groups and virtual groups will submit for eCQM collection types on behalf of 208,921 eligible clinicians; and 104 groups will submit data via the CMS Web Interface on behalf of 46,473 clinicians. In the CY 2020 PFS proposed rule, we estimated that 10,552 groups and virtual groups will submit data for the QCDR or MIPS CQM collection types on behalf of 253,582 clinicians; 4,332 groups and virtual groups will submit for eCQM collection types on behalf of 199,874 eligible clinicians; and 104 groups will submit data via the CMS Web Interface on behalf of 116,342 clinicians (84 FR 40857). Our updated estimates reflect availability of more recent data. In the CY 2017 and CY 2018 Quality Payment Program final rules, the CY 2019 PFS final rule, the CY 2020 PFS proposed rule, we were required to adjust our respondent estimates to account for MIPS eligible clinicians who we assumed would respond as participants in a virtual group. Because we are now able to base our respondent estimates on data from the 2018 MIPS performance period, which was the first performance period in which clinicians could submit as participants in a virtual group, we are no longer making the adjustment for virtual group participation.

TABLE 80—ESTIMATED NUMBER OF GROUPS AND VIRTUAL GROUPS SUBMITTING QUALITY PERFORMANCE CATEGORY DATA BY COLLECTION TYPE ON BEHALF OF CLINICIANS

	Medicare Part B claims	QCDR/ MIPS CQM	eCQM	CMS web interface	Total
Number of groups to collect data by collection type (on behalf of clinicians) in 2020 MIPS performance period (excludes QPs) (a)	0	10,949	4,398	104	15,451
* Number of groups to collect data by collection type on behalf of clinicians in 2019 MIPS performance period (b)	0	10,542	4,304	286	15,132

TABLE 80—ESTIMATED NUMBER OF GROUPS AND VIRTUAL GROUPS SUBMITTING QUALITY PERFORMANCE CATEGORY DATA BY COLLECTION TYPE ON BEHALF OF CLINICIANS—Continued

	Medicare Part B claims	QCDR/ MIPS CQM	eCQM	CMS web interface	Total
Difference (c) = (a) − (b)	0	+407	+94	−182	319

* Currently approved by OMB under control number 0938–1314 (CMS–10621).

The burden associated with the submission of quality performance category data have some limitations. We believe it is difficult to quantify the burden accurately because clinicians and groups may have different processes for integrating quality data submission into their practices' workflows. Moreover, the time needed for a clinician to review quality measures and other information, select measures applicable to their patients and the services they furnish, and incorporate the use of quality measures into the practice workflows is expected to vary along with the number of measures that are potentially applicable to a given clinician's practice and by the collection type. For example, clinicians submitting data via the Medicare Part B claims collection type need to integrate the capture of quality data codes for each encounter whereas clinicians submitting via the eCQM collection types may have quality measures automated as part of their EHR implementation.

We believe the burden associated with submitting quality measures data will vary depending on the collection type selected by the clinician, group, or third-party. As such, we separately estimated the burden for clinicians, groups, and third parties to submit quality measures data by the collection type used. For the purposes of our burden estimates for the Medicare Part B claims, MIPS CQM and QCDR, and eCQM collection types, we also assume that, on average, each clinician or group will submit 6 quality measures. In terms of the quality measures available for clinicians and groups to report for the 2020 MIPS performance period, the total number of quality measures will be 218. The new MIPS quality measures proposed for inclusion in MIPS for the 2020 MIPS performance period and future years are found in Table Group A of Appendix 1; MIPS quality measures with proposed substantive changes can be found in Table Group D of Appendix 1; and MIPS quality measures proposed for removal can be found in Table Group C of Appendix 1. These measures are stratified by collection type in Table 81, as well as counts of new, removed, and substantively changed measures.

TABLE 81—SUMMARY OF QUALITY MEASURES FOR THE 2020 MIPS PERFORMANCE PERIOD

Collection type	Number of measures finalized as new	Number of measures finalized for removal	Number of measures finalized with a substantive change	Number of measures remaining for CY 2020 *
Medicare Part B Claims Specifications	0	9	19	55
MIPS CQMs Specifications	2	39	72	196
eCQM Specifications	1	4	34	47
Survey—CSV	0	0	0	1
CMS Web Interface Measure Specifications	0	0	9	10
Administrative Claims	0	0	0	1
Total	3	42	83	218

* A measure may be specified under multiple collection types but will only be counted once in the total.

For the 2020 MIPS performance period, there is a net reduction of 39 quality measures across all collection types compared to the 257 measures finalized for the 2019 MIPS performance period (83 FR 60003). We do not anticipate that removing these measures will increase or decrease the reporting burden on clinicians and groups as respondents are still required to submit quality data for 6 measures.

As discussed in section III.K.3.c.(1)(c)(ii) of this rule, we proposed to adopt a higher data completeness threshold (the percentage of eligible patients the clinician must check to see whether the measure applies to) for the 2020 MIPS performance period, such that MIPS eligible clinicians and groups submitting quality measure data on QCDR measures, MIPS CQMs, and eCQMs must submit data on at least 70 percent of the MIPS eligible clinician or group's patients that meet the denominator criteria, regardless of payer for the 2020 MIPS performance period. We believe this proposal may increase administrative burden for some clinicians as it affects the amount of data they have to collect, but will have no impact on regulatory burden as it affects neither the number of quality measures they are required to report nor the amount of data they must report for each quality measure once results have been aggregated.

(2) Quality Payment Program Identity Management Application Process

This rule is not finalizing any new or revised collection of information requirements or burden related to the identity management application process. The requirements and burden are currently approved by OMB under control number 0938–1314 (CMS–10621). Consequently, we are not making any identity management application process changes under that control number.

(3) Quality Data Submission by Clinicians: Medicare Part B Claims-Based Collection Type

This rule is not finalizing any new or revised collection of information

requirements related to the submission of Medicare Part B claims data for the quality performance category. However, we are making adjustments to our currently approved burden estimates based on more recent data. The requirements and burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As noted in Table 78, based on 2018 MIPS performance period data, we assume that 94,846 individual clinicians will collect and submit quality data via the Medicare Part B claims collection type. This rule is finalizing to adjust the number of Medicare Part B claims respondents from 257,260 to 94,846 (a decrease of 162,414) based on more recent data and our updated methodology of accounting only for clinicians in small practices who submitted such claims data in the 2018 MIPS performance period rather than all clinicians who submitted quality data codes to us for the Medicare Part B claims collection type. This is a decrease of 15,105 from the CY 2020 PFS proposed rule estimate of 109,951 respondents due to availability of more recent data (84 FR 40858 through 40859). We continue to anticipate that the Medicare Part B claims submission process for MIPS is operationally similar to the way the claims submission process functioned under the PQRS. Specifically, clinicians will need to gather the required information, select the appropriate QDCs, and include the appropriate QDCs on the Medicare Part B claims they submit for payment. Clinicians will collect QDCs as additional (optional) line items on the CMS–1500 claim form or the electronic equivalent HIPAA transaction 837–P, approved by OMB under control number 0938–1197. This final rule's provisions do not necessitate the revision of either form and we made no changes to the associated estimate of reporting burden.

As shown in Table 82, consistent with our currently approved per respondent burden estimates, we estimate that the burden of quality data submission using Medicare Part B claims will range from 0.15 hours at a cost of $13.50 (0.15 hr × $90.02/hr) to 7.2 hours at a cost of $648.14 (7.2 hr × $90.02/hr) per respondent. The burden will involve becoming familiar with MIPS data submission requirements. We believe that the start-up cost for a clinician's practice to review measure specifications is 7 hours, consisting of 3 hours at $109.36/hr for a practice administrator, 1 hour at $202.86/hr for a clinician, 1 hour at $45.24/hr for an LPN/medical assistant, 1 hour at $90.02/hr for a computer systems analyst, and 1 hour at $38.00/hr for a billing clerk. We are not revising our currently approved per response burden estimates.

The estimate for reviewing and incorporating measure specifications for the claims collection type is higher than that of QCDRs/Registries or eCQM collection types due to the more manual, and therefore, more burdensome nature of Medicare Part B claims measures.

Considering both data submission and start-up requirements, the estimated time (per clinician) ranges from a minimum of 7.15 hours (0.15 hr + 7 hr) to a maximum of 14.2 hours (7.2 hr + 7 hr). In this regard the total annual time ranges from 678,149 hours (7.15 hr × 94,846 clinicians) to 1,346,813 hours (14.2 hr × 94,846 clinicians). The estimated annual cost (per clinician) ranges from $717.70 [(0.15 hr × $90.02/hr) + (3 hr × $109.36/hr) + (1 hr × $90.02/hr) + (1 hr × $45.24/hr) + (1 hr × $38.00/hr + (1 hr × $202.86/hr)] to a maximum of $1,352.34 [(7.2 hr × $90.02/hr) + (3 hr × $109.36/hr) + (1 hr × $90.02/hr) + (1 hr × $45.24/hr) + (1 hr × $38.00/hr + (1 hr × $202.86/hr)]. The total annual cost ranges from a minimum of $68,071,259 (94,846 clinicians × $717.70) to a maximum of $128,264,419 (94,846 clinicians × $1,352.34).

Table 82 summarizes the range of total annual burden associated with clinicians submitting quality data via Medicare Part B claims.

BILLING CODE 4120–01–P

TABLE 82: Estimated Burden for Quality Performance Category: Clinicians Using the Medicare Part B Claims Collection Type

	Minimum Burden	Median Burden	Maximum Burden
# of Clinicians (a)	94,846	94,846	94,846
Hours Per Clinician to Submit Quality Data (b)	0.15	1.05	7.2
# of Hours Practice Administrator Review Measure Specifications (c)	3	3	3
# of Hours Computer Systems Analyst Review Measure Specifications (d)	1	1	1
# of Hours LPN Review Measure Specifications (e)	1	1	1
# of Hours Billing Clerk Review Measure Specifications (f)	1	1	1
# of Hours Clinician Review Measure Specifications (g)	1	1	1
Annual Hours per Clinician (h) = (b)+(c)+(d)+(e)+(f)+(g)	7.15	8.05	14.2
Total Annual Hours (i) = (a)*(h)	**678,149**	**763,510**	**1,346,813**
Cost to Submit Quality Data (@ computer systems analyst's labor rate of $90.02/hr) (j)	$13.50	$94.52	$648.14
Cost to Review Measure Specifications (@ practice administrator's labor rate of $109.36/hr) (k)	$328.08	$328.08	$328.08
Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $90.02/hr) (l)	$90.02	$90.02	$90.02
Cost to Review Measure Specifications (@ LPN's labor rate of $45.24/hr) (m)	$45.24	$45.24	$45.24
Cost to Review Measure Specifications (@ billing clerk's labor rate of $38.00/hr) (n)	$38.00	$38.00	$38.00
Cost to Review Measure Specifications (@ physician's labor rate of $202.86/hr) (o)	$202.86	$202.86	$202.86
Total Annual Cost Per Clinician (p) = (j)+(k)+(l)+(m)+(n)+(o)	$717.70	$798.72	$1,352.34
Total Annual Cost (q) = (a)*(p)	**$68,071,259**	**$75,755,492**	**$128,264,419**

As shown in Table 83, using the unchanged currently approved per respondent burden estimates which range from $717.70 to $1,352.34, the decrease in number of respondents from 257,260 to 94,846 results in a total adjustment of between −1,161,260 hours (−162,414 respondents × 7.15 hr/respondent) at a cost of −$116,565,015 (−162,414 respondents × $717.70/respondent) and −2,306,279 hours (−162,414 respondents × 14.2 hr/respondent) at a cost of −$219,639,598 (−162,414 respondents × $1,352.34/respondent). For purposes of calculating total burden associated with the final rule as shown in Table 116, only the maximum burden is used.

TABLE 83: Change in Estimated Burden for Quality Performance Category: Clinicians Using the Medicare Part B Claims Collection Type

	Minimum Burden	Median Burden	Maximum Burden
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	1,839,409	2,070,943	3,653,092
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	678,149	763,510	1,346,813
Difference (c) = (b)-(a)	**-1,161,260**	**-1,307,433**	**-2,306,279**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$184,636,274	$205,478,964	$347,904,017
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$68,071,259	$75,755,492	$128,264,419
Difference (f) = (e)-(d)	**-$116,565,015**	**-$129,723,472**	**-$219,639,598**

We received no public comments related to the burden estimates for submission of quality performance category data using the Medicare Part B claims collection type. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40858 through 40859) due to availability of updated data.

(4) Quality Data Submission by Individuals and Groups Using MIPS CQM and QCDR Collection Types

This rule is not finalizing any new or revised collection of information requirements related to the MIPS CQM or QCDR collection types. However, we are making adjustments to our currently approved burden estimates based on more recent data. The requirements and burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As noted in Tables 78, 79, and 80, and based on 2018 MIPS performance period data, we assume that 391,430 clinicians will submit quality data as individuals or groups using MIPS CQM or QCDR collection types. Of these, we expect 100,269 clinicians, as shown in Table 79, will submit as individuals and 10,949 groups and virtual groups, as shown in Table 80, are expected to submit on behalf of the remaining 291,161 clinicians. This is a decrease of 5,770 individuals and an increase of 397 groups from the CY 2020 PFS proposed rule's estimates of 106,039 individuals and 10,552 groups due to availability of more recent data (84 FR 40860). As previously stated, we assume clinicians in other practices (not small practices) who meet all of the following criteria will submit via the MIPS CQM collection type for the 2020 MIPS performance period because the Medicare Part B claims collection type will no longer be available as an option for collecting and reporting quality data: (1) Scored as individuals; (2) not facility-based; and (3) submitted quality data only via the Medicare Part B claims collection type in the 2018 MIPS performance period. As a result of this assumption and our use of more recent data, this rule is finalizing to adjust the number of QCDR and MIPS CQM respondents from 81,981 to 111,218 (an increase of 29,237). Given that the number of measures required is the same for clinicians and groups, we expect the burden to be the same for each respondent collecting data via MIPS CQM or QCDR, whether the clinician is participating in MIPS as an individual or group.

Under the MIPS CQM and QCDR collection types, the individual clinician or group may either submit the quality measures data directly to us, log in and upload a file, or utilize a third-party intermediary to submit the data to us on the clinician's or group's behalf.

We estimate that the burden associated with the QCDR collection type is similar to the burden associated with the MIPS CQM collection type; therefore, we discuss the burden for both together below. For MIPS CQM and QCDR collection types, we estimate an additional time for respondents (individual clinicians and groups) to become familiar with MIPS collection requirements and, in some cases, specialty measure sets and QCDR measures. Therefore, we believe that the burden for an individual clinician or group to review measure specifications and submit quality data total 9.083 hours at $872.37 per individual clinician or group. This consists of 3 hours at $90.02/hr for a computer systems analyst (or their equivalent) to submit quality data along with 2 hours at $109.36/hr for a practice administrator, 1 hour at $90.02/hr for a computer systems analyst, 1 hour at $45.24/hr for a LPN/medical assistant, 1 hour at $38.00/hr for a billing clerk, and 1 hour at $202.86/hr for a clinician to review measure specifications. Additionally, clinicians and groups who do not submit data directly will need to authorize or instruct the qualified registry or QCDR to submit quality measures' results and numerator and denominator data on quality measures to us on their behalf. We estimate that the time and effort associated with authorizing or instructing the quality registry or QCDR to submit this data will be approximately 5 minutes (0.083 hours) per clinician or group (respondent) for a cost of $7.50 (0.083 hr × $90.02/hr for a computer systems analyst).

In aggregate, we estimate an annual burden of 1,010,193 hours (9.083 hr/response × 111,218 groups plus clinicians submitting as individuals) at a cost of $97,023,431 (111,218 responses × $872.37/response). Based on these assumptions, we have estimated in Table 84 the burden for these submissions.

TABLE 84: Estimated Burden for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group) Using the MIPS CQM/QCDR Collection Type

	Burden Estimate
# of clinicians submitting as individuals (a)	100,269
# of groups submitting via QCDR or MIPS CQM on behalf of individual clinicians (b)	10,949
# of Respondents (groups plus clinicians submitting as individuals) (c)=(a)+(b)	111,218
Hours Per Respondent to Report Quality Data (d)	3
# of Hours Practice Administrator Review Measure Specifications (e)	2
# of Hours Computer Systems Analyst Review Measure Specifications (f)	1
# of Hours LPN Review Measure Specifications (g)	1
# of Hours Billing Clerk Review Measure Specifications (h)	1
# of Hours Clinician Review Measure Specifications (i)	1
# of Hours Per Respondent to Authorize Qualified Registry to Report on Respondent's Behalf (j)	0.083
Annual Hours Per Respondent (k)= (d)+(e)+(f)+(g)+(h)+(i)+(j)	9.083
Total Annual Hours (l) = (c)*(k)	**1,010,193**
Cost Per Respondent to Submit Quality Data (@ computer systems analyst's labor rate of $90.02/hr) (m)	$270.06
Cost to Review Measure Specifications (@ practice administrator's labor rate of $109.36/hr) (n)	$218.72
Cost Computer System's Analyst Review Measure Specifications (@ computer systems analyst's labor rate of $90.02/hr) (o)	$90.02
Cost LPN Review Measure Specifications (@ LPN's labor rate of $45.24/hr) (p)	$45.24
Cost Billing Clerk Review Measure Specifications (@ clerk's labor rate of $38.00/hr) (q)	$38.00
Cost Clinician Review Measure Specifications (@ physician's labor rate of $202.86/hr) (r)	$202.86
Cost for Respondent to Authorize Qualified Registry/QCDR to Report on Respondent's Behalf (@ computer systems analyst's labor rate of $90.02/hr) (s)	$7.50
Total Annual Cost Per Respondent (t) = (m)+(n)+(o)+(p)+(q)+(r)+(s)	$872.37
Total Annual Cost (u) = (c)*(t)	**$97,023,431**

As shown in Table 85, using the unchanged currently approved per respondent burden estimate, the increase in number of respondents from 81,981 to 111,218 results in a total increase of 265,560 hours (29,237 respondents × 9.083 hr/respondent) at a cost of $25,505,530 (29,237 respondents × $872.37/respondent).

TABLE 85: Change in Estimated Burden for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group) Using the MIPS CQM/QCDR Collection Type

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	744,633
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	1,010,193
Difference (c) = (b)-(a)	**+265,560**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$71,517,901
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$97,023,431
Difference (f) = (e)-(d)	**+$25,505,530**

We received no public comments related to the burden estimates for submission of quality performance category data using the MIPS CQM/QCDR collection type. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40860 through 40861) due to availability of updated data.

(5) Quality Data Submission by Clinicians and Groups: eCQM Collection Type

This rule is not finalizing any new or revised collection of information requirements related to the eCQM

collection type. However, we are making adjustments to our currently approved burden estimates based on more recent data. The requirements and burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As noted in Tables 78, 79, and 80, based on 2018 MIPS performance period data, we assume that 254,469 clinicians will elect to use the eCQM collection type; 38,935 clinicians are expected to submit eCQMs as individuals; and 4,398 groups and virtual groups are expected to submit eCQMs on behalf of the remaining 208,921 clinicians. This rule finalizes to adjust the number of eCQM respondents from 51,861 to 43,333 (a decrease of 8,528) based on more recent data. This is a decrease of 8,520 individuals and an increase of 66 groups from the CY 2020 PFS proposed rule's estimates of 47,455 individuals and 4,332 groups due to availability of more recent data (84 FR 40861). We expect the burden to be the same for each respondent using the eCQM collection type, whether the clinician is participating in MIPS as an individual or group.

Under the eCQM collection type, the individual clinician or group may either submit the quality measures data directly to us from their eCQM, log in and upload a file, or utilize a third-party intermediary to derive data from their CEHRT and submit it to us on the clinician's or group's behalf.

To prepare for the eCQM collection type, the clinician or group must review the quality measures on which we will be accepting MIPS data extracted from eCQMs, select the appropriate quality measures, extract the necessary clinical data from their CEHRT, and submit the necessary data to the CMS-designated clinical data warehouse or use a health IT vendor to submit the data on behalf of the clinician or group. We assume the burden for collecting quality measures data via eCQM is similar for clinicians and groups who submit their data directly to us from their CEHRT and clinicians and groups who use a health IT vendor to submit the data on their behalf. This includes extracting the necessary clinical data from their CEHRT and submitting the necessary data to the CMS-designated clinical data warehouse.

We estimate that it will take no more than 2 hours at $90.02/hr for a computer systems analyst to submit the actual data file. The burden will also involve becoming familiar with MIPS submission. In this regard, we estimate it will take 6 hours for a clinician or group to review measure specifications. Of that time, we estimate 2 hours at $109.36/hr for a practice administrator, 1 hour at $202.86/hr for a clinician, 1 hour at $90.02/hr for a computer systems analyst, 1 hour at $45.24/hr for an LPN/medical assistant, and 1 hour at $38.00/hr for a billing clerk.

In aggregate we estimate an annual burden of 346,664 hours (8 hr × 43,333 groups and clinicians submitting as individuals) at a cost of $33,577,875 (43,333 responses × $774.88/response). Based on these assumptions, we have estimated in Table 86 the burden for these submissions.

TABLE 86: Estimated Burden for Quality Performance Category: Clinicians (Submitting Individually or as Part of a Group) Using the eCQM Collection Type

	Burden estimate
# of clinicians submitting as individuals (a)	38,935
# of Groups submitting via EHR on behalf of individual clinicians (b)	4,398
# of Respondents (groups and clinicians submitting as individuals) (c)=(a)+(b)	43,333
Hours Per Respondent to Submit MIPS Quality Data File to CMS (d)	2
# of Hours Practice Administrator Review Measure Specifications (e)	2
# of Hours Computer Systems Analyst Review Measure Specifications (f)	1
# of Hours LPN Review Measure Specifications (g)	1
# of Hours Billing Clerk Review Measure Specifications (h)	1
# of Hours Clinicians Review Measure Specifications (i)	1
Annual Hours Per Respondent (j)=(d)+(e)+(f)+(g)+(h)+(i)	8
Total Annual Hours (k)=(c)*(j)	346,664
Cost Per Respondent to Submit Quality Data (@ computer systems analyst's labor rate of $90.02/hr) (l)	$180.04
Cost to Review Measure Specifications (@ practice administrator's labor rate of $109.36/hr) (m)	$218.72
Cost to Review Measure Specifications (@ computer systems analyst's labor rate of $90.02/hr) (n)	$90.02
Cost to Review Measure Specifications (@ LPN's labor rate of $45.24/hr) (o)	$45.24
Cost to Review Measure Specifications (@ clerk's labor rate of $38.00/hr) (p)	$38.00
Cost to D21Review Measure Specifications (@ physician's labor rate of $202.86/hr) (q)	$202.86
Total Cost Per Respondent (r)=(l)+(m)+(n)+(o)+(p)+(q)	$774.88
Total Annual Cost (s) = (c)*(r)	**$33,577,875**

As shown in Table 87, using the unchanged currently approved per respondent burden estimate, the decrease in number of respondents from 51,861 to 43,333 results in a total difference of −68,224 hours (−8,528

respondents × 8 hr/respondent) at a cost of −$6,608,177 (−8,528 respondents × $774.88/respondent).

TABLE 87: Change in Estimated Burden for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group) Using the eCQM Collection Type

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	414,888
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	346,664
Difference (c) = (b)-(a)	**-68,224**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$40,186,052
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$33,577,875
Difference (f) = (e)-(d)	**-$6,608,177**

We received no public comments related to the burden estimates for submission of quality performance category data using the eCQM collection type. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40861 through 40862) due to availability of updated data.

(6) Quality Data Submission via CMS Web Interface

This rule is not finalizing any new or revised collection of information requirements related to submission of quality data via the CMS Web Interface. However, we are making adjustments to our currently approved burden estimates based on more recent data. The requirements and burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

We assume that 104 groups will submit quality data via the CMS Web Interface based on the number of groups who completed 100 percent of reporting quality data via the Web Interface in the 2018 MIPS performance period. This is a decrease of 182 groups from the currently approved number of 286 groups provided in the CY 2019 PFS final rule (83 FR 60007) due to receipt of more current data. We estimate that 46,473 clinicians will submit as part of groups via this method, a decrease of 92,758 from our currently approved estimate of 139,231 clinicians. This is a decrease of 69,869 individuals from the CY 2020 PFS proposed rule's estimate of 116,342 individuals due to availability of more recent data (84 FR 40862).

The burden associated with the group submission requirements is the time and effort associated with submitting data on a sample of the organization's beneficiaries that is prepopulated in the CMS Web Interface. Our burden estimate for submission includes the time (61.67 hours) needed for each group to populate data fields in the web interface with information on approximately 248 eligible assigned Medicare beneficiaries and submit the data (we will partially pre-populate the CMS Web Interface with claims data from their Medicare Part A and Part B beneficiaries). The patient data either can be manually entered, uploaded into the CMS Web Interface via a standard file format, which can be populated by CEHRT, or submitted directly. Each group must provide data on 248 eligible assigned Medicare beneficiaries (or all eligible assigned Medicare beneficiaries if the pool of eligible assigned beneficiaries is less than 248) for each measure. In aggregate, we estimate an annual burden of 6,414 hours (104 groups × 61.67 hr) at a cost of $577,359 (6,414 hr × $90.02/hr). Based on the assumptions discussed in this section, Table 88 summarizes the burden for groups submitting to MIPS via the CMS Web Interface.

TABLE 88: Estimated Burden for Quality Data Submission via the CMS Web Interface

	Burden Estimate
# of Eligible Group Practices (a)	104
Total Annual Hours Per Group to Submit (b)	61.67
Total Annual Hours (c) = (a)*(b)	6,414
Cost Per Group to Report (@ computer systems analyst's labor rate of $90.02/hr.) (d)	$5,551.53
Total Annual Cost (e) = (a)*(d)	$577,359

As shown in Table 89, using our unchanged currently approved per respondent burden estimate, the decrease in number of respondents results in a total adjustment of −11,224 hours (−182 respondents × 61.67 hr) at −$1,010,379 (−11,224 hr × $90.02/hr).

TABLE 89: Change in Estimated Burden for Quality Data Submission via the CMS Web Interface

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	17,637
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	6,413
Difference (c) = (b)-(a)	**-11,224**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$1,587,739
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$577,359
Difference (f) = (e)-(d)	**-$1,010,379**

We received no public comments related to the burden estimates for submission of quality performance category data using the CMS Web Interface. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40862 through 40863) due to availability of updated data.

(7) Beneficiary Responses to CAHPS for MIPS Survey

This rule is not finalizing any new or revised collection of information requirements or burden related to the CAHPS for MIPS survey. The CAHPS for MIPS survey requirements and burden are currently approved by OMB under control number 0938–1222 (CMS–10450). Consequently, we are not making any MIPS survey vendor changes under that control number.

(8) Group Registration for CMS Web Interface

This rule is not finalizing any new or revised collection of information requirements related to the group registration for CMS Web Interface. However, we are adjusting our currently approved burden estimates based on more recent data. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

Groups interested in participating in MIPS using the CMS Web Interface for the first time must complete an online registration process. After first time registration, groups will only need to opt out if they are not going to continue to submit via the CMS Web Interface. In Table 90, we estimate that the registration process for groups under MIPS involves approximately 0.25 hours at $90.02/hr for a computer systems analyst (or their equivalent) to register the group.

In this rule, we are adjusting the number of respondents from 67 to 69 based on more recent data; an increase of 18 from our estimate of 51 in the CY 2020 PFS proposed rule (84 FR 40863). We assume that approximately 69 groups will elect to use the CMS Web Interface for the first time during the 2020 MIPS performance period based on the number of new registrations received during the CY 2019 registration period; an increase of 2 compared to the number of groups currently approved by OMB. As shown in Table 90, we estimate a burden of 17.25 hours (69 new registrations × 0.25 hr/registration) at a cost of $1,553 (17.255 hr × $90.02/hr).

TABLE 90: Estimated Burden for Group Registration for CMS Web Interface

	Burden Estimate
Number of New Groups Registering for CMS Web Interface (a)	69
Annual Hours Per Group (b)	0.25
Total Annual Hours (c) = (a)*(b)	**17.25**
Labor rate for a computer systems analyst (d)	$90.02/hr
Total Annual Cost (e) = (a)*(d)	**$1,553**

As shown in Table 91 using our unchanged currently approved per respondent burden estimates, the decrease in the number of groups registering to submit MIPS data via the CMS Web Interface results in an adjustment to the total time burden of 0.5 hours at a cost of $45 (−2 groups × 0.25 hr × $90.02/hr).

TABLE 91: Change in Estimated Burden for Group Registrations for the CMS Web Interface

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	16.75
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	17.25
Difference (c) = (b)-(a)	**+0.5**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$1,508
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$1,553
Difference (f) = (e)-(d)	**+$45**

We received no public comments related to the burden estimates for group registrations for the CMS Web Interface. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40863 through 40864) due to availability of updated data.

(9) Group Registration for CAHPS for MIPS Survey

This rule is not finalizing any new or revised collection of information requirements or burden related to the group registration for the CAHPS for MIPS Survey. The CAHPS for MIPS survey requirements and burden are currently approved by OMB under control number 0938–1222 (CMS–10450). Consequently, are not making any MIPS survey vendor changes under that control number.

e. ICRs Regarding the Nomination of Quality Measures

The requirements and burden associated with this data submission will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

Quality measures are selected annually through a call for quality measures under consideration, with a final list of quality measures being published in the **Federal Register** by November 1 of each year. Under section 1848(q)(2)(D)(ii) of the Act, the Secretary must solicit a ''Call for Quality Measures'' each year. Specifically, the Secretary must request that eligible clinician organizations and other relevant stakeholders identify and submit quality measures to be considered for selection in the annual list of MIPS quality measures, as well as updates to the measures. Under section 1848(q)(2)(D)(ii) of the Act, eligible clinician organizations are professional organizations as defined by nationally recognized specialty boards of certification or equivalent certification boards.

As we described in the CY 2017 Quality Payment Program final rule (81 FR 77137), we will accept quality measures submissions at any time, but only measures submitted during the timeframe provided by us through the pre-rulemaking process of each year will be considered for inclusion in the annual list of MIPS quality measures for the performance period beginning 2 years after the measure is submitted. This process is consistent with the pre-rulemaking process and the annual call for measures, which are further described at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html.*

To identify and submit a quality measure, eligible clinician organizations and other relevant stakeholders use a one-page online form that requests information on background, a gap analysis which includes evidence for the measure, reliability, validity, endorsement and a summary which includes how the proposed measure relates to the Quality Payment Program and the rationale for the measure. In addition, proposed measures must be accompanied by a completed Peer Review Journal Article form. As discussed in section III.K.3.c.(1)(d)(i) of this rule, we are finalizing that beginning with the 2020 Call for Measures process, MIPS quality measure stewards will be required to link their MIPS quality measures to existing and related cost measures and improvement activities, as applicable and feasible. MIPS quality measure stewards will also be required to provide a rationale as to how they believe their measure correlates to other performance category measures and activities. We believe this will require approximately 0.6 hours at $109.36/hr for a practice administrator and 0.4 hours at $202.86 for a clinician to research existing measures or activities and provide a rationale for the linkage to the new measure. We also estimate it will require 0.3 hours at $109.36/hr for a practice administrator to make a strategic decision to nominate and submit a measure and 0.2 hours at $202.86/hr for clinician review time. We recognize there is additional burden on respondents associated with development of a new quality measure beyond the 1.5 hour estimate (0.6 hr + 0.4 hr + 0.3 hr + 0.2 hr) which only accounts for the time required for recordkeeping, reporting, and third-party disclosures associated with the policy; but we believe this estimate to be reasonable to nominate and submit a measure. The 1.5 hour estimate also assumes that submitters will have the necessary information to complete the nomination form readily available, which we believe is a reasonable assumption. Additionally, some submitters familiar with the process or who are submitting multiple measures may require significantly less time, while other submitters may require more if the opposite is true. Representing an average across all respondents based on our review of the nomination process, the information required to complete the nomination form, and the criteria required to nominate the measure, we believe the total estimate of 1.5 hours per measure to be reasonable and appropriate.

As shown in Table 92, we estimate that 28 submissions will be received during the 2020 Call for Quality Measures based on the number of submissions received during the 2019 Call for Quality Measures process; a decrease of 112 compared to the number of submissions currently approved by OMB (140 submissions). This is an increase of 2 from the CY 2020 PFS proposed rule due to availability of more recent data (84 FR 40865). In keeping with the focus on clinicians as the primary source for recommending new quality measures, we are using

practice administrators and clinician time for our burden estimates.

Consistent with the CY 2017 Quality Payment Program final rule, we also estimate it will take 4 hours at $202.86/hr for a clinician (or equivalent) to complete the Peer Review Journal Article Form (81 FR 77153 through 77155). This assumes that measure information is available and testing is complete in order to have the necessary information to complete the form, which we believe is a reasonable assumption.

As shown in Table 92, in aggregate we estimate an annual burden of 154 hours (28 submissions × 5.5 hr/submission) at a cost of $28,884 {28 submissions × [(0.9 hr × $109.36/hr) + (4.6 hr × $202.86/hr)}.

TABLE 92: Estimated Burden for Call for Quality Measures

	Burden estimate
# of New Quality Measures Submitted for Consideration (a)	28
# of Hours Per Practice Administrator to Identify, Propose, and Link Measure (b)	0.9
# of Hours Per Clinician to Identify and Link Measure (c)	0.6
# of Hours Per Clinician to Complete Peer Review Article Form (d)	4.00
Annual Hours Per Response (e)= (b) + (c) + (d)	5.50
Total Annual Hours (f) = (a)*(e)	**154**
Cost to Identify and Submit Measure (@ practice administrator's labor rate of $109.36/hr.) (g)	$98.42
Cost to Identify Quality Measure and Complete Peer Review Article Form (@ physician's labor rate of $202.86/hr.) (h)	$933.16
Total Annual Cost Per Respondent (i)=(g)+(h)	$1,031.58
Total Annual Cost (j)=(a)*(i)	**$28,884**

Independent of the decrease in the number of new quality measures submitted for consideration, the increase in burden per nominated measure results in a difference of 140 hours at a cost of $20,546 {140 submissions × [(0.6 hr × $109.36/hr) + (0.4 hr × $202.86/hr)]}. The decrease in the number of new quality measures submitted results in an adjustment of −616 hours at −$115,537 (−112 submissions × [(0.9 hr × $109.36/hr) + (4.6 hr × $202.86/hr)]). As shown in Table 93, in aggregate, the combine impact of these changes is −476 hours (140 − 616) at a cost of −$94,991 ($20,546 − $115,537).

TABLE 93: Change in Estimated Burden for Call for Quality Measures

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	630
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	154
Difference (c) = (b)-(a)	**-476**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$123,875
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$28,884
Difference (f) = (e)-(d)	**-$94,991**

We received no public comments related to the burden estimates for the Call for Quality Measures. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40864 through 40865) due to availability of updated data.

f. ICRs Regarding Promoting Interoperability Data (§§ 414.1375 and 414.1380)

(1) Background

For the 2020 MIPS performance period, clinicians and groups can submit Promoting Interoperability data through direct, log in and upload, or log in and attest submission types. We have worked to further align the Promoting Interoperability performance category with other MIPS performance categories. With the exception of submitters who elect to use the log in and attest submission type for the Promoting Interoperability performance category, which is not available for the quality performance category, we anticipate that individuals and groups will use the same data submission type for the both of these performance categories and that the clinicians, practice managers, and computer systems analysts involved in supporting the quality data submission will also support the Promoting Interoperability data submission process. In the 2019 and prior MIPS performance periods, individuals and groups submitting data for the quality performance category via a qualified registry or QCDR that did not also support reporting of data for the Promoting Interoperability or improvement activity performance categories would be required to submit data for these performance categories using an alternate submission type. The finalized policies discussed in sections III.K.3.g.(3)(a)(i) and III.K.3.g.(4)(a)(i) of this rule requiring qualified registries and QCDRs to be able to submit data for the quality, improvement activities, and Promoting Interoperability performance categories will alleviate this issue. Hence, the following burden estimates

show only incremental hours required above and beyond the time already accounted for in the quality data submission process. Although this analysis assesses burden by performance category and submission type, we emphasize that MIPS is a consolidated program and submission analysis and decisions are expected to be made for the program as a whole.

(2) Reweighting Applications for Promoting Interoperability and Other Performance Categories

This rule is not finalizing any new or revised collection of information requirements related to the submission of reweighting applications for Promoting Interoperability and other performance categories. However, we are making adjustments to our currently approved burden estimates based on more recent data from the 2019 MIPS performance period. The adjusted burden estimates will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As established in the CY 2017 and CY 2018 Quality Payment Program final rules, MIPS eligible clinicians who meet the criteria for a significant hardship or other type of exception may submit an application requesting a zero percent weighting for the Promoting Interoperability performance category in the following circumstances: Insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over the availability of CEHRT, clinicians who are in a small practice, and decertified EHR technology (81 FR 77240 through 77243 and 82 FR 53680 through 53686, respectively). In addition, in the CY 2018 Quality Payment Program final rule, we established that MIPS eligible clinicians and groups citing extreme and uncontrollable circumstances may also apply for a reweighting of the quality, cost, and/or improvement activities performance categories (82 FR 53783 through 53785). As discussed in section III.K.3.d.(2)(b)(ii)(A), we are finalizing, beginning with the 2018 MIPS performance period and 2020 MIPS payment year, to reweight the performance categories for a MIPS eligible clinician who we determine has data for a performance category that are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. Because this is a new policy and we believe these occurrences are rare based on our experience, we are unable to estimate the number of clinicians, groups, or third party intermediaries that may contact us regarding a potential data issue. Similarly, the extent and source of documentation provided to us for each event may vary considerably. Therefore, we are not finalizing any changes to our currently approved burden estimates as a result of this policy. Respondents who apply for a reweighting for any of these performance categories have the option of applying for reweighting for the Promoting Interoperability performance category on the same online form. We assume that respondents applying for a reweighting of the Promoting Interoperability performance category due to extreme and uncontrollable circumstances will also request a reweighting of at least one of the other performance categories simultaneously and not submit multiple reweighting applications.

Table 94 summarizes the burden for clinicians to apply for reweighting the Promoting Interoperability performance category to zero percent due to a significant hardship exception (including a significant hardship exception for small practices) or as a result of a decertification of an EHR. Based on the number of reweighting applications received for the 2018 MIPS performance period, we assume 30,472 respondents (eligible clinicians or groups) will submit a request to reweight the Promoting Interoperability performance category to zero percent due to a significant hardship (including clinicians in small practices) or EHR decertification and an additional 148 respondents will submit a request only to reweight one or more of the quality, cost, or improvement activity performance categories, for a total of 30,620 reweighting applications submitted. This is an increase of 24,447 from our estimate of 6,025 in the CY 2020 PFS proposed rule due to availability of more recent data (84 FR 40866). A significant portion of this increase is due to a data issue CMS was made aware of and is specific to a single third-party intermediary. While we do not anticipate similar data issues to occur in each performance period, we do believe future similar incidents may occur and are electing to use this data without adjustment to reflect this belief. Of our total respondent estimate of 30,620, we estimate that 24,377 respondents (eligible clinicians or groups) will submit a request for reweighting the Promoting Interoperability performance category to zero percent due to extreme and uncontrollable circumstances, insufficient internet connectivity, lack of control over the availability of CEHRT, or as a result of a decertification of an EHR. An additional 6,243 respondents will submit a request for reweighting the Promoting Interoperability performance category to zero percent as a small practice experiencing a significant hardship.

The application to request a reweighting to zero percent only for the Promoting Interoperability performance category is a short online form that requires identifying the type of hardship experienced or whether decertification of an EHR has occurred and a description of how the circumstances impair the clinician or group's ability to submit Promoting Interoperability data, as well as some proof of circumstances beyond the clinician's control. The application for reweighting of the quality, cost, Promoting Interoperability, and/or improvement activities performance categories due to extreme and uncontrollable circumstances requires the same information with the exception of there being only one option for the type of hardship experienced. We estimate it will take 0.25 hours at $90.02/hr for a computer system analyst to complete and submit the application. As shown in Table 94, we estimate an annual burden of 7,655 hours (30,620 applications × 0.25 hr/application) at a cost of $689,103 (7,655 hr × $90.02/hr).

TABLE 94: Estimated Burden for Reweighting Applications for Promoting Interoperability and Other Performance Categories

	Burden estimate
# of Eligible Clinicians or Groups Applying Due to Significant Hardship and Other Exceptions (a)	24,377
# of Eligible Clinicians or Groups Applying Due to Significant Hardship for Small Practice (b)	6,243
Total Respondents Due to Hardships, Other Exceptions and Hardships for Small Practices (c)	30,620
Hours Per Applicant per application submission (d)	0.25
Total Annual Hours (e)=(a)*(c)	**7,655**
Labor Rate for a computer systems analyst (f)	$90.02/hr
Total Annual Cost (g)=(a)*(f)	**$689,103**

As shown in Table 95, using our unchanged currently approved per respondent burden estimate, the increased number of respondents results in a total adjustment of 6,145 hours (24,579 respondents × 0.25 hr/respondent) and $553,150 (24,579 respondents × $22.50/respondent).

TABLE 95: Change in Estimated Burden for Reweighting Applications for Promoting Interoperability and Other Performance Categories

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	1,510
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	7,655
Difference (c) = (b)-(a)	**+6,145**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$135,953
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$689,103
Difference (f) = (e)-(d)	**+$553,150**

We received no public comments related to the burden estimates for reweighting applications for Promoting Interoperability and other performance categories. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40866 through 40867) due to availability of updated data.

(3) Submitting Promoting Interoperability Data

This rule is not finalizing any new or revised collection of information requirements related to the submission of Promoting Interoperability data. However, we are making adjustments to our currently approved burden estimates based on updated estimates of QPs and MIPS APMs for 2020 MIPS performance period. The adjusted burden estimates will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

A variety of organizations will submit Promoting Interoperability data on behalf of clinicians. Clinicians not participating in a MIPS APM may submit data as individuals or as part of a group. In the CY 2017 Quality Payment Program final rule (81 FR 77258 through 77260, 77262 through 77264) and CY 2019 PFS final rule (83 FR 59822–59823), we established that eligible clinicians in MIPS APMs (including the Shared Savings Program) may report for the Promoting Interoperability performance category as an APM Entity group, individuals, or a group.

As shown in Table 96, based on data from the 2018 MIPS performance period, we estimate that a total of 74,281 respondents consisting of 59,865 individual MIPS eligible clinicians and 14,416 groups and virtual groups will submit Promoting Interoperability data; this is an adjustment to the number of respondents from 93,869 to 74,281 (a decrease of 19,588) based on more recent data. This is a decrease of 21,493 individuals and an increase of 1,911 groups from the CY 2020 PFS proposed rule's estimates of 81,358 individuals and 12,505 groups also due to availability of more recent data (84 FR 40868). In the CY 2017 and CY 2018 Quality Payment Program final rules, the CY 2019 PFS final rule, the CY 2020 PFS proposed rule, we were required to adjust our respondent estimates to account for MIPS eligible clinicians who we assumed would respond as participants in a virtual group. Because we are now able to base our respondent estimates on data from the 2018 MIPS performance period, which was the first performance period in which clinicians could submit as participants in a virtual group, we are no longer making the adjustment for virtual group participation.

Because our respondent estimates are based on the number of actual submissions received for the Promoting Interoperability performance category, it is not necessary to account for policies adopted in the CY 2017 Quality Payment Program final rule regarding reweighting, which state that if a clinician submits Promoting Interoperability data, they will be scored and the performance category will not be reweighted (81 FR 77238–77245). This approach is identical to the approach we used in the CY 2019 PFS final rule (83 FR 60013 through 60014);

however, we failed to state the distinction in that final rule that we no longer need to make modifications to our estimates due to the use of actual MIPS submission data. As established in the CY 2017 and CY 2018 Quality Payment Program final rules and the CY 2019 PFS final rule, certain MIPS eligible clinicians will be eligible for automatic reweighting of the Promoting Interoperability performance category to zero percent, including MIPS eligible clinicians that are hospital-based, ambulatory surgical center-based, non-patient facing clinicians, physician assistants, nurse practitioners, clinician nurse specialists, certified registered nurse anesthetists, physical therapists; occupational therapists; qualified speech-language pathologists or qualified audiologist; clinical psychologists; and registered dieticians or nutrition professionals (81 FR 77238 through 77245, 82 FR 53680 through 53687, and 83 FR 59819 through 59820, respectively). For the same reasons discussed above regarding our use of data reflecting the actual number of Promoting Interoperability data submissions received, these estimates already account for the reweighting policies in the CY 2017 and CY 2018 Quality Payment Program final rules, including exceptions for MIPS eligible clinicians who have experienced a significant hardship (including clinicians who are in small practices), as well as exceptions due to decertification of an EHR (81 FR 77240 through 77243 and 82 FR 53680 through 53686).

In section III.K.3.c.(4)(f)(iii) of this rule, we are finalizing to revise the definition of a hospital-based MIPS eligible clinician under § 414.1305 to include groups and virtual groups. We are finalizing that, beginning with the 2022 MIPS payment year, a hospital-based MIPS eligible clinician under § 414.1305 means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period. We are also finalizing to revise § 414.1380(c)(2)(iii) to specify that for the Promoting Interoperability performance category to be reweighted for a MIPS eligible clinician who elects to participate in MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting, or the group or virtual group must meet the finalized revised definition of a hospital-based MIPS eligible clinician or the definition of a non-patient facing MIPS eligible clinician as defined in § 414.1305. We believe these policies could result in a decrease in the number of data submissions for the Promoting Interoperability performance category, but we do not currently have the data necessary to determine how many groups would elect to forego submission. As additional information becomes available in future years, we will revisit the impact of this policy and adjust our burden estimates accordingly.

As discussed in section III.K.3.c.(4)(d)(i)(B) of this rule, we are finalizing to allow clinicians to satisfy the optional bonus Query of PDMP measure by submitting a ''yes/no'' attestation, rather than reporting a numerator and denominator. In the CY 2019 PFS final rule, we updated our burden assumptions from 3 hours to 2.67 hours to reflect the change from 5 base measures, 9 performance measures, and 4 bonus measures to the reporting of 4 base measures (83 FR 60013 through 60014). Due to a lack of data regarding the number of health care providers who would submit data for bonus Promoting Interoperability measures, we have consistently been unable to estimate burden related to the reporting of bonus measures and are therefore unable to account for any change in burden due to the proposed change to a ''yes/no'' attestation for the Query of PDMP measure. If we have better data in the future, we may reassess our burden assumptions and whether we can reasonably quantify the burden associated with the reporting of bonus measures.

We assume that MIPS eligible clinicians scored under the APM scoring standard, as described in section III.K.3.c.(5) of this rule, will continue to submit Promoting Interoperability data the same as in 2018. Each MIPS eligible clinician in an APM Entity reports data for the Promoting Interoperability performance category through either their group TIN or individual reporting. Sections 1899 and 1115A of the Act (42 U.S.C. 1395jjj and 42 U.S.C. 1315a, respectively) state that the Shared Savings Program and the testing, evaluation, and expansion of Innovation Center models are not subject to the PRA. However, in the CY 2019 PFS final rule, we established that MIPS eligible clinicians who participate in the Shared Savings Program are no longer limited to reporting for the Promoting Interoperability performance category through their ACO participant TIN (83 FR 59822–59823). Burden estimates for this final rule assume group TIN-level reporting as we believe this is the most reasonable assumption for the Shared Savings Program, which requires that ACOs include full TINs as ACO participants. As we receive updated information which reflects the actual number of Promoting Interoperability data submissions submitted by Shared Savings Program ACO participants, we will update our burden estimates accordingly.

TABLE 96—ESTIMATED NUMBER OF RESPONDENTS TO SUBMIT PROMOTING INTEROPERABILITY PERFORMANCE DATA ON BEHALF OF CLINICIANS

	Number of respondents
Number of individual clinicians to submit Promoting Interoperability (a)	59,865
Number of groups to submit Promoting Interoperability (b)	14,416
Total Respondents in 2020 MIPS performance period (CY 2020 Final Rule) (c) = (a) + (b)	74,281
* Total Respondents in 2019 MIPS performance period (CY 2019 Final Rule) (d)	93,869
Difference (e) = (c) − (d)	−19,588

We estimate the time required for an individual or group to submit Promoting Interoperability data to be 2.67 hours. As previously discussed, we are finalizing changes to § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all the MIPS performance categories identified in the regulation. Based on our review of 2019 qualified registries and QCDRs, we have determined that 70

percent and 72 percent of these vendors, respectively, are already able to submit data for these performance categories. For clinicians who currently utilize qualified registries or QCDRs that have not previously offered the ability to report Promoting Interoperability or improvement activity data, we believe this will result in a reduction of burden as it will simplify MIPS reporting. In order to estimate the impact on reporting burden, we would need to correlate the specific individual clinicians and groups who submitted quality performance category data via the MIPS CQM/QCDR collection type that are required to report data for both the quality and Promoting Interoperability performance categories with the specific qualified registries or QCDRs that are affected by this proposal. Currently, we do not have the necessary information to perform this correlation and are therefore unable to estimate the resulting impact on burden. If data becomes available in the future which enables us to perform this analysis, we will update our burden estimates at that time.

As shown in Table 97, the total burden estimate for submission of data on the specified Promoting Interoperability objectives and measures is estimated to be 198,083 hours (74,281 respondents × 2.67 incremental hours for a computer analyst's time above and beyond the clinician, practice manager, and computer system's analyst time required to submit quality data) at a cost of $17,831,402 (198,083 hr × $90.02/hr).

TABLE 97: Estimated Burden for Promoting Interoperability Performance Category Data Submission

	Burden Estimate
Number of individual clinicians to submit Promoting Interoperability (a)	59,865
Number of groups to submit Promoting Interoperability (b)	14,416
Total (c) = (a) + (b)	74,281
Total Annual Hours Per Respondent (b)	2.67
Total Annual Hours (c) = (a)*(b)	**198,083**
Labor rate for a computer systems analyst to submit Promoting Interoperability data (d)	$90.02/hr
Total Annual Cost (e) = (a)*(d)	**$17,831,402**

As shown in Table 98, using our unchanged currently approved per respondent burden estimate, the decrease in number of respondents results in a total adjustment of −52,235 hours (−19,588 respondents × 2.67 hr/respondent) at a cost of −$4,702,165 (−52,235 hr × $90.02/hr).

TABLE 98: Change in Estimated Burden for Promoting Interoperability Performance Category Data Submission

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	250,317
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	198,083
Difference (c) = (b)-(a)	**-52,235**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$22,533,566
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$17,831,402
Difference (f) = (e)-(d)	**-$4,702,165**

We received no public comments related to the burden estimates for submission of data for the Promoting Interoperability performance category. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40867 through 40869) due to availability of updated data.

g. ICRs Regarding the Nomination of Promoting Interoperability (PI) Measures

This rule is not finalizing any new or revised collection of information requirements related to the nomination of Promoting Interoperability measures. However, we are making adjustment to our currently approved burden estimates based on data from the 2019 MIPS performance period. The adjusted burden estimates will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

Consistent with our requests for stakeholder input on quality measures and improvement activities, we also requested potential measures for the Promoting Interoperability performance category that measure patient outcomes, emphasize patient safety, support improvement activities and the quality performance category, and build on the advanced use of CEHRT using 2015 Edition standards and certification criteria. Promoting Interoperability measures may be submitted via the Call for Promoting Interoperability

Performance Category Measures Submission Form that includes the measure description, measure type (if applicable), reporting requirement, and CEHRT functionality used (if applicable). This rule does not propose any changes to that form.

We estimate 10 proposals will be submitted for new Promoting Interoperability measures, based on the number of proposals submitted during the CY 2019 nomination period. This is a decrease of 37 from the estimate currently approved by OMB (47 proposals) under the aforementioned control number and a decrease of 18 from the 28 proposals estimated in the CY 2020 PFS proposed rule due to availability of more recent data (84 FR 40869). We estimate it will take 0.5 hours per organization to submit an activity to us, consisting of 0.3 hours at $109.36/hr for a practice administrator to make a strategic decision to nominate that activity and submit an activity to us via email and 0.2 hours at $202.86/hr for a clinician to review the nomination. As shown in Table 99, we estimate an annual burden of 5 hours (10 proposals × 0.5 hr/response) at a cost of $734 (10 × [(0.3 h × $109.36/hr) + (0.2 hr × $202.86/hr)].

TABLE 99: Estimated Burden for Call for Promoting Interoperability Measures

	Burden Estimate
# of Promoting Interoperability Measure Nominations (a)	10
# of Hours Per Practice Administrator to Identify and Propose Measure (b)	0.30
# of Hours Per Clinician to Identify Measure (c)	0.20
Annual Hours Per Respondent (d)= (b) + (c)	0.50
Total Annual Hours (e) = (a)*(d)	**5**
Cost to Identify and Submit Measure (@ practice administrator's labor rate of $109.36/hr) (f)	$32.81
Cost to Identify Improvement Measure (@ physician's labor rate of $202.86/hr) (g)	$40.57
Total Annual Cost Per Respondent (h)=(f)+(g)	$73.38
Total Annual Cost (i)=(a)*(h)	**$734**

As shown in Table 100, using our unchanged currently approved per respondent burden estimate, the decrease in the number of respondents results in an adjustment of −18.5 hours at a cost of −$2,715 (−37 respondents × 0.5 hr × $73.38 per respondent).

TABLE 100: Change in Estimated Burden for Call for Promoting Interoperability Measures

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	23.5
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	5
Difference (c) = (b)-(a)	**-18.5**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$3,449
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$734
Difference (f) = (e)-(d)	**-$2,715**

BILLING CODE 4120–01–C

We received no public comments related to the burden estimates for the Call for Promoting Interoperability measures. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40869 through 40870) due to availability of updated data.

h. ICRs Regarding Improvement Activities Submission (§§ 414.1305, 414.1355, 414.1360, and 414.1365)

This rule is not finalizing any new or revised collection of information requirements related to the submission of Improvement Activities data. However, we are making adjustments to our currently approved burden estimates based on more recent data. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

As discussed in section III.K.3.c.(3)(d)(iii) of this rule, after consideration of comments received, we are modifying our final policy to state that beginning with the 2020 MIPS performance period and for future years, each improvement activity for which groups and virtual groups submit a ''yes'' response must be performed by at least 50 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable; and the NPIs must perform the same activity during a continuous 90-day period within the same performance year. Because eligible clinicians attest to improvement activities at the group level, there is no impact on reporting burden as a result of this policy.

As previously discussed, beginning with the 2023 MIPS payment year and for future years, we are finalizing to require QCDRs and qualified registries be able to submit data for three performance categories: Quality, improvement activities, and Promoting Interoperability; our discussion of burden for submitting Promoting Interoperability data in section VI.B.7.f.(3) noted our inability to account for the reduction in burden associated with the proposal. Consistent with our decision not to change our per respondent burden estimate to submit

Promoting Interoperability data, we are not changing our per respondent burden estimate to submit improvement activity data as a result of this policy.

Furthermore, as discussed in section III.K.3.c.(3)(e)(i) of this rule, we are finalizing to establish removal factors to consider when proposing to remove improvement activities from the Inventory. However, we do not believe this will affect reporting burden, because respondents will still be required to submit the same number of improvement activities and this policy will not require respondents to submit any additional information. We are also finalizing for the CY 2020 performance period and future years to: Add 2 new improvement activities, modify 7 existing improvement activities, and remove 15 existing improvement activities. Because MIPS eligible clinicians are still required to submit the same number of activities, we do not expect these proposals to affect our currently approved burden estimates. In addition, in order for an eligible clinician or group to receive credit for being a patient-centered medical home or comparable specialty practice, the eligible clinician or group must attest in the same manner as any other improvement activity. In In section III.K.3.c.(3)(d)(iii) of this final rule, we are also finalizing: (1) To modify the definition of rural area; (2) to update § 414.1380(b)(3)(ii)(A) and (C) remove the reference to the four listed accreditation organizations to be recognized as patient-centered medical homes and removing the reference to the specific accrediting organization for comparable specialty practices; and (3) to conclude and remove the CMS Study on Factors Associated with Reporting Quality Measures. Because these policies neither impact the number of respondents nor the time to submit data for the improvement activities performance category, we have made no associated changes to our burden estimate. We discuss the cost reduction associated with concluding the CMS Study on Factors Associated with Reporting Quality Measures in section VII.F.10.d of this final rule

While these finalized policies do not add additional reporting burden, we have adjusted our currently approved burden estimates based on more recent data. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

The CY 2018 Quality Payment Program final rule provides: (1) That for activities that are performed for at least a continuous 90 days during the performance period, MIPS eligible clinicians must submit a ''yes'' response for activities within the Improvement Activities Inventory (82 FR 53651); (2) that the term ''recognized'' is accepted as equivalent to the term ''certified'' when referring to the requirements for a patient-centered medical home to receive full credit for the improvement activities performance category for MIPS (82 FR 53649); and (3) that for the 2020 MIPS payment year and future years, to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice, at least 50 percent of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice (82 FR 53655).

In the CY 2017 Quality Payment Program final rule, we described how we determine MIPS APM scores (81 FR 77185). We compare the requirements of the specific MIPS APM with the list of activities in the Improvement Activities Inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians (81 FR 77817 through 77831). If, based on our assessment, the MIPS APM does not receive the maximum improvement activities performance category score, then the APM Entity can submit additional improvement activities. We anticipate that MIPS APMs in the 2020 MIPS performance period will not need to submit additional improvement activities as the models will already meet the maximum improvement activities performance category score.

A variety of organizations and in some cases, individual clinicians, will submit improvement activity performance category data. For clinicians who are not part of APMs, we assume that clinicians submitting quality data as part of a group through direct, log in and upload submission types, and CMS Web Interface will also submit improvement activities data. In the 2019 and prior MIPS performance periods, individuals and groups submitting data for the quality performance category through a MIPS CQM or QCDR that did not also support reporting of data for the Promoting Interoperability or improvement activity performance categories would be required to submit data for these performance categories using an alternate submission type, the finalized policies discussed in sections III.K.3.g.(3)(a)(i) and III.K.3.g.(4)(a)(i) of this rule requiring qualified registries and QCDRs to be able to submit data for all three of the MIPS performance categories identified in § 414.1400(a)(2) will help to alleviate this issue. As finalized in the CY 2017 Quality Payment Program final rule (81 FR 77264), APM Entities only need to report improvement activities data if the CMS-assigned improvement activities score is below the maximum improvement activities score. Our CY 2018 Quality Payment Program final rule burden estimates assumed that all APM Entities will receive the maximum CMS-assigned improvement activities score (82 FR 53921 through 53922).

As represented in Table 101, based on 2018 MIPS performance period data, we estimate that a total of 103,813 respondents consisting of 86,935 individual clinicians and 16,878 groups will submit improvement activities during the 2020 MIPS performance period; this is an adjustment to the number of respondents from 136,004 to 103,813 (a decrease of 32,191) based on more recent data. This is a decrease of 15,819 individuals and an increase of 1,117 groups from the estimates of 102,754 individuals and 15,761 groups provided in the CY 2020 PFS proposed rule due to availability of more recent data (84 FR 40871). In the CY 2017 and CY 2018 Quality Payment Program final rules, the CY 2019 PFS final rule, the CY 2020 PFS proposed rule, we were required to adjust our respondent estimates to account for MIPS eligible clinicians who we assumed would respond as participants in a virtual group. Because we are now able to base our respondent estimates on data from the 2018 MIPS performance period, which was the first performance period in which clinicians could submit as participants in a virtual group, we are no longer making the adjustment for virtual group participation. In addition, as previously discussed regarding our estimate of clinicians and groups submitting data for the quality and Promoting Interoperability performance categories, we have updated our estimates for the number of clinicians and groups that will submit improvement activities data based on projections of the number of eligible clinicians that were not QPs or members of an APM in the 2018 MIPS performance period but will be in the 2020 MIPS performance period, and will therefore not be required to submit improvement activities data.

Our burden estimates assume there will be no improvement activities burden for MIPS APM participants. We will assign the improvement activities performance category score at the APM Entity level. We also assume that the MIPS APM models for the 2020 MIPS performance period will qualify for the maximum improvement activities performance category score and, as

such, APM Entities will not submit any additional improvement activities.

TABLE 101: Estimated Numbers of Organizations Submitting Improvement Activities Performance Category Data on Behalf of Clinicians

	Count
# of clinicians to participate in improvement activities data submission as individuals during the 2020 MIPS performance period (a)	86,935
# of Groups to submit improvement activities on behalf of clinicians during the 2020 MIPS performance period (b)	16,878
Total # of Respondents (Groups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the 2020 MIPS performance period (CY 2020 Final Rule) (c) = (a) + (b)	103,813
*Total # of Respondents (Groups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the 2019 MIPS performance period (CY 2019 Final Rule) (d)	136,004
Difference (e)=(c)-(d)	**-32,191**

*Currently approved by OMB under control number 0938-1314 (CMS-10621).

Consistent with the CY 2019 PFS final rule, we estimate that the per response time required per individual or group is 5 minutes at $90.02/hr for a computer system analyst to submit by logging in and manually attesting that certain activities were performed in the form and manner specified by CMS with a set of authenticated credentials (83 FR 60016).

As shown in Table 102, we estimate an annual burden of 8,651 hours (103,813 responses × 5 minutes/60) at a cost of $778,771 (8,651 hr × $90.02/hr).

TABLE 102: Estimated Burden for Improvement Activities Submission

	Burden Estimate
Total # of Respondents (Groups, Virtual Groups, and Individual Clinicians) to submit improvement activities data on behalf of clinicians during the 2019 MIPS performance period (a)	103,813
Total Annual Hours Per Respondent (b)	5 minutes
Total Annual Hours (c) = (a)*(b)	**8,651**
Labor rate for a computer systems analyst to submit improvement activities (d)	$90.02/hr
Total Annual Cost (e) = (c)*(d)	**$778,771**

As shown in Table 103, using our unchanged currently approved per respondent burden estimate, the decrease in the number of respondents results in an adjustment of −2,683 hours (−32,191 responses × 5 minutes/60) at a cost of −$241,486 (−2,683 hr $90.02/hr).

TABLE 103: Change in Estimated Burden for Improvement Activities Submission

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	11,334
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	8,651
Difference (c) = (b)-(a)	**-2,683**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$1,020,257
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$778,771
Difference (f) = (e)-(d)	**-$241,486**

We received no public comments related to the burden estimates for submission of data for the Improvement Activities performance category. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40870 through 40872) due to availability of updated data.

i. ICRs Regarding the Nomination of Improvement Activities (§ 414.1360)

This rule is not finalizing any new or revised reporting, recordkeeping, or third-party disclosure requirements related to the nomination of improvement activities. However, we are making adjustments to our currently approved burden estimates based on data from the 2019 MIPS performance period. The adjusted burden estimates will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

In the CY 2018 Quality Payment Program final rule, for the 2018 and future MIPS performance periods, stakeholders were provided an opportunity to propose new activities formally via the Annual Call for Activities nomination form that was posted on the CMS website (82 FR 53657). The 2019 Annual Call for Activities lasted from February 1, 2019 through July 1, 2019, during which we received 31 nominations of new or modified activities which will be evaluated for the Improvement Activities Under Consideration (IAUC) list for possible inclusion in the CY 2020 Improvement Activities Inventory. Based on the number of improvement activity nominations received in the CY 2019 Annual Call for Activities, we estimate that we will receive 31 nominations for the 2020 Annual Call for Activities, which is a decrease of 94 from the 125 nominations currently approved by OMB and a decrease of 97 from the estimate of 128 provided in the CY 2020 PFS proposed rule (84 FR 40872).

We estimate 1.2 hours at $109.36/hr for a practice administrator or equivalent to make a strategic decision to nominate and submit that activity and 0.8 hours at $202.86/hr for a clinician's review. As shown in Table 104, we estimate an annual burden of 62 hours (31 nominations × 2 hr/nomination) at a cost of $9,099 (31 × [(1.2 hr × $109.36/hr) + (0.8 hr × $202.86/hr)]).

TABLE 104: Estimated Burden for Nomination of Improvement Activities

	Burden Estimate
# of Nominations of New Improvement Activities (a)	31
# of Hours Per Practice Administrator to Identify and Propose Activity (b)	1.2
# of Hours Per Clinician to Identify Activity (c)	0.8
Annual Hours Per Respondent (d)= (b) + (c)	2
Total Annual Hours (e) = (a)*(d)	**62**
Cost to Identify and Submit Activity (@ practice administrator's labor rate of $109.36/hr) (f)	$131.23
Cost to Identify Improvement Activity (@ physician's labor rate of $202.86/hr) (g)	$162.29
Total Annual Cost Per Respondent (h)=(f)+(g)	$293.52
Total Annual Cost (i)=(a)*(h)	**$9,099**

As shown in Table 105, using our unchanged currently approved per respondent burden estimate, the decrease in the number of nominations results in an adjustment of −188 hours at a cost of −$27,591 {−94 activities × [(1.2 hr × $109.36/hr) + (0.8 hr × $202.86/hr)]}.

TABLE 105: Change in Estimated Burden for Nomination of Improvement Activities

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	250
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	62
Difference (c) = (b)-(a)	**-188**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$36,690
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$9,099
Difference (f) = (e)-(d)	**-$27,591**

We received no public comments related to the burden estimates for nomination of Improvement Activities. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40872 through 40873) due to availability of updated data.

j. ICRs Regarding the Cost Performance Category (§ 414.1350)

The cost performance category relies on administrative claims data. The Medicare Parts A and B claims submission process (OMB control number 0938–1197; CMS–1500 and CMS–1490S) is used to collect data on cost measures from MIPS eligible clinicians. MIPS eligible clinicians are not required to provide any documentation by CD or hardcopy, including for the 10 episode-based measures we are finalizing to include in the cost performance category as discussed in section III.K.3.c.(2)(b)(iii) of this rule. Moreover, the provisions of this final rule do not result in the need to add or revise or delete any claims data fields. Therefore, we are not finalizing any new or revised collection

of information requirements or burden for MIPS eligible clinicians resulting from the cost performance category.

k. Quality Payment Program ICRs Regarding Partial QP Elections (§§ 414.1310(b)(ii) and 414.1430)

This rule is not finalizing any new or revised collection of information requirements related to the Partial QP Elections to participate in MIPS as a MIPS eligible clinician. However, we are making adjustments to our currently approved burden estimates based on updated projections for the 2020 MIPS performance period. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

In section III.K.4.d.(2)(b), we are finalizing that, beginning for eligible clinicians who become Partial QPs in the 2021 MIPS performance period, Partial QP status will only apply to the TIN/NPI combination through which Partial QP status is attained. Any Partial QP election will only apply to TIN/NPI combination through which Partial QP status is attained so that an eligible clinician who is a Partial QP for only one TIN/NPI combination may still report under MIPS for other TIN/NPI combinations.

As shown in Table 106, based on our predictive QP analysis for the 2020 QP performance period, which accounts for the increase in QP and Partial QP thresholds, we estimate that 12 APM Entities and 2,010 eligible clinicians will make the election to participate as a Partial QP in MIPS representing approximately 15,500 Partial QPs, an increase of 1,941 from the 81 elections currently approved by OMB under the aforementioned control number. We estimate it will take the APM Entity representative or eligible clinician 15 minutes (0.25 hr) to make this election. In aggregate, we estimate an annual burden of 505.5 hours (2,022 respondents × 0.25 hr/election) at a cost of $45,080 (505.5 hours × $90.02/hr).

TABLE 106: Estimated Burden for Partial QP Election

	Burden Estimate
# of respondents making Partial QP election (12 APM Entities, 2010 eligible clinicians) (a)	2,022
Total Hours Per Respondent to Elect to Participate as Partial QP (b)	0.25
Total Annual Hours (c) = (a)*(b)	**505.5**
Labor rate for computer systems analyst (d)	$90.02/hr
Total Annual Cost (e) = (c)*(d)	**$45,505**

As shown in Table 107, using our unchanged currently approved per respondent burden estimate, the increase in the number of Partial QP elections results in an adjustment of 485.25 (1,941 elections × 0.25hr) at a cost of $43,682 (485.25 hr × $90.02/hr).

TABLE 107: Change in Estimated Burden for Partial QP Election

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	20.25
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	505.5
Difference (c) = (b)-(a)	**+485.25**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$1,823
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$45,505
Difference (f) = (e)-(d)	**+$43,682**

We received no public comments related to the burden estimates for Partial QP election. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40873 through 40874) due to availability of updated data.

l. ICRs Regarding Other Payer Advanced APM Determinations: Payer-Initiated Process (§ 414.1445) and Eligible Clinician Initiated Process (§ 414.1445)

As indicated below, the finalized requirements and burden discussed under this section will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

(1) Payer Initiated Process (§ 414.1445)

This rule is not finalizing any new or revised collection of information requirements related to the Payer-Initiated Process. However, we are making adjustments to our currently approved burden estimates based on updated projections for the 2020 MIPS performance period. As mentioned above, the adjusted burden will be submitted to OMB for approval.

As shown in Table 108, based on the actual number of requests received in the 2018 QP performance period, we estimate that in CY 2020 for the 2021 QP performance period 110 payer-initiated requests for Other Payer Advanced APM determinations will be submitted (10 Medicaid payers, 50 Medicare Advantage Organizations, and 50 remaining other payers), a decrease of 105 from the 215 total requests currently approved by OMB under the

aforementioned control number. We estimate it will take 10 hours at $90.02/hr for a computer system analyst per arrangement submission. In aggregate, we estimate an annual burden of 1,100 hours (110 submissions × 10 hr/submission) at a cost of $99,022 (1,100 hr × $90.02/hr).

TABLE 108: Estimated Burden for Other Payer Advanced APM Identification Determinations: Payer-Initiated Process

	Burden Estimate
# of other payer payment arrangements (10 Medicaid, 50 Medicare Advantage Organizations, 50 remaining other payers) (a)	110
Total Annual Hours Per other payer payment arrangement (b)	10
Total Annual Hours (c) = (a)*(b)	**1,100**
Labor rate for a computer systems analyst (d)	$90.02/hr
Total Annual Cost (e) = (c)*(d)	**$99,022**

As shown in Table 109, using our unchanged currently approved per respondent burden estimate, the decrease in the number of payer-initiated requests from 215 to 110 results in an adjustment of −1,050 hours (−105 requests × 10 hr) at a cost of −$94,521 (−1,050 hr × $90.02/hr).

TABLE 109: Change in Estimated Burden for Other Payer Advanced APM Identification Determinations: Payer-Initiated Process

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	2,150
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	1,100
Difference (c) = (b)-(a)	**-1,050**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$193,543
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$99,022
Difference (f) = (e)-(d)	**-$94,521**

We received no public comments related to the burden estimates for the Other Payer Advanced APM Identification Determinations: Payer-Initiated Process. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40874) due to availability of updated data.

(2) Eligible Clinician Initiated Process (§ 414.1445)

This rule is not finalizing any new or revised collection of information requirements or burden related to the Eligible-Clinician Initiated Process. The requirements and burden are currently approved by OMB under control number 0938–1314 (CMS–10621). Consequently, we are not making any changes to the eligible clinician initiated process under that control number.

(3) Submission of Data for QP Determinations Under the All-Payer Combination Option (§ 414.1440)

This rule is not finalizing any new or revised collection of information requirements related to the Submission of Data for QP Determinations under the All-Payer Combination Option. However, we are making adjustments to our currently approved burden estimates based on updated projections for the 2020 MIPS performance period. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

The CY 2017 Quality Payment Program final rule provided that either APM Entities or individual eligible clinicians must submit by a date and in a manner determined by us: (1) Payment arrangement information necessary to assess whether each other payer arrangement is an Other Payer Advanced APM, including information on financial risk arrangements, use of CEHRT, and payment tied to quality measures; (2) for each payment arrangement, the amounts of payments for services furnished through the arrangement, the total payments from the payer, the numbers of patients furnished any service through the arrangement (that is, patients for whom the eligible clinician is at risk if actual expenditures exceed expected expenditures), and (3) the total number of patients furnished any service through the arrangement (81 FR 77480). The rule also specified that if we do not receive sufficient information to complete our evaluation of another payer arrangement and to make QP determinations for an eligible clinician using the All-Payer Combination Option, we will not assess the eligible clinicians under the All-Payer Combination Option (81 FR 77480).

In the CY 2018 Quality Payment Program final rule, we explained that in order for us to make QP determinations under the All-Payer Combination Option using either the payment

amount or patient count method, we will need to receive all of the payment amount and patient count information: (1) Attributable to the eligible clinician or APM Entity through every Other Payer Advanced APM; and (2) for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician during the QP performance period (82 FR 53885). We also finalized that eligible clinicians and APM Entities will not need to submit Medicare payment or patient information for QP determinations under the All-Payer Combination Option (82 FR 53885).

The CY 2018 Quality Payment Program final rule also noted that we will need this payment amount and patient count information for the periods January 1 through March 31, January 1 through June 30, and January 1 through August 31 (82 FR 53885). We noted that the timing may be challenging for APM Entities or eligible clinicians to submit information for the August 31 snapshot date. If we receive information for either the March 31 or June 30 snapshots, but not the August 31 snapshot, we will use that information to make QP determinations under the All-Payer Combination Option. This payment amount and patient count information is to be submitted in a way that allows us to distinguish information from January 1 through March 31, January 1 through June 30, and January 1 through August 31 so that we can make QP determinations based on the two finalized snapshot dates (82 FR 30203 through 30204).

The CY 2018 Quality Payment Program final rule specified that APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination, as well as the payment amount and patient count information sufficient for us to make QP determinations by December 1 of the calendar year that is 2 years to prior to the payment year, which we refer to as the QP Determination Submission Deadline (82 FR 53886).

In the CY 2019 PFS final rule, we finalized the addition of a third alternative to allow QP determinations at the TIN level in instances where all clinicians who have reassigned billing rights to the TIN participate in a single (the same) APM Entity (83 FR 59936). This option will therefore be available to all TINs participating in Full TIN APMs, such as the Medicare Shared Savings Program. It will also be available to any other TIN for which all clinicians who have reassigned billing rights to the TIN are participating in a single APM Entity. To make QP determinations under the All-Payer Combination Option at the TIN level as finalized using either the payment amount or patient count method, we will need to receive, by December 1 of the calendar year that is 2 years to prior to the payment year, all of the payment amount and patient count information: (1) Attributable to the eligible clinician, TIN, or APM Entity through every Other Payer Advanced APM; and (2) for all other payments or patients, except from excluded payers, made or attributed to the eligible clinician(s) during the QP performance period for the periods January 1 through March 31, January 1 through June 30, and January 1 through August 31.

As shown in Table 110, we assume that 20 APM Entities, 448 TINs, and 83 eligible clinicians will submit data for QP determinations under the All-Payer Combination Option in 2019, and increase of 242 from the 309 total submissions currently approved by OMB under the aforementioned control number. We estimate it will take the APM Entity representative, TIN representative, or eligible clinician 5 hours at $109.36/hr for a practice administrator to complete this submission. In aggregate, we estimate an annual burden of 2,755 hours (551 respondents × 5 hr) at a cost of $301,287 (2,755 hr × $109.36/hr).

TABLE 110: Estimated Burden for the Submission of Data for All-Payer QP Determinations

	Burden Estimate
# of APM Entities submitting data for All-Payer QP Determinations (a)	20
# of TINs submitting data for All-Payer QP Determinations (b)	448
# of eligible submitting data for All-Payer QP Determinations (c)	83
Hours Per respondent QP Determinations (d)	5
Total Hours (e)= [(a)*(d)]+[(b)*(d)]+[(c)*(d)]	**2,755**
Labor rate for a Practice Administrator (f)	$109.36/hr
Total Annual Cost (g) = (e)*(f)	**$301,287**

As shown in Table 111, using our unchanged currently approved per respondent burden estimate, the increase in the number of data submissions from 309 to 551 results in an adjustment of 1,210 hours (242 requests × 5 hr) at a cost of $132,326 (1,210 hr × $109.36/hr).

TABLE 111: Change in Estimated Burden for the Submission of Data for All-Payer QP Determinations

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	1,545
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	2,755
Difference (c) = (b)-(a)	**+1,210**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$168,961
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$301,287
Difference (f) = (e)-(d)	**+$132,326**

We received no public comments related to the burden estimates for the submission of data for All-Payer QP Determinations. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40875 through 40876) due to availability of updated data.

m. ICRs Regarding Voluntary Participants Election To Opt-Out of Performance Data Display on Physician Compare (§ 414.1395)

This rule is not finalizing any new or revised collection of information requirements related to the election by voluntary participants to opt-out of public reporting on Physician Compare. However, we are making adjustment to our currently approved burden estimates based on data from the 2018 MIPS performance period. The adjusted burden will be submitted to OMB for approval under control number 0938–1314 (CMS–10621).

We estimate that 10 percent of the total clinicians and groups who will voluntarily participate in MIPS will also elect not to participate in public reporting. This results in a total of 10,042 (0.10 × 100,415 voluntary MIPS participants) clinicians and groups, a decrease of 1,575 from the currently approved estimate of 11,617 and a decrease of 1,474 from the estimate of 11,516 respondents in the CY 2020 PFS proposed rule due to availability of more recent data (84 FR 40876) due to the availability of more recent data. Voluntary MIPS participants are clinicians that are not QPs and are expected to be excluded from MIPS after applying the eligibility requirements set out in the CY 2019 PFS final rule but have elected to submit data to MIPS. As discussed in the RIA section of the CY 2019 PFS final rule, we estimate that 33 percent of clinicians that exceed one (1) of the low-volume criteria, but not all three (3), will elect to opt-in to MIPS, become MIPS eligible, and no longer be considered a voluntary reporter (83 FR 60050).

In section III.K.3.h.(6) of this rule, we are finalizing to publicly report (1) an indicator if a MIPS eligible clinician is scored using facility-based measurement beginning with Year 3 (2019 performance information available for public reporting in late 2020) and (2) aggregate MIPS data beginning with Year 2 (2018 performance information available for public reporting in late 2019). We believe it is possible that the percentage of voluntary participants electing not to participate in public reporting may change as a result of these policies, we lack the ability to predict the behavior of clinicians' response to them. Table 112 shows that for these voluntary participants, we estimate it will take 0.25 hours at $90.02/hr for a computer system analyst to submit a request to opt-out. In aggregate, we estimate an annual burden of 2,511 hours (10,042 requests × 0.25 hr/request) at a cost of $225,995 (2,511 hr × $90.02/hr).

TABLE 112: Estimated Burden for Voluntary Participants to Elect Opt Out of Performance Data Display on Physician Compare

	Burden Estimate
# of Voluntary Participants Opting Out of Physician Compare (a)	10,042
Total Annual Hours Per Opt-out Requester (b)	0.25
Total Annual Hours (c) = (a)*(b)	**2,511**
Labor rate for a computer systems analyst (d)	$90.02/hr
Total Annual Cost (e) = (a)*(d)	**$225,995**

As shown in Table 113, using our unchanged currently approved per respondent burden estimate, the decrease in the number of opt outs by voluntary participants from 11,617 to 10,042 results in an adjustment of 393.75 hours (−1,575 requests × 0.25 hr) at a cost of −$35,445 (−393.75 hr × $90.02/hr).

TABLE 113: Change in Estimated Burden for Voluntary Participants to Elect Opt Out of Performance Data Display on Physician Compare

	Burden Estimate
Total Annual Hours for Respondents in CY 2019 Final Rule (a)	2,904.25
Total Annual Hours for Respondents in CY 2020 Final Rule (b)	2,511
Difference (c) = (b)-(a)	**-393.75**
Total Annual Cost for Respondents in CY 2019 Final Rule (d)	$261,441
Total Annual Cost for Respondents in CY 2020 Final Rule (e)	$225,995
Difference (f) = (e)-(d)	**-$35,445**

We received no public comments related to the burden estimates for voluntary participants to opt-out of performance data display on Physician Compare. The burden estimates have been updated from the CY 2020 PFS proposed rule (84 FR 40876 through 40877) due to availability of updated data.

n. Summary of Annual Quality Payment Program Burden Estimates

Table 114 summarizes this final rule's burden estimates for the Quality Payment Program. To understand the burden implications of the policies finalized in this rule, we have also estimated a baseline burden of continuing the policies and information collections set forth in the CY 2019 PFS final rule into the 2020 MIPS performance period. Our estimated baseline burden estimates reflect the availability of more accurate data to account for all potential respondents and submissions across all the performance categories, more accurately reflect the exclusion of QPs from all MIPS performance categories, and better estimate the number of third-parties likely to self-nominate as qualified registries and QCDRs, as well as the number of measures submitted per QCDR. The baseline burden estimate is 2,932,925 hours at a cost of $279,573,747. This baseline burden estimate is lower than the burden approved for information collection related to the CY 2019 PFS final rule due to updated data and assumptions. The difference of −276 hours and −$23,257 between this baseline estimate and the total burden shown in Tables 114 and 116 is the reduction in burden associated with impacts of finalized policies to require QCDRs to perform measure testing, partially offset by an increase in burden due to finalized policies requiring QCDRs to submit measure testing data and to require quality measures and QCDR measures be linked to existing cost measures, improvement activities, or MIPS Value Pathways, as feasible and applicable at the time of self-nomination.

BILLING CODE 4120–01–P

TABLE 114: Summary of Quality Payment Program Burden Estimates and Requirements

Requirement	Currently Approved Responses*	Finalized Responses	Change in Responses	Currently Approved Total Burden Hours*	Finalized Total Burden Hours	Change in Total Burden Hours
§ 414.1400 Registry self- nomination (see Tables 74 and 75)	150	153	3	450	459	9
§ 414.1400 QCDR self-nomination (see Tables 76 and 77)	200	76	-124	2,400	608	-1,792
§§ 414.1325 and 414.1335 (Quality Performance Category) Medicare Part B Claims Collection Type (see Table 82)	257,260	94,846	-162,414	3,653,092	1,346,813	-2,306,279
§§ 414.1325 and 414.1335 (Quality Performance Category) QCDR/ MIPS CQM Collection Type (see Table 84)	81,981	111,218	29,237	744,633	1,010,193	265,560
§§ 414.1325 and 414.1335 (Quality Performance Category) eCQM Collection Type (see Table 86)	51,861	43,333	-8,528	414,888	346,664	-68,224
§ 414.1325 and 414.1335 (Quality Performance Category) CMS Web Interface (see Table 88)	286	104	-182	17,637.7	6,413.7	-11,224
§§ 414.1325 and 414.1335 (Quality Performance Category) Registration and Enrollment for CMS Web Interface (see Table 90)	67	69	2	16.75	17.25	0.5
(Quality Performance Category) Call for Quality Measures (see Table 92)	140	28	-112	630	154	-476
§ 414.1375 (Promoting Interoperability Performance Category) Reweighting Applications for Promoting Interoperability and Other Performance Categories (see Table 94)	6,041	30,620	24,579	1,510	7,655	6,145
§§ 414.1375 and 414.1380 (Promoting Interoperability Performance Category) Data Submission (see Table 97)	93,869	74,281	-19,588	250,317	198,083	-52,235
(Promoting Interoperability Performance Category) Call for Promoting Interoperability Measures (see Table 99)	47	10	-37	23.5	5	-18.5
§ 414.1360 (Improvement Activities Performance Category) Data Submission (see Table 102)	136,004	103,813	-32,191	11,334	8,651	-2,683
§ 414.1360 (Improvement Activities Performance Category) Nomination of Improvement Activities (see Table 104)	125	31	-94	250	62	-188
§ 414.1430 Partial Qualifying APM Participant (QP) Election (see Tables 106 and 107)	81	2,022	1,941	20.25	505.5	+485.25
§ 414.1440 Other Payer Advanced APM Identification: Payer Initiated Process (see Table 108)	215	110	-105	2,150	1,100	-1,050
§ 414.1440 Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option (see Table 110)	309	551	242	1,545	2,755	1,210
§ 414.1395 (Physician Compare) Opt Out for Voluntary Participants (see Table 112)	11,617	10,042	-1,575	2,904.25	2,511	-393.75
TOTAL	**640,253**	**471,307**	**-168,946**	**5,103,801**	**2,932,649**	**2,171,152**

*Currently approved under OMB control number 0938-1314 (CMS-10621).

Table 115 provides the reasons for changes in the estimated burden for information collections in the Quality Payment Program segment of this final rule. We have divided the reasons for our change in burden into those related to new policies and those related to adjustments in burden from continued Quality Payment Program Year 3 policies that reflect updated data and revised methods.

TABLE 115: Reasons for Change in Burden Compared to the Currently Approved CY 2019 Information Collection Burdens

Quality Payment Program Table	Changes in burden due to CY 2020 Final Rule policies	Adjustments in burden from continued CY 2019 Final Rule policies due to revised methods or updated data
Table 74: Qualified Registry Self-Nomination	None.	Increase in number of respondents due to availability of data from the 2019 self-nomination period.
Table 76: QCDR Self-Nomination	*Decrease in number of QCDR measures (from 9 to 2) submitted for approval due to finalized requirement for QCDRs to perform measure testing.* *Increase of 2 hours (1 hour per proposed measure) per QCDR self-nomination due to finalized policy to require QCDRs to link their QCDR measures as feasible to at least one cost measure, improvement activity, or MIPS Value Pathway.* *Increase of 1 hours (0.5 hour per proposed measure) per QCDR nomination due to finalized policy to require QCDRs to provide measure testing data at the time of self-nomination*	Decrease in number of respondents due to availability of data from the 2019 self-nomination period.
Table 82: Quality Performance Category Medicare Part B Claims Collection Type	None.	Decrease in number of respondents due to use of updated data from the 2018 MIPS performance period and data incorporating limitation on submission of quality data via Medicare Part B claims to small practices.
Table 84: Quality Performance Category QCDR/ MIPS CQM Collection Type	None.	Increase in number of respondents due to use of updated data from the 2018 MIPS performance period and data incorporating limitation on submission of quality data via Medicare Part B claims to small practices, and our assumption that affected clinicians will submit via the MIPS CQM collection type.
Table 86: Quality Performance Category eCQM Collection Type	None.	Decrease in number of respondents due to use of updated data from the 2018 MIPS performance period.
Table 88: Quality Performance Category CMS Web Interface	None.	Decrease in number of respondents due to use of updated data from the 2018 MIPS performance period.

Quality Payment Program Table	Changes in burden due to CY 2020 Final Rule policies	Adjustments in burden from continued CY 2019 Final Rule policies due to revised methods or updated data
Table 90: Registration for CMS Web Interface	None.	Increase in number of respondents due to updated data from the 2019 registration period.
Table 92: Call for Quality Measures	*Increase of 1 hour per measure due to finalized requirement to link nominated measures to existing cost measures or improvement activities.*	Decrease in number of measures submitted due to updated data from the 2019 Call for Quality Measures.
Table 95: Reweighting Applications for Promoting Interoperability and Other Performance Categories	None.	Increase in number of applications submitted due to updated data from the 2019 MIPS performance period.
Table 97: Promoting Interoperability Performance Category Data Submission	None.	Decrease in number of respondents due use of updated data from the 2018 MIPS performance period.
Table 99: Call for Promoting Interoperability Measures	None.	Decrease in number of measures submitted due to updated data from the 2019 Call for Promoting Interoperability Measures.
Table 102: Improvement Activities Submission	None.	Decrease in number of respondents due to use of updated data from the 2018 MIPS performance period.
Table 104: Nomination of Improvement Activities	None.	Decrease in number of activities nominated due to updated data from the 2019 Improvement Activity nomination period.
Table 106: Partial QP Election	None.	Increase in number of respondents due to updated projections for the 2020 MIPS performance period.
Table 108: Other Payer Advanced APM Identification: Other Payer Initiated Process	None.	Increase in number of respondents due to updated projections for the 2020 MIPS performance period.
Table 110: Submission of Data for All-Payer QP Determinations under the All-Payer Combination Option	None.	Increase in number of respondents due to updated projections for the 2020 MIPS performance period.
Table 112: Voluntary Participants to Elect to Opt Out of Performance Data Display on Physician Compare	None.	Decrease in the number of respondents due to use of updated data from the 2018 MIPS performance period.

BILLING CODE 4120–01–C

C. Summary of PRA-Related Requirements and Annual Burden Estimates

A summary of the PRA-related requirements and annual burden estimates is shown in Table 116.

TABLE 116: Annual Requirements and Burden

Regulation Section(s) Under Title 42 of the CFR	OMB Control Number**	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($/hr)	Total Cost ($)*
§§ 403.902 and 403.904 ("Nature of Payment" Categories)***	0938-1237	400	400	5 - 30	5,895	44.92	264,804
		1,600	1,600	2 - 5	7,767	varies	410,941
§§ 403.902 and 403.904 (Standardizing Data Reporting for Covered Drugs, Devices, Biologicals, or Medical Supplies)***	0938-1237	450	450	20 - 100	24,840	44.92	1,115,813
		850	850	10 – 40	21,100	varies	1,013,740
		750	750	2 - 10	5,637	varies	311,384
Medicare Enrollment of Opioid Treatment Programs	0938-0685	633	633	2	1,900	37.50	262,523
Provider Agreement as Part of Enrollment Process	0938-0832-	633	633	0.167	53	varies	12,501
Quality Payment Program (See Subtotal Under Table 115)	0938-1314	343,152	-168,946	varies	-2,171,152	varies	-206,382,840
TOTAL		**384,432**	**-123,919**	**Varies**	**-1,722,544**	**Varies**	**-166,778,034**

* As it relates to the PRA, this rule will not impose any non-labor costs.

**OMB and CMS' PRA package ID numbers: OMB 0938-1237 (CMS-10495), OMB 0938-0685 (CMS-855B), and OMB 0938-1314 (CMS-10621).

***The burden for these changes to the Open Payments program represent one-time system changes.

D. Beneficiary Liability

Many policy changes could result in a change in beneficiary liability as it relates to coinsurance (which is 20 percent of the fee schedule amount, if applicable for the particular provision after the beneficiary has met the deductible). To illustrate this point, as shown in our public use file Impact on Payment for Selected Procedures available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/,* the CY 2019 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new) was $109.92, which means that in CY 2019, a beneficiary would be responsible for 20 percent of this amount, or $21.98. Based on this final rule, using the CY 2020 CF, the CY 2020 national payment amount in the nonfacility setting for CPT code 99203, as shown in the Impact on Payment for Selected Procedures public use file, is $110.43, which means that, in CY 2020, the final beneficiary coinsurance for this service would be $22.09.

VII. Regulatory Impact Analysis

A. Statement of Need

This final rule makes payment and policy changes under the Medicare PFS and implements required statutory changes under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Achieving a Better Life Experience Act (ABLE), the Protecting Access to Medicare Act of 2014 (PAMA), section 603 of the Bipartisan Budget Act of 2015, the Consolidated Appropriations Act of 2016, the Bipartisan Budget Act of 2018, and sections 2005 6063, and 6111 of the SUPPORT for Patients and Communities Act of 2018. This final rule also makes changes to payment policy and other related policies for Medicare Part B.

This final rule is necessary to make policy changes under Medicare fee-for-service. Therefore, we included a detailed Regulatory Impact Analysis (RIA) to assess all costs and benefits of available regulatory alternatives and explained the selection of these regulatory approaches that we believe adhere to statutory requirements and, to the extent feasible, maximize net benefits.

B. Overall Impact

We examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2013), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). An RIA must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimated, as discussed in this section, that the PFS provisions included in this final rule will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking. The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals, practitioners and most other providers and suppliers are small entities, either by nonprofit status or by having annual revenues that qualify for small business status under the Small Business Administration standards. (For details, *see* the SBA's website at *http://www.sba.gov/content/table-small-business-size-standards* (refer to the 620000 series)). Individuals and states are not included in the definition of a small entity.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Approximately 95 percent of practitioners, other providers, and suppliers are considered to be small entities, based upon the SBA standards. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS. Because many of the affected entities are small entities, the analysis and discussion provided in this section, as well as elsewhere in this final rule is intended to comply with the RFA requirements regarding significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. The PFS does not reimburse for services provided by rural hospitals; the PFS pays for physicians' services, which can be furnished by physicians and nonphysician practitioners (NPPs) in a variety of settings, including rural hospitals. We did not prepare an analysis for section 1102(b) of the Act because we determined, and the Secretary certified, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits on state, local, or tribal governments or on the private sector before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2019, that threshold is approximately $154 million. This final rule will impose no mandates on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

Executive Order 13771, entitled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017. We estimate the rule generates $0.61 million in annualized savings in 2016 dollars, discounted at 7 percent relative to year 2016 over a perpetual time horizon. This final rule is still considered an E.O. 13771 regulatory action due to potential unquantified cost. Details on the estimated costs of this rule can be found in the preceding and subsequent analyses.

For the Quality Payment Program, we estimate that between 210,000 and 270,000 clinicians will become Qualifying APM Participants (QPs) and the total lump sum APM Incentive Payments will be approximately $535–685 million in the 2022 Quality Payment Program payment year. We estimate that approximately 880,000 clinicians will be MIPS eligible clinicians for the 2020 MIPS performance period. We estimate that MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments and positive MIPS payment adjustments ($433 million redistributed) to MIPS eligible clinicians, as required by the statute to ensure budget neutrality. Up to an additional $500 million is also available for the 2022 MIPS payment year for additional positive MIPS payment adjustments for exceptional performance. Please refer to section VII.F.10 of this final rule for the full RIA of the Quality Payment Program.

We prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we would use to minimize the burden on small entities. As indicated elsewhere in this final rule, we proposed a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services, and implementing statutory provisions. We provide information for each of the policy changes in the relevant sections of this final rule. We are unaware of any relevant federal rules that duplicate, overlap, or conflict with this final rule. The relevant sections of this final rule contain a description of significant alternatives if applicable.

C. Changes in Relative Value Unit (RVU) Impacts

1. Resource-Based Work, PE, and MP RVUs

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality.

Our estimates of changes in Medicare expenditures for PFS services compared payment rates for CY 2019 with payment rates for CY 2020 using CY 2018 Medicare utilization. The payment impacts in this final rule reflect averages by specialty based on Medicare utilization. The payment impact for an individual practitioner could vary from the average and would depend on the mix of services he or she furnishes. The average percentage change in total revenues will be less than the impact displayed here because practitioners and other entities generally furnish services to both Medicare and non-Medicare patients. In addition, practitioners and other entities may receive substantial Medicare revenues for services under other Medicare payment systems. For instance, independent laboratories receive approximately 83 percent of their Medicare revenues from clinical laboratory services that are paid under the Clinical Laboratory Fee Schedule (CLFS).

The annual update to the PFS conversion factor (CF) was previously calculated based on a statutory formula; for details about this formula, we refer readers to the CY 2015 PFS final rule with comment period (79 FR 67741 through 67742). Section 101(a) of the MACRA repealed the previous statutory update formula and amended section 1848(d) of the Act to specify the update adjustment factors for CY 2015 and beyond. The update adjustment factor for CY 2020, as required by section 1848(d)(19) of the Act, is 0.00 percent before applying other adjustments.

To calculate the CY 2020 CF, we multiplied the product of the current year CF and the update adjustment factor by the budget neutrality adjustment described in the preceding paragraphs. We estimated the CY 2020 PFS CF to be 36.0896 which reflects the budget neutrality adjustment under section 1848(c)(2)(B)(ii)(II) of the Act and the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act. We estimate the CY 2020 anesthesia CF to be 22.2774, which reflects the same overall PFS adjustments with the addition of anesthesia-specific PE and MP adjustments.

TABLE 117—CALCULATION OF THE CY 2020 PFS CONVERSION FACTOR

CY 2019 Conversion Factor		36.0391
Statutory Update Factor	0.00 percent (1.0000)	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Conversion Factor		36.0896

TABLE 118—CALCULATION OF THE CY 2020 ANESTHESIA CONVERSION FACTOR

CY 2019 National Average Anesthesia Conversion Factor		22.2730
Statutory Update Factor	0.00 percent (1.0000)	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	−0.46 percent (0.9954)	
CY 2020 Conversion Factor		22.2016

Table 119 shows the payment impact on PFS services of the policies contained in this final rule. To the extent that there are year-to-year changes in the volume and mix of services provided by practitioners, the actual impact on total Medicare revenues will be different from those shown in Table 119 (CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty). The following is an explanation of the information represented in Table 119.

- *Column A (Specialty):* Identifies the specialty for which data are shown.
- *Column B (Allowed Charges):* The aggregate estimated PFS allowed charges for the specialty based on CY 2018 utilization and CY 2019 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.
- *Column C (Impact of Work RVU Changes):* This column shows the estimated CY 2020 impact on total allowed charges of the changes in the work RVUs, including the impact of changes due to potentially misvalued codes.
- *Column D (Impact of PE RVU Changes):* This column shows the estimated CY 2020 impact on total allowed charges of the changes in the PE RVUs.
- *Column E (Impact of MP RVU Changes):* This column shows the estimated CY 2020 impact on total allowed charges of the changes in the MP RVUs.
- *Column F (Combined Impact):* This column shows the estimated CY 2020 combined impact on total allowed charges of all the changes in the previous columns. Column F may not equal the sum of columns C, D, and E due to rounding.

BILLING CODE 4120–01–P

TABLE 119: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$237	0%	0%	0%	0%
Anesthesiology	$2,002	0%	0%	0%	0%
Audiologist	$71	0%	1%	0%	1%
Cardiac Surgery	$281	-1%	-1%	0%	-2%
Cardiology	$6,618	0%	0%	0%	0%
Chiropractor	$756	0%	0%	-1%	-1%
Clinical Psychologist	$793	1%	2%	0%	3%
Clinical Social Worker	$787	0%	3%	0%	4%
Colon And Rectal Surgery	$163	0%	1%	0%	1%
Critical Care	$349	0%	0%	0%	0%
Dermatology	$3,550	0%	1%	-1%	0%
Diagnostic Testing Facility	$703	0%	-3%	0%	-3%
Emergency Medicine	$3,035	1%	0%	1%	1%
Endocrinology	$490	0%	0%	0%	0%
Family Practice	$6,056	0%	0%	0%	0%
Gastroenterology	$1,721	0%	0%	-1%	0%
General Practice	$410	0%	0%	0%	0%
General Surgery	$2,047	0%	0%	0%	0%
Geriatrics	$188	0%	0%	0%	0%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,678	0%	0%	0%	0%
Independent Laboratory	$597	0%	1%	0%	1%
Infectious Disease	$643	0%	0%	0%	0%
Internal Medicine	$10,581	0%	0%	0%	0%
Interventional Pain Mgmt	$890	0%	1%	0%	1%
Interventional Radiology	$434	0%	-2%	0%	-1%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,176	0%	0%	0%	0%
Neurology	$1,512	-1%	-1%	0%	-2%
Neurosurgery	$807	0%	0%	-1%	0%
Nuclear Medicine	$50	0%	1%	0%	1%
Nurse Anes / Anes Asst	$1,297	0%	0%	0%	0%
Nurse Practitioner	$4,532	0%	0%	0%	0%
Obstetrics/Gynecology	$624	0%	1%	0%	1%
Ophthalmology	$5,413	-2%	-2%	0%	-4%
Optometry	$1,335	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	$72	0%	0%	-1%	-1%
Orthopedic Surgery	$3,750	0%	1%	0%	1%
Other	$35	0%	0%	0%	0%
Otolaryngology	$1,230	0%	0%	0%	0%
Pathology	$1,212	0%	0%	0%	0%
Pediatrics	$64	0%	0%	0%	0%
Physical Medicine	$1,117	0%	0%	0%	1%
Physical/Occupational Therapy	$4,273	0%	0%	0%	0%
Physician Assistant	$2,650	0%	0%	0%	0%
Plastic Surgery	$373	0%	0%	0%	0%
Podiatry	$2,017	0%	1%	0%	2%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Portable X-Ray Supplier	$96	0%	0%	0%	0%
Psychiatry	$1,134	0%	1%	0%	1%
Pulmonary Disease	$1,665	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,762	0%	0%	0%	0%
Radiology	$4,995	0%	0%	0%	0%
Rheumatology	$536	0%	0%	0%	0%
Thoracic Surgery	$355	-1%	0%	0%	-1%
Urology	$1,745	0%	1%	0%	1%
Vascular Surgery	$1,211	0%	-2%	0%	-2%
TOTAL	**$93,487**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.

BILLING CODE 4120–01–C

2. CY 2020 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty impacts of the RVU changes are generally related to the changes to RVUs for specific services resulting from the misvalued code initiative, including RVUs for new and revised codes. The estimated impacts for some specialties, including clinical social workers, podiatry, urology, and obstetrics/gynecology reflect increases relative to other physician specialties. These increases can largely be attributed to finalized increases in value for particular services following the recommendations from the American Medical Association (AMA)'s Relative Value Scale Update Committee and CMS review, increased payments as a result of finalized updates to supply and equipment pricing, and the continuing implementation of the adjustment to indirect PE allocation for some office-based services.

The estimated impacts for several specialties, including ophthalmology and optometry, reflect decreases in payments relative to payment to other physician specialties as a result of revaluation of individual procedures reviewed by the AMA's relative value scale update committee (RUC) and CMS. The estimated impacts for other specialties, including vascular surgery, reflect decreased payments as a result of continuing implementation of the previously finalized updates to supply and equipment pricing. The estimated impacts also reflect decreased payments due to continued implementation of previously finalized code-level reductions that are being phased-in over several years. We also note that the estimated impact for the neurology specialty is decreasing as compared to the proposed impacts due to the decision to finalize contractor pricing for some of the new long term EEG monitoring services. For independent laboratories, it is important to note that these entities receive approximately 83 percent of their Medicare revenues from services that are paid under the CLFS. As a result, the estimated 1 percent increase for CY 2020 is only applicable to approximately 17 percent of the Medicare payment to these entities.

We often receive comments regarding the changes in RVUs displayed on the specialty impact table (Table 119), including comments received in response to the proposed rates. We remind stakeholders that although the estimated impacts are displayed at the specialty level, typically the changes are driven by the valuation of a relatively small number of new and/or potentially misvalued codes. The percentages in Table 119 are based upon aggregate estimated PFS allowed charges summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty, and compared to the same summed total from the previous calendar year. Therefore, they are averages, and may not necessarily be representative of what is happening to the particular services furnished by a single practitioner within any given specialty.

b. Impact

Column F of Table 119 displays the estimated CY 2020 impact on total allowed charges, by specialty, of all the RVU changes. A table showing the estimated impact of all of the changes on total payments for selected high volume procedures is available under ''downloads'' on the CY 2020 PFS final rule website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/*. We selected these procedures for sake of illustration from among the procedures most commonly furnished by a broad spectrum of specialties. The change in both facility rates and the nonfacility rates are shown. For an explanation of facility and nonfacility PE, we refer readers to Addendum A on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/*.

c. Estimated Impacts Related to Changes for Office/Outpatient E/M Services for CY 2021

Although we did not propose changes to E/M coding and payment for CY 2020, we proposed certain changes for CY 2021. In the proposed rule, we displayed an impact table that illustrated the specialty level impact associated with implementing the proposed changes to the office/outpatient E/M code set in CY 2020, rather than CY 2021. Table 120 reflects that we are finalizing as proposed.

We believe these estimates provide insight into the magnitude of potential changes for certain physician specialties but note that Table 120 does not take into account other changes to payment rates finalized for CY 2020 and should be considered for illustrative purposes only. Furthermore, as the CY 2021 impact of the revalued office/outpatient E/M code set will be inclusive of policies finalized in that year's rulemaking, we believe it would be premature to provide updated impacts for CY 2020. Table 120 illustrates the estimated specialty level impacts associated with finalizing the work values for the office/outpatient E/M codes, as well as the revalued HCPCS add-on G-code for primary care and certain types of specialty visits as proposed for CY 2020, exclusive of any other changes finalized for CY 2020.

BILLING CODE 4120–01–P

TABLE 120: Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	$236	4%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-7%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-8%
Cardiology	$6,595	2%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-7%	0%	0%	-7%
Clinical Social Worker	$781	-7%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	-1%	-1%	-4%
Critical Care	$346	-5%	-1%	0%	-6%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	-1%	-4%	0%	-4%
Emergency Medicine	$3,021	-6%	-2%	1%	-7%
Endocrinology	$488	11%	5%	1%	16%
Family Practice	$6,019	8%	4%	1%	12%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	2%	1%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	8%	4%	1%	12%
Independent Laboratory	$592	-3%	-1%	0%	-4%
Infectious Disease	$640	-3%	-1%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-3%	-3%	0%	-6%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-4%	0%	0%	-5%
Nurse Anes / Anes Asst	$1,291	-7%	-2%	0%	-9%
Nurse Practitioner	$4,503	5%	3%	0%	8%
Obstetrics/Gynecology	$620	4%	3%	0%	7%
Ophthalmology	$5,398	-4%	-5%	0%	-10%
Optometry	$1,325	-2%	-3%	0%	-5%
Oral/Maxillofacial Surgery	$71	-1%	-1%	-1%	-4%
Orthopedic Surgery	$3,734	-1%	0%	0%	-2%
Other	$34	-3%	-2%	0%	-5%
Otolaryngology	$1,225	3%	2%	0%	5%
Pathology	$1,203	-5%	-3%	-1%	-8%
Pediatrics	$62	3%	2%	0%	6%
Physical Medicine	$1,110	-2%	0%	0%	-2%
Physical/Occupational Therapy	$4,248	-4%	-3%	0%	-8%
Physician Assistant	$2,637	4%	2%	0%	7%
Plastic Surgery	$369	-3%	-1%	-1%	-5%
Podiatry	$1,998	0%	1%	0%	1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Portable X-Ray Supplier	$94	-1%	-3%	0%	-4%
Psychiatry	$1,120	4%	3%	0%	7%
Pulmonary Disease	$1,658	0%	1%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-2%	-2%	0%	-4%
Radiology	$4,971	-5%	-3%	0%	-8%
Rheumatology	$534	9%	5%	1%	15%
Thoracic Surgery	$352	-5%	-2%	-1%	-7%
Urology	$1,739	4%	4%	0%	8%
Vascular Surgery	$1,203	-2%	-3%	0%	-5%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

** Column F May Not Equal The Sum Of Columns C, D, And E Due To Rounding.*

BILLING CODE 4120–01–C

Overall, those specialties that bill higher level established patient visits, such as endocrinology or family practice, see the greatest increases as those codes were revalued higher relative to the rest of the office/outpatient E/M code set. Those specialties that see the greatest decreases are those that do not generally bill office/outpatient E/M visits. Other specialty level impacts are primarily driven by the extent to which those specialties bill using the office/outpatient E/M code set and the relative increases to the particular office/outpatient E/M codes predominantly billed by those specialties. We note that any potential coding changes and recommendations in overall valuation for new and existing codes between the CY 2020 rule and the CY 2021 final rule could impact the actual change in overall RVUs for office/outpatient visits relative to the rest of the PFS. Given the various factors that will be considered by the variety of stakeholders involved in the CPT and RUC processes, we do not believe we can estimate with any degree of certainty what the impact of potential changes might be. We also, note, however, that any changes in coding and payment for these services would be subject to notice and comment rulemaking.

As discussed elsewhere in this section of the final rule, we estimate this approach would lead to burden reduction for practitioners, while allowing a year of preparatory time and time for potential refinement over the next year as we take into account any feedback from stakeholders on these changes.

Comment: We received a number of comments on the impact analysis conducted to show the estimated specialty level impacts associated with implementing the proposed changes to the office/outpatient E/M code family for CY 2020, rather than CY 2021. Overall commenters requested that CMS provide more details as to how the impacts analysis was conducted, particularly the assumptions behind estimated utilization for HCPCS code GPC1X.

Response: For purposes of estimating the specialty level impacts we assumed that the following specialties would bill HCPCS code GPC1X with 100 percent of their office/outpatient E/M visit codes: Family practice, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease. We want to underscore that this was an assumption regarding which specialties are likely to furnish the types of medical care services that serve as the continuing focal point for all needed health care services or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition and is not meant to be prescriptive as to which specialties may bill for this service. As stated earlier, there are no specialty restrictions for billing HCPCS code GPC1X.

We encourage the public to submit additional information and recommendations regarding utilization for HCPCS code GPC1X prior to the February 10th deadline for submission of RUC and stakeholder valuation recommendations to be considered in CY 2021 rulemaking.

D. Effect of Changes Related to Telehealth

As discussed in section II.F. of this final rule, we proposed to add three new codes, HCPCS codes G2086, G2087, and G2088, to the list of Medicare telehealth services for CY 2020. Although we expect these changes to have the potential to increase access to care in rural areas, based on recent telehealth utilization of services already on the list, including services similar to the additions, we estimate there will only be a negligible impact on PFS expenditures from these additions. For example, for services already on the list, they are furnished via telehealth, on average, less than 0.1 percent of the time they are reported overall. The restrictions placed on Medicare telehealth by the statute limit the magnitude of utilization; however, we believe there is value in allowing physicians and patients the greatest flexibility when appropriate.

E. Effect of Changes Related to Physician Supervision for Physician Assistant (PA) Services

As discussed in section II.I of this final rule, we proposed to revise § 410.74(a)(2) such that the statutory physician supervision requirement for PA services at section 1861(s)(2)(K)(i) of the Act would be met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished, with medical direction and appropriate supervision as required by state law in which the services are performed. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to

working with physicians in furnishing their services. This change would substantially align the regulation on physician supervision for PA services at § 410.74(a)(2) with our current regulations on physician collaboration for NP and CNS services at §§ 410.75(c)(3) and 410.76(c)(3). Our finalized policies are responsive to practitioner concerns that Medicare requirement for supervision of PA services may impose a more stringent standard than state laws governing physician supervision of PA services, and suggestions that the current regulatory definition of physician supervision as it applies to PAs could inappropriately restrict the practice of PAs in delivering their professional services to the Medicare population. While we expect that our finalized policies may result in increased administrative flexibility for PAs as they furnish services to patients, we cannot determine the specific impact our revised policies will have on practice business plans and demand for certain levels of clinicians though we expect that any emerging trends may be indicative of the current and expanded role of nonphysician practitioners as members of the medical team.

F. Other Provisions of the Regulation

1. Effect of Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

As discussed in section II.G of this final rule, section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act establishes a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs) for episodes of care beginning on or after January 1, 2020. The Substance Abuse and Mental Health Services Administration (SAMHSA) currently performs regulatory certification of OTPs. Currently, SAMHSA certifies about 1,700 OTPs. They are located predominately in urban areas, tend to be freestanding facilities, and provide a range of services, including medication-assisted treatment (MAT). The payor mix for OTPs currently includes Medicaid, private payors, TRICARE, as well as individual pay patients. The updated total estimated net Medicare and Medicaid impact, including FFS and Medicare Advantage, over 10 years is $1,484,000,000. We note that this estimate has increased compared to the estimate in the proposed rule, to reflect changes in the policies being finalized compared to the proposed policies, including the adoption of add-on codes describing intake activities and periodic assessments. In developing this estimate, it was assumed that the average treatment length would be 12 months in duration and the average rate per week in CY 2020 was assumed to be $220, which is a weighted average of the rates we are finalizing for the bundled payments for treatment with methadone, buprenorphine, and naltrexone and reflects the payment methodology that was finalized for the non-drug component, which sums the rates of similar services paid for under Medicare. It also includes payment for initial and periodic assessments that were added in this final rule. The initial assessment was assumed to be provided once at the beginning of treatment for patients new to the program. For the purpose of this estimate, it was assumed that periodic assessments would occur twice per year. These rates were updated annually by the Medicare Economic Index (MEI), based on our finalized policy.

We assumed that the impact in the first year would be reduced by 50 percent due to potential delays in provider enrollment and necessary investment by providers to transition to Medicare coding and billing systems. Additionally, any change to FFS benefits has an associated impact on payments to Medicare Advantage plans so an adjustment was made to reflect this impact, based on the projected distribution of spending in each year. The estimate also accounts for the impact on the program due to the change in the monthly Part B premium as a result of implementation of this new benefit, which we estimate to increase from approximately $0.09 (9 cents) in 2021 to $0.14 (14 cents) in 2029. The Part B enrollment and MEI assumptions were based on the President's Fiscal Year 2020 Budget baseline that was released in July of 2019. As with all estimates, and particularly those for new separately billable services, this outcome is highly uncertain because the available information on which to base estimates is limited and is not directly applicable to a new Medicare payment. The cost and utilization estimates are based on Medicare and Medicaid claims data for beneficiaries with OUD, together with statistics about the types of services typically furnished at OTPs.

It is difficult for us to predict how coverage of OTP services will specifically affect the market. We anticipate current OTPs may expand access to care for Medicare beneficiaries since they will be able to receive payment from Medicare for services furnished to beneficiaries when they previously were unable to do so. Coverage may also create financial incentives to establish new OTPs. However, since TRICARE, Medicaid, and some private payers already pay for OTP services, it is less clear whether the presence of Medicare payment rates will have any effect on current rates for OTP services or on new rates should additional private coverage be established.

2. Changes to the Ambulance Physician Certification Statement Requirement

This final rule will clarify the requirements at §§ 410.40 and 410.41 regarding the requirements for physician certification and non-physician certification statements and expand the list of staff members who can sign non-physician certification statements. While we believe that clarification of the regulatory provisions associated with physician certification and non-physician certification statements is needed and would be well received by stakeholders, we do not believe that these clarifications would have any substantive monetary or impact the amount of time needed to complete the certification statements. We believe the primary benefit of the clarification would be for providers and suppliers in preparing and submitting the original certification statements. It is feasible the clarification could result in fewer claims being denied. However, hypothetically, these denials are likely a small subset of the ambulance claim denials and those denied for technical PCS issues are likely appealed and overturned.

Moreover, we have examined the impact of expanding the list of individuals who may sign the non-physician certification statement. This added flexibility in accessing additional individuals to sign a non-physician certification statement would be needed only when the physician was unavailable. Thus, while we anticipate that some providers would use the increased flexibility, the precise impact is not calculable.

3. Medicare Ground Ambulance Data Collection System

As discussed in section III.B.2. of this final rule, section 50203(b) of the BBA of 2018 added a new paragraph (17) to section 1834(l) of the Act, which requires the Secretary to develop a data collection system to collect cost, revenue, utilization, and other information determined appropriate with respect to providers and suppliers of ground ambulance services. In

section III.B.4 through III.B.7. of this final rule, we outline the provisions that implement this section, including the data that will be collected through the data collection system, sampling methodology, requirements for reporting data, payment reductions that will apply to ground ambulance providers and suppliers that fail to sufficiently report data and that do not qualify for a hardship exemption, informal review process that will be available to ground ambulance providers and suppliers that are subject to a payment reduction, and our policies for making the data available to the public.

We estimate that ground ambulance providers and suppliers will need to engage in two primary activities with respect to these requirements, both of which will require them to incur cost and burden: Data collection and data reporting. The data collection activity includes: (1) Reviewing instructions to understand the data required for reporting; (2) accessing existing data systems and reports to obtain the required information; (3) obtaining required information from other entities where appropriate; and (4) if necessary, developing processes and systems to collect data that are not currently collected, but that they will be required to report under the data collection system. The data reporting activity includes entering the collected information in the Medicare Ground Ambulance Data Collection Instrument.

To estimate the data collection impact, we assumed that each ground ambulance organization that is selected to submit data for a year would take up to 20 hours to collect the required data, which would include 4 hours to review the instructions and 16 hours to collect the required data. These estimates were informed by our discussions with ambulance organizations during stakeholder engagements and through more in-depth interviews with nine ambulance organizations for the purpose of soliciting feedback on data collection instrument items as described in section III.B.3. and III.B.4. of this final rule. Most participants indicated that they would be able to provide some of the required information with an investment of 1–2 hours and complete information with additional hours to collect the missing data. Many participants indicated that they would need to reach out to other staff at the organization, at contracted organizations (such as billing companies), or at other entities (such as municipal government financial staff for government ambulance organizations) to collect required information that was not in the organization's accounting or billing systems. Some participants indicated that their organization would need to adjust data collection processes or collect new data over the course of a year to ensure that required data was available in the appropriate format prior to submission.

Actual data collection and reporting will vary depending on the mix of employees at sampled ambulance organizations, the staff with available time to dedicate to data collection and data reporting activities at each organization, the staff in different roles that already perform similar activities in each organization, and whether billing services are contracted out or conducted internally.

Because we expect that the staff (by category) that will contribute to data collection and reporting will be highly variable across ground ambulance organizations, we calculated a blended mean wage for the purposes of estimating burden. Table 121 lists the Standard Occupational Classification (SOC) categories contributing to the blended wage, the mean wage for each SOC specific to North American Industry Classification System (NAICS) industry code 621910 (Ambulance Services), and the relative contribution of each SOC to the blended mean. The source mean wage and employment data is from the Bureau of Labor Statistics May 2018 Occupational Employment Statistics data (available from *https://download.bls.gov/pub/time.series/oe/*) for the indicated SOC and NAICS codes, which was most recently available wage and employment data set. We assumed that financial clerks (SOC category 433000) would account for 25 percent of the total data collection and reporting effort, and that six other SOC categories would contribute to the remaining 75 percent (*see* Table 121).

TABLE 121: Estimated Mean Hourly Wages for Occupations Involved in Data Collection

Standard Occupational Classification Category	Mean Hourly Wage ($)	Weight (% Effort)*
Top Executives (111000)	51.49	17%
Other Management Occupations (119000)	39.23	12%
Business and Financial Operations Occupations (130000)	28.60	15%
Secretaries and Administrative Assistants (436010)	18.11	10%
Other Office and Administrative Support Workers (439000)	16.20	10%
Financial Clerks (433000)	18.51	25%
First-Line Supervisors of Office and Administrative Support Workers (431011)	27.92	10%
Blended Mean Hourly Wage	28.91	100%

*Note: Weights may not sum to 100 percent due to rounding. Source: Bureau of Labor Statistics Occupational Employment Statistics, May 2018, available from https://download.bls.gov/pub/time.series/oe/.

In addition, we calculated the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage. Although we recognize that fringe benefits and overhead costs may vary significantly by employer, and that there are different accepted methods for estimating these costs, doubling the mean blended wage rate to estimate total cost is an accepted method to provide a reasonably accurate estimate. Therefore, assuming a mean blended wage of $28.91 for data collection, and assuming the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, we calculated a wage plus benefits estimate of $57.82 per hour of data collection. To calculate at the total data collection cost per sampled ground ambulance organization, we multiplied the time

required for data collection by the burdened hourly wage (20 hours * $57.82/hour) for a total of $1,156.

We discussed several sampling options in section III.B.5. of this final rule. We finalized our proposed sampling rate of 25 percent that would yield an expected 2,690 respondents (based on 2016 data) in the first sample, resulting in a total estimated data collection cost of $3,110,684 (2,690 respondents * $1,156 per respondent).

To estimate the cost of data reporting, we assumed it will require 3 hours to enter, review, and submit information into the proposed web-based data collection system. The estimate of 3 hours was also informed by interviews with nine ambulance organizations to solicit feedback on the data instrument items under consideration. We included time for staff to review the collected data before entering it into the data collection system. We also assumed that staff responsible for reporting the data would have the same blended hourly wage used to estimate data collection costs above ($28.91) as the staff that collected the data. Again, assuming the cost of overhead at 100 percent of the mean hourly wage, we calculated at a wage plus benefits estimate of $57.82. Therefore, we estimate a per-respondent cost for data submission of $173.46 (3 hours * $57.82/hour). To calculate the total cost for data reporting under a 25 percent sampling rate, we multiplied the number of ground ambulance organizations sampled annually by the time required for data entry times the total hourly wage estimate, for a total of $466,603 across all respondents (2,690 respondents * 3 hours * $57.82/hour).

Adding the total data collection and reporting costs yields a total annual impact for ground ambulance organizations of $3,577,287 ($3,110,684 for data collection [2,690 respondents * 20 hours * $57.82/hour] + $466,603 total cost for data submission [2,690 respondents * 3 hours * $57.82/hour]) with a 25 percent sampling rate. Our estimate of total annual impact would be lower at $1,430,649 ($1,244,042 for data collection [1,076 respondents * 20 hours * $57.82/hour] + $186,606 for data submission [1,076 respondents * 3 hours * $57.82/hour]) under a 10 percent sampling rate alternative and higher at $7,153,244 ($6,220,212 for data collection [5,379 respondents * 20 hours * $57.82/hour] + $933,032 for data submission [5,379 respondents * 3 hours * $57.82/hour]) under a 50 percent sampling rate. In all cases, the estimated cost of collecting and reporting data is $1,330 per organization sampled ($1,156 for data collection [20 hours * $57.82/hour] + $173.46 for data submission [3 hours * $57.82/hour]). The per-organization estimate reflects an average. Based on discussions with ambulance organizations to provide feedback on instrument items, we do not anticipate that larger or smaller ambulance organizations in terms of transport volume, costs, or revenue will face systematically more or less burden in data collection or reporting. While larger organizations generally have higher transport volumes, costs, and revenue, and more complex financial arrangements that may increase reporting burden, they also tend to have existing data collection and reporting processes and staff that will reduce the additional effort required to submit the required data. On the other hand, while smaller organizations have less data to collect and report, they may not have current processes in place to begin collecting some required data.

Comment: Two commenters disagreed with our estimate to complete the survey. One commenter stated for smaller organizations, compliance with the proposed cost reporting requirements will take considerably longer than the 20 hours over the course of 12 months estimated by CMS because a lot of the data being sought is not currently collected or sorted. The other commenter stated that the proposed estimate of 20 hours is not valid and should be 40 hours but would not include the time taken by others, such as the dispatcher or medical director, to collect the data. According to the commenter, the volunteer services do not collect a lot of data that is not directly needed for their operations and thus much of this will be new data.

Response: We understand that the length of time it will take to complete the data collection will vary considerably, depending on numerous factors including the organizational structure of the ambulance organization, the existing accounting and cost reporting system, and the size and characteristics of the ambulance organization. For some, the amount of time required will be less than the estimate, and for others, it will be more. The estimate we provided is based on our experience in working with ambulance organizations during the development of the survey, and the time generally required by other programs with similar data collection requirements. We note that the data collection system was designed so that respondents only are required to answer the questions that are relevant for their organization, so for some organizations, the reporting requirements will also be less than for others.

b. Hardship Exemption Process

As discussed in section III.B.7.b. of this final rule, we proposed a process for ground ambulance organizations to request and for CMS to grant hardship exemptions from the 10 percent payment reduction. To request a hardship exemption, we proposed that a ground ambulance organization would be required to complete and submit a request form that we would make available on the Ambulances Services Center website at *https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html.*

We estimate that 25 percent of the total number of ground ambulance organizations will be selected each year as the representative sample to report the required information under the data collection system. That is, 25 percent out of the total 10,758 NPIs, or 2,690 ambulance providers and suppliers.

While we expect that few, if any, ground ambulance organizations will request a hardship exception, we do not have experience in collecting data from ground ambulance organizations that could be used to develop an estimate, so we based our estimate on the total number of organizations being surveyed. As a result, we estimated that a total of 2,690 ground ambulance organizations would apply for a hardship exemption, and that it would take 15 minutes for each of these ground ambulance organizations 15 minutes to complete and submit the request form.

We assumed for purposes of this estimate that the mix of staff responsible for completing this form would have the same blended hourly wage used to estimate the data collection and data reporting costs. We also calculated the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, as we did above. As a result, we estimated that the total cost burden associated with the completion and submission of the hardship exemption request form would be approximately $38,884.

We did not receive any comments on our estimate to complete the hardship exemption form. As we discussed in section III.B.7.b. of this final rule, we are finalizing our proposed process for hardship exemptions.

c. Informal Review Process

As discussed in section III.B.7.c. of this final rule, we proposed a process for a ground ambulance organization to seek an informal review of our determination that it is subject to the 10 percent reduction.

We estimate that a collection of information burden of 15 minutes for a

ground ambulance organization that is requesting an informal review to gather the requested information and send an email to our AMBULANCEODF mailbox.

We used the total number of ambulance organizations that will be surveyed each year to develop our estimates and estimated a total burden of 40,350 minutes (15 × 2,690) or 672.5 hours for 2,690 ground ambulance organizations to complete this process. Taking into account the same blended mean hourly wage and fringe benefits as we did for our other estimates, we estimated that the total for all sampled ground ambulance organizations to gather the requested information and submit the form would be approximately $38,884.

We did not receive any comments on our estimate to collect and submit the information for an informal review. As we discussed in section III.B.7.c. of this final rule, we are finalizing our proposed process to request an informal review.

4. Intensive Cardiac Rehabilitation (ICR)

As discussed in section III.C. of this final rule, we are adding stable, chronic heart failure (CHF) (defined as patient with left ventricular ejection fraction of 35 percent or less and NYHA class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks) to the list of covered conditions for ICR, as well as, the ability for use to use the NCD process to add additional covered conditions for ICR. Heart failure impacts approximately 5.7 million adults, and approximately 80 percent of individuals over age 65 have heart failure. (The majority (86 percent) of Medicare beneficiaries are over age 65.) We estimate 4,560,000 beneficiaries over age 65 have heart failure.

The uptake by beneficiaries has historically been low for CR and ICR. From February 2014 to 2017, after stable CHF was added to the covered conditions for CR, only 439,888 claims were processed for this service with a diagnosis code of CHF. Less than 1 percent of beneficiaries with heart failure utilized CR. Given that the uptake of ICR has been even lower than CR, we expect the same trend (low uptake) for intensive cardiac rehabilitation due to the nature of these programs which entail rehabilitation through lifestyle modification. We conducted a claims analysis that examined claims prior to and after a 2014 NDC that added stable CHF to the list of covered conditions for CR. Prior to the implementation of stable CHF as a covered condition for CR, 1.8 percent of claims for CR included a diagnosis code for CHF. After implementation, 4.7 percent of claims for CR included a diagnosis code for CHF. Therefore, for ICR, which has historically been utilized much less than CR (for example, when all CR and ICR claims are combined, only 1 percent of the claims are for ICR), we anticipate there may be a similar slight percentage increase in claims for ICR for treatment of stable CHF. Assuming a 4.7 percent increase in ICR claims due to adding stable CHF as a covered condition, we estimate an increase of 3,378 claims annually. For 2019, the facility and non-facility prices for CR and ICR are the same, and the average price is $120.93. Therefore, based on our estimated increase in claims, at an average price of $120.93, the estimated total cost of adding stable, chronic heart failure to the list of covered conditions for ICR is estimated at $408,502 annually. From 2010–2017, the median number of ICR visits per calendar year was 18 visits per beneficiary. Therefore, based on our expected increase in the number of claims (3,378), the estimated number of beneficiaries covered would be 187. Based on these estimates, we estimate there will only be a negligible impact on Medicare expenditures by finalizing this rule.

Additionally, we do not anticipate providers currently offering ICR would need to obtain any specialized technology and equipment to treat ICR patients with stable CHF beyond what they would obtain for ICR patients seeking treatment for the existing six covered conditions.

With the finalization of this rule, we now cover the seven cardiac conditions that constitute the vast majority of cardiac conditions that CR and ICR can treat. Due to the breadth of the covered conditions, we do not anticipate the need to use the NCD process to add additional covered conditions to CR and ICR in the near future.

Lastly, while CR and ICR have low utilization at this point in time, an increase in the number of CR and/or ICR providers in underserved areas could result in an increase in utilization due to increased availability/proximity to services. However, we are not able to accurately quantify the number of entities that would seek approval as CR or ICR programs. Additionally, we acknowledge, that the expansion of coverage to ICR could generate attention around the importance of CR/ICR and may increase beneficiary utilization.

5. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs)

In the Medicaid Promoting Interoperability Program, to keep electronic clinical quality measure (eCQM) specifications current and minimize complexity, we proposed to align the eCQMs available for Medicaid EPs in 2020 with those available for MIPS eligible clinicians for the CY 2020 performance period. We are finalizing this proposal as proposed. We anticipate that this alignment will reduce burden for Medicaid EPs by aligning the requirements for multiple reporting programs, and that the system changes required for EPs to implement this change would not be significant, as many EPs are expected to report eCQMs to meet the quality performance category of MIPS and therefore should be prepared to report on those eCQMs for 2020. Not implementing this alignment could lead to increased burden because EPs might have to report on different eCQMs for the Medicaid Promoting Interoperability Program, if they opt to report on newly added eCQMs for MIPS. We expect that this policy will have only a minimal impact on states, by requiring minor adjustments to state systems for 2020 to maintain current eCQM lists and specifications. State expenditures to make any systems changes required as a result of this policy will be eligible for 90 percent Federal financial participation.

For 2020, we proposed to require that Medicaid EPs report on any six eCQMs that are relevant to the EP's scope of practice, including at least one outcome measure, or if no applicable outcome measure is available or relevant, at least one high priority measure, regardless of whether they report via attestation or electronically. This policy would generally align with the MIPS data submission requirement for eligible clinicians using the eCQM collection type for the quality performance category, which is established in § 414.1335(a)(1). If no outcome or high priority measure is relevant to a Medicaid EP's scope of practice, he or she could report on any six eCQMs that are relevant. We are finalizing this policy as proposed. This policy will be a continuation of our policy for 2019 and we believe it will not create new burden for EPs or states.

We also proposed that the 2020 eCQM reporting period for EPs in the Medicaid Promoting Interoperability Program who have demonstrated meaningful use in a prior year would be a minimum of any continuous 274-day period within CY

2020. We proposed to shorten the reporting period from a full calendar year to enable states to take attestations for 2020 as early as October 1, 2020. We noted that we believe this would improve states' flexibility as they move toward the end of the Medicaid Promoting Interoperability Program and the December 31, 2021 statutory deadline to make incentive payments. We explained that we believed that this proposal would create no additional burden for EPs or health IT vendors, as Certified EHR Technology (CEHRT) should be able to run eCQM reports for any number of days and during any time period. The eCQM reporting period would be a minimum and EPs could continue to report on a full calendar year if they wish. As in previous years, we proposed that the 2020 eCQM reporting period for EPs attesting to meaningful use for the first time would be any continuous 90-day period within the calendar year.

After considering the comments we received on this proposal, we are finalizing a continuous 90-day eCQM reporting period for all Medicaid EPs in 2020, rather than requiring a minimum of any continuous 274-day period within CY 2020 for EPs in the Medicaid Promoting Interoperability Program who have demonstrated meaningful use in a prior year. The reporting period is a minimum, and we encourage EPs to report on a longer period if they are able to do so. As discussed above, at section III.D of this final rule, we believe that finalizing a 90-day eCQM reporting period for 2020, as recommended by commenters, instead of the 274-day eCQM reporting period we proposed, is more likely to reduce burden on EPs, health IT vendors, states, and other stakeholders, as compared to a full-year period or the 274-day eCQM reporting period we proposed.

Finally, we proposed to change Medicaid policy for 2021 related to EP Meaningful Use Objective 1, Measure 1 (Conduct or review a security risk analysis (SRA)). We proposed to allow Medicaid EPs to conduct an SRA at any time during CY 2021, even if the EP conducts the SRA after attesting to meaningful use of CEHRT to the state. A Medicaid EP who has not completed an SRA for CY 2021 by the time he or she attests to meaningful use of CEHRT for CY 2021 would be required to attest that he or she will complete the required SRA by December 31, 2021. Currently, this measure must be completed in the same calendar year as the EHR reporting period. This may occur before, during, or after the EHR reporting period, though if it occurs after the EHR reporting period it must occur before the provider attests to meaningful use of CEHRT or before the end of the calendar year, whichever comes first. In practice, this means that EPs do not attest to meaningful use of CEHRT before completing this measure. However, due to the changes we previously made to the EHR and eCQM reporting period timelines for CY 2021, all Medicaid EPs are expected to attest to meaningful use of CEHRT on or before October 31, 2021. Accordingly, if we did not propose to change the deadline for conducting the SRA, Medicaid EPs would no longer have the option of completing an SRA at the end of the calendar year, and would likely have to complete one well before December 2021. If an EP typically conducts the security risk analysis at the end of each year, this timeline could create burden for the EP, and may not be optimal for protecting information security, because it could disrupt the intervals between security risk analyses. We have also heard feedback from health care providers that SRAs are generally conducted for a whole clinic and the current requirement would create burden on non-EP health care providers in 2021. We are finalizing this change as proposed. As noted in the proposed rule, we believe this policy would prevent additional burden for both EPs and non-EP health care providers. We acknowledge that some EPs might experience increased burden due to the risk of recoupments from what we believe would likely be a small minority of EPs who fail to produce sufficient documentation for the SRA. However, we believe this potential additional burden is clearly outweighed by the reduced burden on what we anticipate would be the vast majority of Medicaid EPs that are afforded flexibility to conduct the SRA at any point in the calendar year that aligns with their operational needs.

As also discussed in the proposed rule, this policy could create burden for states, as they might have to adjust their pre-payment and post-payment verification plans and conduct more thorough audits for this meaningful use objective. However, states are already required to conduct adequate oversight of the Medicaid Promoting Interoperability Program, including routine tracking and verification of meaningful use attestations (*see* 42 CFR 495.318(b), 495.332(c), and 495.368), and we did not propose to change that requirement for 2021. We have established at 42 CFR 495.322(b) that 90 percent federal financial participation will be available for state administrative expenditures related to Medicaid Promoting Interoperability Program audits and appeals that are incurred on or before September 30, 2023.

6. Medicare Shared Savings Program

In section III.F.1.b. of this final rule, we summarize certain modifications to the quality measure set used to assess the quality performance of ACOs participating in the Shared Savings Program based on changes made to the CMS Web Interface measures under the Quality Payment Program in section III.I.3.b.(1). Specifically, (1) revisions to the numerator guidance for ACO–17—Preventive Care and Screening: Tobacco use: Screening and Cessation Intervention and maintaining the measure as pay-for-reporting for performance years 2019; and (2) reverting ACO–43—Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) to pay-for-reporting for 2 years (2020 and 2021) to account for a substantive change in the measure.

The net result of these modifications to the Shared Savings Program quality measure set will be a measure set of 23 measures for performance year 2020. These changes will have no impact on the number of measures an ACO is required to report; therefore, there is no expected change in reporting burden for ACOs.

7. Open Payments

a. Expanding the Definition of ''Covered Recipient'' (§§ 403.902, 403.904, and 403.908)

Our initial estimate based on the available information is that there will be approximately $10 million dollar per year in increased burden to reporting entities and the new covered recipient groups for submitting, collecting, retaining, and reviewing data. This estimate is based on existing burden calculations. It assumes that there will be 734,000 new records (~7 percent increase) reported about 205,000 (~33 percent increase) covered recipients.

We also believe there will be costs to reporting entities for updating their systems and reporting processes. However, we are unable to estimate these costs because they will vary depending on the reporting entity's individual circumstances.

As explained in section IV.5. of this final rule, section 6111(c) of the SUPPORT Act states that chapter 35 of title 44 of the U.S. Code, which includes such provisions as the PRA, shall not apply to the changes to the definition of a covered recipient. Therefore, a detailed breakdown is not provided in that section. The above estimates

however, do provide a RIA of this provision.

b. Modification of the ''Nature of Payment'' Categories (§§ 403.902 and 403.904)

We anticipate minor additional costs for system updates associated with our provision to modify the ''nature of payment'' categories. As we indicated in section III.F. of this final rule, said provisions are intended to add clarity. They will not increase the amount of information to be reported. Data already reported to us may simply be reported in a different category. We proposed these changes only to be made prospectively and did *not* propose to have manufactures and GPOs to make changes to previously reported data. This provision would, generally speaking, allow reporting entities to better characterize the nature of a payment and would not constitute a new requirement. Hence, the expected impact is minimal.

c. Standardizing Data Reporting (§§ 403.902 and 403.904)

Approximately 850 entities (approximately 53 percent), have reported a transaction that will require the addition of a device identifier when this final rule is implemented. The total cost of the addition of this new data element cannot be estimated because it would depend on: (1) Whether the entity already tracks this data element and (2) the extent to which the entity would need to update their system to be able to report this data element.

8. OTP Enrollment and Revocation of Physician/Eligible Professional Enrollment for Abusive Part B Prescribing or Patient Harm

i. OTP Enrollment

As stated previously in this final rule, we proposed that OTP providers be required to not only enroll in Medicare, but also to: (1) Pay an application fee at the time of enrollment; and (2) submit a set of fingerprints for a national background check (via FBI Applicant Fingerprint Card FD–258) from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the OTP. The following is a discussion of the associated impacts we estimated in the proposed rule.

a. Application Fee

The application fees for each of the past 3 calendar years (CY) were or are $560 (CY 2017), $569, (CY 2018), and $586 (CY 2019). Consistent with § 424.518, the differing fee amounts were predicated on changes/increases in the Consumer Price Index (CPI) for all urban consumers (all items; United State city average, CPI–U) for the 12-month period ending on June 30 of the previous year. Although we could not predict future changes to the CPI, the fee amounts between 2017 and 2019 increased by an average of $13 per year. We believed this was a reasonable barometer with which to establish estimates (strictly for purposes of the proposed rule) of the fee amounts in the first 3 CYs of this rule (that is, 2020, 2021, and 2022). We thus projected a fee amount of $599 in 2020, $612 for 2021, and $625 for 2022.

Applying these prospective fee amounts to the number of projected applicants in the rule's first 3 years, we estimated a cost to enrollees of $1,058,433 (or 1,767 × $599) in the first year, $41,004 (or 67 × $612) in the second year, and $41,250 (or 66 × $625) in the third year.

b. Fingerprinting

Based on the experiences of the provider community to date, we estimated that it would take each owner (BLS: Top Executives) approximately 2 hours at $123.32/hr to obtain and submit fingerprints. (According to the most recent BLS wage data for May 2018, the mean hourly wage for the general category of ''Top Executives'' is $61.66 (see *http://www.bls.gov/oes/current/oes_nat.htm#43 0000*). With fringe benefits and overhead, the figure is $123.32.)

As mentioned in the preamble of this final rule, SAMHSA statistics indicate that there are currently about 1,677 active OTPs. Of these, approximately 1,585 have full certifications and 92 have provisional certifications.

Although we did not have specific data on the matter, we projected, for purposes of our burden estimates, a total of 1,500 direct or indirect ownership interests in OTP providers that would require the submission of fingerprints over the first 3 years. This 1,500 figure is less than the 1,900 projected applicants (discussed in the ICR section of this rule) in the first 3 years following the final rule's publication because some applicants may have non-profit business structures and, thus, would not have owners. Furthermore, our estimation of individual owners who would qualify to submit fingerprints was based on a sampling of similar provider types, including DMEPOS suppliers (high risk), MDPP suppliers (high risk), rural health clinics (limited risk) and others.

As noted in the preamble to this final rule, however, the only OTPs that will be assigned to the high-risk level of categorical screening (thus requiring the submission of fingerprints) will be those that were not fully and continuously certified by SAMHSA since October 23, 2018. We believe this group represents about one-quarter of all projected OTP applications. Using our previously mentioned per-year projections of the number of enrolling OTPs, we believe that there will be 442 high-risk level applications in the first year, 17 in the second year, and 17 in the third year. (This results in a total of 476 OTPs.) In addition, application of the one-quarter percentage to the above-mentioned universe of 1,500 ownership interests results in a revised figure of 375 (1,500 × 0.25).

Applying these new figures to the aforementioned per year breakdown of applicants, we estimate a first year burden of 698 hours at a cost of $86,077 (698/hr × $123.32/hr). We obtained the 698 hour estimate by first dividing 442 (the number of first-year applicants) by 476, resulting in a figure of 0.93. We then multiplied 0.93 by 375 (the number of ownership interests over the 3-year period) and thereafter by 2 hours.

Applying this same formula, we projected a second-year time estimate of 26 hours (or 0.035 × 375 owners × 2 hr) at a cost of $3,206 (26 hr × $123.32/hr), and a third-year estimate of 26 hours (or 0.035 × 375 applicants × 2 hr) at a cost of $3,206 (26 hr × $123.32/hr). In aggregate, we estimated a burden of 750 hours (698 hr + 26 hr + 26 hr) at a cost of $92,489 ($86,077 + $3,206 + $3,206). When annualized over the 3-year period, we estimated an annual burden of 250 hours (750 hours/3) at a cost of $30,830 ($92,489/3).

c. Conclusion

We received no comments on our proposed estimates regarding application fees and fingerprinting. We are therefore finalizing them, subject to the modification of our fingerprinting projections.

ii. Revocation of Physician/Eligible Professional Enrollment for Improper Part B Prescribing or Patient Harm

As previously discussed in the proposed rule and this final rule, we proposed the following:

- Under existing § 424.535(a)(14), CMS may revoke a physician's or other eligible professional's enrollment if he or she has a pattern or practice of prescribing Part D drugs that:

(i) Is abusive, and/or represents a threat to the health and safety of Medicare beneficiaries; or

(ii) fails to meet Medicare requirements. We proposed to expand the scope of § 424.535(a)(14) to include Part B drugs.

• In new §§ 424.530(a)(15) and 424.535(a)(22), respectively, we proposed that CMS could deny or revoke a physician's or other eligible professional's enrollment if he or she has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm.

Using our current average annual number of revocations for improper Part D prescribing as a barometer, we project that approximately 10 revocations per year will occur due to our expansion of § 424.535(a)(14) to include Part B drugs. Regarding our patient harm provision, we project approximately 5 revocations per year. This is based on our statements in section III.H of this final rule that we will exercise our authority under this provision only in significant and exceptional cases of patient harm. This results in an annual estimated total of 15 revocations for these two provisions. Based on our internal statistics concerning the average annual amount of provider payments, we project a per-revoked provider amount of $50,000. We therefore estimate our combined annual projected savings to the Trust Funds (specifically, monies that would not otherwise be paid to the revoked providers) concerning the abusive Part B prescribing and patient harm revocation provisions to be $750,000 (15 revocations X $50,000) annually. Over 10 years, this results in a total savings of $7.5 million.

9. Deferring to State Scope of Practice Requirements

a. Ambulatory Surgery Centers

Currently, there are approximately 5,800 Medicare-participating ASCs. We are finalizing our proposal with modification at § 416.42(a)(1) to clarify that there are two components to any pre-procedure evaluation and require that, immediately before surgery, a physician must examine the patient to evaluate the risk of the procedure to be performed, and a physician or anesthetist must examine the patient to evaluate the risk of anesthesia for that procedure. We are finalizing this change to reduce ASC compliance burden and provide for patient assessment and care continuity while maintaining patient safety and care. At § 416.42(a)(1)(ii), we will allow an anesthetist or a physician to perform the required pre-surgical anesthesia risk evaluation. We do not believe this modification to the proposed policy affects our estimates.

In total, ASCs provided about 6.4 million services in 2016. We assume that 30 percent of all procedures will utilize the services of a nurse anesthetist instead of a physician to meet this requirement, which reduces the average cost of the examination. We estimate the pre-surgical anesthesia evaluation to take 15 minutes to complete. We are assuming these estimates based on previous experience and conversations with stakeholders.

According to 2018 Bureau of Labor Statistics data, the hourly cost for a physician (including fringe benefits and overhead calculated at 100 percent of the mean hourly wage) is approximately $203 ($51 for 15 minute evaluation), and the hourly cost for a nurse anesthetist is approximately $168 ($42 for 15 minute evaluation). Assuming 1.92 million procedures annually, we can predict a savings of approximately $17.3 million (($51 − $42) × 1.92 million). We have used our best estimate as to the percentage of pre-surgical evaluations by anesthetists overall.

b. Hospice

We are revising § 418.106 to permit hospices to accept orders for drugs from attending physicians who are physician assistants. We do not believe that there are any associated financial impacts for hospices.

10. Changes Due to Updates to the Quality Payment Program

In section III.K. of this final rule, we included our policies for the Quality Payment Program. In this section of the final rule, we present the overall and incremental impacts to the number of expected QPs and associated APM Incentive Payments. In MIPS, we estimate the total MIPS eligible population and the payment impacts by practice size for the 2020 MIPS performance period based on various proposed policies to modify the MIPS final score and the proposed new performance threshold and additional performance threshold. For this RIA, we updated performance period and eligibility data to reflect information submitted in the 2018 MIPS performance period.

a. Estimated APM Incentive Payments to QPs in Advanced APMs and Other Payer Advanced APMs

From 2019 through 2024, through the Medicare Option, eligible clinicians receiving a sufficient portion of Medicare Part B payments for covered professional services or seeing a sufficient number of Medicare patients through Advanced APMs as required to become QPs, for the applicable performance period, will receive a lump-sum APM Incentive Payment equal to 5 percent of their estimated aggregate payment amounts for Medicare covered professional services furnished during the calendar year immediately preceding the payment year. In addition, beginning in payment year 2021, in addition to the Medicare Option, eligible clinicians may become QPs through the All-Payer Combination Option. The All-Payer Combination Option will allow eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs.

The APM Incentive Payment is separate from and in addition to the payment for covered professional services furnished by an eligible clinician during that year. Eligible clinicians who become QPs for a year are exempt from MIPS reporting requirements and payment adjustment. Eligible clinicians who do not become QPs, but meet a lower threshold to become Partial QPs for the year, may elect to report to MIPS and, if they elect to report, would then be scored under MIPS and receive a MIPS payment adjustment. Partial QPs are not eligible to receive the APM Incentive Payment. For the 2020 QP Performance Period, we define Partial QPs to be eligible clinicians in Advanced APMs who collectively have at least 40 percent, but less than 50 percent, of their payments for Part B covered professional services through an APM Entity, or collectively furnish Part B covered professional services to at least 25 percent, but less than 35 percent, of their Medicare beneficiaries through an APM Entity. This MIPS payment adjustment may be positive, negative, or neutral. If an eligible clinician does not attain either QP or Partial QP status, and does not meet any another exemption category, the eligible clinician would be subject to MIPS, would report to MIPS, and would receive the corresponding MIPS payment adjustment.

Beginning in payment year 2026, payment rates for services furnished by clinicians who achieve QP status for a year would be increased each year by 0.75 percent for the year, while payment rates for services furnished by clinicians who do not achieve QP status for the year would be increased by 0.25

percent. In addition, MIPS eligible clinicians would receive positive, neutral, or negative MIPS payment adjustments to payment for their Part B PFS services in a payment year based on performance during a prior performance period. Although the statute establishes overall payment rate and procedure parameters until 2026 and beyond, this impact analysis covers only the fourth payment year (2022 payment year) of the Quality Payment Program.

In section III.K.4.e.(3)(c)(ii) of this final rule, we amended the marginal risk standard finalized in § 414.1420(d)(5) by amending paragraph (d)(5)(i) to provide that in event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the average marginal risk rate across all possible levels of actual expenditures would be used for comparison to the marginal risk rate specified in paragraph (d)(3)(ii) of § 414.1420(d), and we retained the exceptions for large losses and small losses as described in that section. We do not yet have experience with QP and Partial QP Determinations under the All-Payer Combination Option, as the 2019 QP Performance Period is the first year in which eligible clinicians can become QPs or Partial QPs under the All-Payer Combination Option. To date, we have only determined a modest number of payment arrangements from non-Medicare payers that meet the Other Payer Advanced APM criteria. However, we expect this policy may increase the number of arrangements that may meet the Other Payer Advanced APM financial risk criterion.

Based on our analysis there are 21,000 providers within 5 percent of performance year 2020 QP thresholds in Advanced APMs, and therefore, could potentially benefit from participation in Other Payer Advanced APMs. Assuming a static marketplace, there are between 100–150 eligible clinicians that would benefit from the change in the marginal risk requirement at this time (that is, in 2020 QP Performance Period). This is because there are likely to be only a small number of eligible clinicians who both (1) participate in the payment arrangements we determined were not Other Payer Advanced APMs, but will become Other Payer Advanced APMs under the policy, and (2) have QP scores just below the QP threshold. While this number may grow in the future as payers adopt payment arrangements designed to reflect the change in the marginal risk requirement, we anticipate the incremental impact of this policy will have a small impact on the number of clinicians that meet the QP threshold and the total number of payment arrangements that are determined to be Other Payer Advanced APMs for the 2020 QP Performance Period.

Overall, we estimated that for the 2020 QP Performance Period between 210,000 and 270,000 eligible clinicians will become QPs, therefore be excluded from MIPS, and qualify for the lump sum APM incentive payment in Payment Year 2022 based on 5 percent of their Part B allowable charges for covered professional services in the preceding year. These allowable charges for QPs are estimated to be between approximately $10,700 million and $13,700 million in total for the 2020 performance year. The analysis for this final rule used the 2019 second snapshot participation file, and the 2019 third snapshot participation file for the MSSP Basic Level E and MSSP Enhanced models. We estimate that the total lump sum APM Incentive Payments will be approximately $535–685 million for the 2022 Quality Payment Program payment year.

In section VII.F.10.b. of this final rule, we projected the number of eligible clinicians that will be QPs, and thus excluded from MIPS, using several sources of information. First, the projections are anchored in the most recently available public information on Advanced APMs. The projections reflect Advanced APMs that will be operating during the 2020 QP Performance Period, as well as some Advanced APMs anticipated to be operational during the 2020 QP Performance Period. The projections also reflect an estimated number of eligible clinicians that would attain QP status through the All-Payer Combination Option. The following APMs are expected to be Advanced APMs for the 2020 QP Performance Period:

- Next Generation ACO Model, Comprehensive Primary Care Plus (CPC+) Model;
- Comprehensive ESRD Care (CEC) Model (Two-Sided Risk Arrangement);
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative);
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track);
- Oncology Care Model (Two-Sided Risk Arrangements);
- Medicare ACO Track 1+ Model;
- Bundled Payments for Care Improvement Advanced;
- Maryland Total Cost of Care Model (Maryland Care Redesign Program; Maryland Primary Care Program); and
- Medicare Shared Savings Program (Track 2, Basic Track Level E, and the ENHANCED Track).

We used the APM Participant Lists and Affiliated Practitioner Lists, as applicable, (*see* 81 FR 77444 through 77445 for information on the APM Participant Lists and QP determinations) for the Predictive QP determination file for 2019 to estimate QPs, total Part B allowed charges for covered professional services, and the aggregate total of APM incentive payments for the 2020 QP Performance Period. We examined the extent to which Advanced APM participants would meet the QP Thresholds of having at least 50 percent of their Part B covered professional services or at least 35 percent of their Medicare beneficiaries furnished Part B covered professional services through the APM Entity.

We received the following comments on the APM estimates:

Comment: One commenter expressed concern that the RIA estimates similar totals for the number of QPs in performance year 2019 and performance year 2020, reflecting a relatively flat projected growth of QPs in 2020.

Response: In the CY 2020 PFS proposed rule (84 FR 40732), we estimated the number of QPs based on the best data at the time of publication. Our current analysis reflects the most recent participation data as of August 31, 2019 and as a result our projections indicate an increase in the number of QPs for PY2020.

As a result of the availability of more recent data, we have updated our calculations in this final rule and estimate that for the 2020 QP Performance Period between 210,000 and 270,000 eligible clinicians will become QPs.

b. Estimated Number of Clinicians Eligible for MIPS Eligibility

(1) Methodology To Assess MIPS Eligibility

(a) Clinicians Included in the Model Prior to Applying the Low-Volume Threshold Exclusion

To estimate the number of MIPS eligible clinicians for the 2020 MIPS performance period in this final rule, our scoring model used a combination of the first determination period from the 2019 MIPS performance period (from October 1, 2017 to September 30, 2018) and data from the end of calendar year 2018 (from October 1, 2018 to December 31, 2018). The first determination period from the 2019 MIPS performance period eligibility file was selected as it includes several eligibility files changes that affect the Quality Payment Program moving forward. The rationale for including the data from the end of CY 2018 was to create a 15-month window for assigning

MIPS eligible clinicians as we finalized in the CY 2019 PFS final rule (83 FR 59727 through 59730). We included 1.6 million clinicians (*see* Table 122) who had PFS claims from October 1, 2017 to December 31, 2018. We excluded from our analysis individual clinicians who were affected by the automatic extreme and uncontrollable policy finalized for the 2018 MIPS performance period/2020 MIPS payment year in the CY 2019 PFS final rule (83 FR 59876) as we are unable to predict how these clinicians would perform in a year where there was no extreme and uncontrollable event.

Clinicians are ineligible for MIPS (and are excluded from MIPS payment adjustment) if they are newly enrolled to Medicare; are QPs; are partial QPs who elect to not participate in MIPS; are not one of the clinician types included in the definition for MIPS eligible clinician; or do not exceed the low-volume threshold as an individual or as a group. Therefore, we excluded these clinicians when calculating those clinicians eligible for MIPS. Due to policy changes the exclusion for participants in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) has been removed.

For the estimated MIPS eligible population for the 2022 MIPS payment year, we restricted our analysis to clinicians who are a physician (as defined in section 1861(r) of the Act); a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act); a certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act); a physical therapist, occupational therapist, speech-language pathologist, audiologist, clinical psychologist, and registered dietitian or nutrition professional as finalized in the CY 2019 PFS final rule (83 FR 60076).

As noted previously, we excluded QPs from our scoring model since these clinicians are not MIPS eligible clinicians. To determine which clinicians in the initial population of 1.6 million should be excluded as QPs, we used the APM Participant List for the first snapshot date for the 2019 QP performance period, supplemented by the most recent 2018 performance period APM participation data for those clinicians not on the 2019 first snapshot list. From this data, we calculated the QP determinations as described in the Qualifying APM Participant definition at § 414.1305 for the 2020 QP performance period. We assumed that all Partial QPs would elect to participate in MIPS and included them in our scoring model and eligibility counts. The projected number of QPs excluded from our model is 163,200. Due to data limitations, we could not identify specific clinicians who may become QPs in the 2020 Medicare QP Performance Period; hence, our model may underestimate or overestimate the fraction of clinicians and allowed charges for covered professional services that will remain subject to MIPS after the exclusions.

We also excluded newly enrolled Medicare clinicians from our model. To identify newly enrolled Medicare clinicians, we used the enrollment date from the 2018 Quality Payment Program performance period data.

(b) Assumptions Related to Applying the Low-Volume Threshold Exclusion

The low-volume threshold policy may be applied at the individual (that is, TIN/NPI) or group (that is, TIN or APM entity) levels based on how data are submitted or at the APM Entity level if the clinician is part of a MIPS APM Entity scored under the APM scoring standard. To determine who among those in the total initial population of 1.6 million is a MIPS APM participant, we used those who are APMs in the 2018 performance period as well as the additional clinicians in the first snapshot date of the 2019 QP performance period. To determine who is a member of a virtual group we used those who are in a virtual group for the 2018 performance period. If a MIPS eligible clinician is determined to not be scored as a MIPS APM or virtual group participant, then their reporting type, that is, group (TIN) or individual (TIN/NPI) is based on their reporting for the CY 2018 MIPS performance period. If no data are submitted by a clinician (TIN/NPI) or the clinician's group (TIN), and the TIN/NPI is not associated with an APM Entity or virtual group during the performance period, then the low-volume threshold is applied at the TIN/NPI level to PFS charges and beneficiary count for the 2019 first determination period. A clinician or group that exceeds at least one but not all three low-volume threshold criteria may become MIPS eligible by electing to opt-in and subsequently submitting data to MIPS, thereby getting measured on performance and receiving a MIPS payment adjustment. Our method of modeling opt-in participation is described later in this section.

Table 122 presents the estimated MIPS eligibility status and the associated PFS allowed charges of clinicians in the initial population of 1.6 million clinicians in the analysis of the 2020 MIPS performance period after using 2018 MIPS performance period data and applying the policies for the 2020 MIPS performance period.

For the purposes of modeling, we made assumptions on group reporting to apply the low-volume threshold. One extreme and unlikely assumption is that no practices elect group reporting, virtual group reporting, or participate in an APM and the low-volume threshold would always be applied at the individual level. Although we believe a scenario in which only these clinicians would participate as individuals is unlikely, this assumption is important because it quantifies the minimum number of MIPS eligible clinicians. For this final rule model, we estimate there were approximately 220,000 clinicians [132] who would be MIPS eligible because they exceed the low volume threshold as individuals and are not otherwise excluded. In Table 122, we identify clinicians under this assumption as having ''required eligibility.''

We anticipate that groups that submitted to MIPS as a group or registered as a virtual group for the CY 2018 MIPS performance period will continue to do so for the CY 2020 MIPS performance period. Using this group assumption and including those identified with MIPS APM entities in our scoring model, we identified 639,004 MIPS eligible clinicians. In Table 122, we identify these clinicians who do not meet the low-volume threshold individually but are anticipated to submit to MIPS as a group, virtual group or MIPS APM as having ''group eligibility.'' Using CY 2018 MIPS performance period data, we can identify group reporting through the submission of improvement activities, Promoting Interoperability, or quality performance category data.

To model the opt-in policy finalized in the CY 2019 PFS final rule (83 FR 59735), we assumed that 33 percent of the clinicians who exceed at least one but not all low-volume threshold criteria and submitted data to CY 2018 MIPS performance period would elect to opt-in to MIPS. We selected a random sample of 33 percent of clinicians without accounting for performance. We believe this assumption of 33 percent opt-in participation is reasonable because some clinicians may choose not to submit data due to performance, practice size, or resources or alternatively, some may submit data, but elect to be a voluntary reporter and not be subject to a MIPS payment

[132] The count of 224,082 MIPS eligible clinicians for required eligibility includes those who participated in MIPS (206,226 MIPS eligible clinicians), as well as those who did not participate (17,856 MIPS eligible clinicians).

adjustment based on their performance. This 33 percent participation assumption is identified in Table 122 as ''Opt-In eligibility''. In this final rule analysis, we estimate an additional 20,644 clinicians would be eligible through this policy for a total MIPS eligible population of approximately 880,000. The leads to an associated $69 billion allowed PFS charges estimated to be included in the 2020 MIPS performance period.

TABLE 122: Description of MIPS Eligibility Status for CY 2022 MIPS Payment Year Using the CY 2020 PFS Assumptions**

		CY 2020 PFS Final Rule estimates	
Eligibility Status	**Predicted Participation Status in MIPS Among Clinicians***	**Number of Clinicians**	**PFS allowed charges ($ in mil)*****
Required eligibility (always subject to a MIPS payment adjustment because individual clinicians exceed the low-volume threshold in all 3 criteria)	Participate in MIPS	201,708	$48,349
	Do not participate in MIPS	18,610	$4,147
Group eligibility (only subject to payment adjustment because clinicians' groups exceed low-volume threshold in all 3 criteria and submit as a group)	Submit data as a group	639,004	$15,426
Opt-In eligibility assumptions (only subject to a positive, neutral, or negative adjustment because the individual or group exceeds the low-volume threshold in at least 1 criterion but not all 3, and they elect to opt-in to MIPS and submit data)	Elect to opt-in and submit data	20,644	$1,019
Total Number of MIPS Eligible Clinicians and the associated PFS allowed charges		**879,966***	68,941
Not MIPS Eligible			
Potentially MIPS Eligible (not subject to payment adjustment for non-participation; could be eligible for one of two reasons: (1) meet group eligibility; or (2) opt-in eligibility criteria)	Do not opt-in; or Do not submit as a group	380,352	$9,069
Below the low-volume threshold (never subject to payment adjustment; both individual and group is below all 3 low-volume threshold criteria)	Not applicable	81,982	$444
Excluded for other reasons (Non-eligible clinician type, newly enrolled, QP)	Not applicable	265,982	$10,980
Total Number of Clinicians Not MIPS Eligible		728,316	20,493
Total Number of Clinicians (MIPS and Not MIPS Eligible)		1,608,282	89,434

* Estimated MIPS Eligible Population

** Table 122 does not include clinicians impacted by the automatic extreme and uncontrollable policy (approximately 20,000 clinicians and $1,672 million in PFS allowed charges). It also does not include excluded eligible clinicians in CPC+ APMs who otherwise would have been MIPS eligible (approximately 765 clinicians and $36 million in PFS allowed charges).

*** Allowed charges estimated using 2017 and 2018 dollars. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount.

There are approximately 380,352 clinicians who are not MIPS eligible, but could be if their practice decides to participate or they elect to opt-in. We describe this group as ''Potentially MIPS eligible''. These clinicians would be included as MIPS eligible in the unlikely scenario in which all group practices elect to submit data as a group and all clinicians that could elect to opt-into MIPS do elect to opt-in. This assumption is important because it quantifies the maximum number of MIPS eligible clinicians. When this unlikely scenario is modeled, we estimate that the MIPS eligible clinician population could be as high as 1.26 million clinicians.

Finally, there are some clinicians who would not be MIPS eligible either because they or their group are below the low-volume threshold on all three criteria (approximately 82,000) or because they are excluded for other reasons (approximately 266,000).

Since eligibility among many clinicians is contingent on submission to MIPS as a group, virtual group, APM participation or election to opt-in, we will not know the number of MIPS eligible clinicians until the submission period for the 2020 MIPS performance period is closed. For this impact analysis, we used the estimated population of 879,966 MIPS eligible clinicians described above.

c. Estimated Impacts on Payments to MIPS Eligible Clinicians

(1) Summary of Approach

In sections III.K.3.c., III.K.3.d. and III.K.3.e. of this final rule, we present several provisions which impact the measures and activities that impact the performance category scores, final score calculation, and the MIPS payment adjustment. We discuss these changes in more detail in section VII.F.10.c.(2) of this RIA as we describe our methodology to estimate MIPS payments for the 2022 MIPS payment year. We note that many of the MIPS policies from the CY 2019 Quality Payment Program final rule were only defined for the 2019 MIPS performance period and 2021 MIPS payment year (including the performance threshold, the additional performance threshold, the policy for redistributing the weights of the performance categories, and many scoring policies for the quality performance category) which precludes us from developing a baseline for the 2020 MIPS performance period and 2022 MIPS payment year if there was no new regulatory action. Therefore, our impact analysis looks at the total effect of the finalized MIPS policies on the MIPS final score and payment adjustment for CY 2020 MIPS performance period/CY 2022 MIPS payment year.

The payment impact for a MIPS eligible clinician is based on the clinician's final score, which is a value determined by their performance in the four MIPS performance categories: Quality, cost, improvement activities, and Promoting Interoperability. As discussed in section VII.F.10.c.(2) of this final rule, we generally used the most recently available data from the Quality Payment Program which is data submitted for the 2018 MIPS performance period.

The estimated payment impacts presented in this final rule reflect averages by practice size based on Medicare utilization. The payment impact for a MIPS eligible clinician could vary from the average and would depend on the combination of services that the MIPS eligible clinician furnishes. The average percentage change in total revenues that clinicians earn would be less than the impact displayed here because MIPS eligible clinicians generally furnish services to both Medicare and non-Medicare patients; this program does not impact payment from non-Medicare patients. In addition, MIPS eligible clinicians may receive Medicare revenues for services under other Medicare payment systems, such as the Medicare Federally Qualified Health Center Prospective Payment System, that would not be affected by MIPS payment adjustment factors.

(2) Methodology To Assess Impact

To estimate participation in MIPS for the CY 2020 Quality Payment Program for this final rule, we generally used 2018 MIPS performance period data. Our scoring model includes the 879,966 estimated number of MIPS eligible clinicians as described in section VII.F.10.b.(1)(b) of this RIA.

To estimate the impact of MIPS on eligible clinicians, we generally used the 2018 MIPS performance period data, including data submitted for the quality, improvement activities, and Promoting Interoperability performance categories, CAHPS for MIPS and CAHPS for ACOs, the total per capita cost measure, Medicare Spending Per Beneficiary (MSPB) clinician measure and other data sets.[133] We calculated a hypothetical final score for the 2020 MIPS performance period/2022 MIPS payment year for each MIPS eligible clinician using score estimates described in this section for quality, cost, Promoting Interoperability, and improvement activities performance categories.

Starting with the 2018 performance period, certain groups could apply to be a virtual group and would be scored as a single group. For our model, we assumed that clinicians who participated as virtual groups for 2018 would continue to be a virtual group for the 2020 performance period.

[133] Data submitted to MIPS for the 2017 MIPS performance period data was used for the improvement score for the quality performance category. We also incorporated some additional data sources when available to represent more current data.

(a) Methodology To Estimate the Quality Performance Category Score

We estimated the quality performance category score using a similar methodology described in the CY 2019 PFS final rule (83 FR 60053 through 60054) with the following modifications that reflect the newly finalized policies for the 2020 MIPS performance period and improvement to our modeling methodology. As discussed in section III.K.3.c.(1)(c)(ii) of this final rule, we increased the data completeness requirement for the CY 2020 performance period from 60 percent to 70 percent. As discussed in section III. K.3.c.(1) of this final rule, we finalized a quality performance category weight of 45 percent for the 2020 MIPS performance period.

We also applied modifications that were previously finalized including the validation process that was finalized in the CY 2017 Quality Payment Program final rule (81 FR 77289 through 77291), applying the topped out scoring cap that was finalized (82 FR 53721 through 53727) to the measures subject to the scoring cap for the 2019 MIPS performance period, and the provisions in section III.K.3.d.(1)(b)(i)(C) of this final rule for benchmarks based on flat percentages to avoid potential inappropriate treatment.

Finally, our model applied the APM scoring standard policies finalized in the CY 2019 PFS final rule (83 FR 59754) as modified by the provisions in section III.K.3.c.(5)(c)(i)(B) of this final rule to MIPS eligible clinicians identified as being scored as a MIPS APM in the eligibility section VII.F.10.b.(1)(b) of this final rule. As described in section III.K.3.c.(5)(c)(i)(B) of this final rule, we will apply a minimum score of 50 percent, or an 'APM Quality Reporting Credit', under the MIPS quality performance category for certain APM entities participating in MIPS. In our model, this 'APM Quality Reporting Credit' was implemented for APM Entities that do not use Web Interface. As described in section III.K.3.c.(5)(c)(i)(A) of this final rule, we calculate an aggregated APM Entity quality performance category score from submitted MIPS data by the participants in an APM Entity not required to use Web Interface.

As described in section VII.F.10.b.(1)(b) of this final rule, we are using the APM Participant List for the first snapshot date for the 2019 QP performance period supplemented by the most recent 2018 performance period APM participation data for those clinicians not on the 2019 first snapshot list, using all available data to identify

who is an APM participant. For this analysis, the only MIPS reported measures available that are reported by a MIPS APM Entity would be the Web Interface measures and CAHPS for ACOs. In the case of MIPS APM entities associated with APMs that require participating entities to report Web Interface measures and CAHPS for ACOs, if the APM Entity existed in 2018, we calculated a score based on the Web Interface submission and CAHPS for ACOs from the 2018 performance period. If the APM Entity did not submit MIPS quality performance data for the 2018 performance period and was participating in the Shared Savings Program, we calculated an aggregate score based on individual submissions similar to how we estimate aggregate scores for MIPS APM entities that are not required to utilize the Web Interface. If the APM Entity is new for 2019 and is associated with an APM that requires participating entities to submit Web Interface measures and CAHPS for ACOs (and therefore did not have the ability to submit Web Interface measures for the 2018 performance period), and the participating clinician was associated with a different APM Entity in 2018 we used the score of the 2018 associated Entity. If that participating clinician was not associated with a different APM Entity in 2018 we used the median Web Interface score because we would anticipate the new APM Entities would report quality using the Web Interface in the future. For the MIPS APMs that do not utilize Web Interface only, we calculated an average quality performance category score based on group and individual submissions and then applied the APM Quality Reporting Credit policy to add 50 percent to the MIPS quality performance category score for APM Entities submitting to MIPS as discussed in section III.K.3.c.(5)(c)(i)(B) of this final rule. All quality performance category scores would be capped at 100 percent after receiving the 50 percent APM Quality Reporting Credit.

(b) Methodology To Estimate the Cost Performance Category Score

In section III.K.3.c.(2) of this final rule, we finalized a cost performance category weight of 15 percent for the 2020 MIPS performance period. In section III.K.3.c(2)(b)(iii) of this final rule, we added 10 episode-based measures to the cost performance category beginning with the 2020 performance period in addition to the 8 episode-based measures finalized in the CY 2019 PFS final rule (83 FR 59767). In section III.K.3.c.(2)(b)(v) of this rule, we included the revised total per capita cost and MSPB clinician measures.

We estimated the cost performance category score using all measures finalized in section III.K.3.c.(2)(b)(viii) of this final rule. The total per capita cost measure performance was estimated based on the revised measure using claims data from October 2016 through September 2017. The MSPB clinician measure performance was estimated based on the revised measure using claims data from January through December of 2017. For the episode-based measures, we used the specifications for the 8 episode-based measures finalized in the CY 2019 PFS final rule (83 FR 35902 through 35903), the specifications for the 10 new episode-based measures discussed in section III.K.3.c.(2)(b)(iii) of this final rule and claims data from January through December of 2017. A limitation of this cost data is that it does not overlap with the 2018 calendar year so we did not have cost measures for clinicians (TIN/NPIs) that newly bill in 2018. Cost measures are scored if the clinicians or groups met or exceed the case volume: 20 For the total per capita cost measure, 35 for MSPB clinician, 10 for procedural episode-based measures, and 20 for acute inpatient medical condition episode-based measures. The cost measures are calculated for both the TIN/NPI and the TIN, except for the lower gastrointestinal hemorrhage measure, which we discussed in section III.K.3.c.(2)(vi)(B) of this final rule to calculate only for groups. For clinicians participating as individuals, the TIN/NPI level score was used if available and if the minimum case volume was met. For clinicians participating as groups, the TIN level score was used, if available, and if the minimum case volume was met. For clinicians with no measures meeting the minimum case requirement, we did not estimate a score for the cost performance category, and the weight for the cost performance category was redistributed according to section III.K.3.c.(2) of this final rule. The raw cost measure scores were mapped to scores on the scale of 1–10, using benchmarks based on all measures that met the case minimum and if the group or clinician exceeded the low-volume threshold during the relevant performance period. For the episode-based cost measures, separate benchmarks were developed for TIN/NPI level scores and TIN level scores. For each clinician, a cost performance category score was calculated as the average of the measure scores available for the clinician.

(c) Methodology To Estimate the Facility-Based Measurement Scoring

As finalized in the CY2019 PFS final rule (83 FR 59856), we determine the eligible clinician's MIPS cost and quality performance category score in facility-based measurement based on Hospital VBP Program Total Performance Score for eligible clinicians or groups who meet the eligibility criteria, which we designed to identify those who primarily furnish services within a hospital. We estimate the facility-based score using the scoring policies finalized in the CY2018 Quality Payment Program final rule (82 FR 53763). In section III.K.3.d.(1)(c) of this final rule, we finalized technical changes for clarity and those changes do not affect the facility-based policies.

We used data for the first determination period for the 2019 performance period to attribute clinicians and groups to hospitals and assign the specific Hospital VBP Program Total Performance Score. If a Hospital VBP Program Total Performance Score could not be assigned to a clinician, in instances in which the attributed facility does not participate in the Hospital VBP program or no facility could be attributed, that clinician was determined as not eligible for facility-based measurement and assumed to participate in MIPS via other methods. We are not requiring eligible clinicians to opt-in to facility-based measurement; it is possible that a MIPS eligible clinician or a group is automatically eligible for facility-based measurement, but they participate in MIPS as an individual or a group. In these cases, we used the higher combined quality and cost performance category score, as reflected in the final score, from facility-based scoring compared to the combined quality and cost performance category score from MIPS submission-based scoring.

(d) Methodology To Estimate the Promoting Interoperability Performance Category Score

We estimated the Promoting Interoperability performance category score using the methodology described in the CY 2019 PFS final rule (83 FR 60055) with the following modifications that reflect the new policies for the 2020 MIPS performance period.

In section III.K.3.c.(4)(d)(i)(B) of this final rule, we modified the Query of PDMP measure to a yes/no response. The Query of PDMP measure was not modeled because the measure was not available in the 2018 MIPS performance period submissions data.

In section III.K.3.c.(4)(f)(iii) of this final rule, we revised the definition of hospital-based MIPS eligible clinician to include groups and virtual groups. We also stated that a hospital-based MIPS eligible clinician under § 414.1305 means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician. In section III.K.3.c.(4)(f)(iv) of this final rule, we discussed accounting for a group or virtual group that meets the definition of a non-patient facing MIPS eligible clinician such that the group or virtual group only has to meet a threshold of more than 75 percent. Also, as described in sections III.K.3.c.(4)(f)(iii) and III.K.3.c.(4)(f)(iv) of this final rule, we assigned a zero percent weight for the Promoting Interoperability performance category for groups defined as hospital-based and non-patient facing, and redistribute the points associated with the Promoting Interoperability performance category to another performance category or categories. Therefore, in our impact analysis model, a group was only assigned a zero percent weight for the Promoting Interoperability performance category and the points for Promoting Interoperability performance category was redistributed if: (1) All the TIN/NPIs were eligible for reweighting as established at § 414.1380(c)(2)(iii) for MIPS eligible clinicians submitting data as a group or virtual group, or 2) the group met the revised definition of a hospital-based MIPS eligible clinician as discussed in section III.K.3.c.(4)(f)(iii) of this final rule or the definition of a non-patient facing MIPS eligible clinician, as discussed in section III.K.3.c.(4)(f)(iv) of this final rule, as defined in § 414.1305. We also incorporated into our model the policy to continue automatic reweighting for NPs, PAs, CNSs and CRNAs, physical therapists, occupational therapist, speech-language pathologists, audiologists, clinical psychologists, and registered dietitians or nutrition professionals as described in sections III.K.3.c.(4)(f)(i) and III.K.3.c.(4)(f)(ii) of this final rule.

In our model, for the APM participants identified in section VII.F.10.b.(1).(b).of this final rule, we simulated MIPS APM Entity scores by using submitted Promoting Interoperability data by groups or individuals that we identified as being in a MIPS APM to calculate an APM Entity score.

All other policies for the Promoting Interoperability performance category described in section III.K.3.c.(4) of this final rule did not impact our modeling methodology for this performance category because either the data were not available in the 2018 MIPS performance period submissions data or the changes reflect the modeling strategy previously used and described in the CY 2019 PFS final rule (83 FR 60055). For example, since the Verify Opioid Treatment Agreement measure was not modeled in the CY 2019 PFS final rule (83 FR 60055) because the measure was not available in the 2017 MIPS performance period submissions data, the removal of this measure did not impact our methodology for this final rule.

This is the first iteration of the model where there are small practice hardship applications, therefore, we only reweighted small practices if they submitted an application and did not submit Promoting Interoperability performance category data.

(e) Methodology To Estimate the Improvement Activities Performance Category Score

We modeled the improvement activities performance category score based on CY 2018 MIPS performance period data and APM participation identified in section VII.F.10.b.(1)(b) of this final rule. In section III.K.3.c.(3)(d)(iii) of this final rule, we increase the minimum number of clinicians in a group or virtual group who are required to perform an improvement activity to 50 percent for the improvement activities performance category beginning with the CY 2020 performance year and future years. We did not incorporate this change into our model because we did not have the information to model this provision. For the APM participants identified in section VII.F.10.b.(1)(b) of this final rule, we assigned an improvement activity performance category score of 100 percent.

Clinicians and groups not participating in a MIPS APM were assigned their CY 2018 MIPS performance period improvement activities performance category score.

(f) Methodology To Estimate the Complex Patient Bonus

In section III.K.3.d.(2)(a) of this final rule, we continued the complex patient bonus for the 2020 MIPS performance period. Consistent with the policy to define complex patients as those with high medical risk or with dual eligibility, our scoring model used the complex patient bonus information calculated for the 2018 performance period data.

(g) Methodology To Estimate the Final Score

As discussed in sections III.K.3.c.(1)(b), III.K.3.c.(2)(a), and summarized in section III.K.3.d.(2)(b) of this final rule, our model assigns a final score for each TIN/NPI by multiplying each performance category score by the corresponding performance category weight, adding the products together, multiplying the sum by 100 points, and adding the complex patient bonus. After adding any applicable bonus for complex patients, we reset any final scores that exceeded 100 points equal to 100 points. For MIPS eligible clinicians who were assigned a weight of zero percent for any performance category, we redistributed the weights according to section III.K.3.d.(2)(b)(iii) of this final rule.

(h) Methodology To Estimate the MIPS Payment Adjustment

As described in the CY 2018 Quality Payment Program final rule (82 FR 53785 through 53787), we applied a hierarchy to determine which final score should be used for the payment adjustment for each MIPS eligible clinician when more than one final score is available (for example if a clinician qualifies for a score for an APM entity and a group score, we select the APM entity score).

We then calculated the parameters of an exchange function in accordance with the statutory requirements related to the linear sliding scale, budget neutrality, minimum and maximum adjustment percentages and additional payment adjustment for exceptional performance (as finalized under § 414.1405), using a performance threshold of 45 points and the additional performance threshold of 85 points (as discussed in sections III.K.3.e.(2) and III.K.3.e.(3) of this final rule). We used these resulting parameters to estimate the positive or negative MIPS payment adjustment based on the estimated final score and the paid amount for covered professional services furnished by the MIPS eligible clinician. We considered other performance thresholds which are discussed in section VII.F.2. of this RIA.

(3) Impact of Payments by Practice Size

Using the assumptions provided above, our model estimates that $433 million would be redistributed through budget neutrality and that $500 million would be distributed to MIPS eligible clinicians that meet or exceed the additional performance threshold. The model further estimates that the maximum positive payment adjustments are 6.2 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance.

Table 123 shows the impact of the payment adjustments by practice size and based on whether clinicians are expected to submit data to MIPS. We estimate that a smaller proportion of clinicians in small practices (1–15 clinicians) who participate in MIPS will receive a positive or neutral payment adjustment compared to larger sized practices. In aggregate, the cohort of clinicians in small practices participating in MIPS and who submit to MIPS receive a 1.0 percent increase in total paid amount, which is lower than the comparative payment increases received by the cohort of MIPS eligible clinicians in larger-sized practices. Table 123 also shows that 92.5 percent of MIPS eligible clinicians that participate in MIPS are expected to receive positive or neutral payment adjustments. We want to highlight that we are using 2018 MIPS performance period submissions data for these calculations, and it is likely that there will be changes that we cannot account for at this time because the performance thresholds increased for the 2020 MIPS performance period to avoid a negative payment adjustment.

The combined impact of negative and positive adjustments and the additional positive adjustments for exceptional performance as a percent of paid amount among those that do not submit data to MIPS was not the maximum negative payment adjustment of 9 percent possible because these clinicians do not all receive a final score of zero. Indeed, some MIPS eligible clinicians that do not submit data to MIPS may receive final scores above zero through performance on the cost performance category, which utilizes administrative claims data and does not require separate data submission to MIPS. Among those who we estimate would not submit data to MIPS, 89 percent are in small practices (15,993 out of 18,017 clinicians who do not submit data). To address participation concerns, we have policies targeted towards small practices including technical assistance and special scoring policies to minimize burden and facilitate small practice participation in MIPS or APMs. We also note this participation data is generally based off participation for the 2018 performance period and that participation may change for the 2020 performance period.

TABLE 123: MIPS Estimated Payment Year 2022 Impact on Total Estimated Paid Amount by Participation Status and Practice Size*[a]

Practice Size*	Number of MIPS eligible clinicians	Percent MIPS Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent MIPS Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent MIPS Eligible Clinicians with Negative Payment Adjustment	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount**
Among those submitting data* **					
1) 1-15	140,825	81.1%	36.2%	18.9%	1.0%
2) 16-24	43,304	87.4%	40.0%	12.6%	1.3%
3) 25-99	199,829	92.0%	40.7%	8.0%	1.4%
4) 100+	477,991	96.5%	50.3%	3.5%	1.8%
Overall	**861,949**	**92.5%**	**45.3%**	**7.5%**	**1.4%**
Among those not submitting data					
1) 1-15	15,993	0.0%	0.0%	100.0%	-8.6%
2) 16-24	663	0.0%	0.0%	100.0%	-8.6%
3) 25-99	904	0.0%	0.0%	100.0%	-8.8%
4) 100+	457	0.0%	0.0%	100.0%	-8.7%
Overall	**18,017**	**0.0%**	**0.0%**	**100.0%**	**-8.6%**

*Practice size is the total number of TIN/NPIs in a TIN.

** 2018 data used to estimate 2020 performance period payment adjustments. Payments estimated using 2018 dollars trended to 2022. The percentage represents the total adjustments after taking all the positive adjustments and subtracting the negative adjustments for all MIPS eligible clinicians in the same respective practice size.

***Includes facility-based clinicians whose quality data is submitted through hospital programs.

We received the following comments about our MIPS impact analysis:

Comment: One commenter raised concerns that scoring policies may inadvertently disadvantage smaller (but not small) groups and individual clinicians, and encouraged CMS to continue analyzing and addressing differences that are found.

Response: We agree on the importance of evaluating the impact of scoring policies that affect payment distributions. Table 123 analyzes the impact of payment redistribution by differing practice sizes. In our analysis, over 80 percent of clinicians in small practices (1–15 clinicians) that submit data to MIPS would receive a positive or neutral adjustment. The table also shows the results for practices of 16 to 25 clinicians.

After consideration of public comments, we have not updated our approach to the estimating the impact of the MIPS payments, however, we did update several data sources.

e. Potential Costs of Compliance With the Promoting Interoperability and Improvement Activities and Cost Performance Categories for Eligible Clinicians

(1) Potential Costs of Compliance With Promoting Interoperability Performance Category

In section III.K.3.c.(4)(d)(i)(B) of this final rule, we allow clinicians and groups to satisfy the optional bonus Query of PDMP measure by submitting a ''yes/no'' attestation, rather than reporting a numerator and denominator. As discussed in the Collection of Information section of this final rule, we are not changing our burden assumptions to account for this policy due to a lack of information regarding the number of clinicians reporting bonus measures combined with our currently approved burden estimates being based only on the reporting of required measures. However, we do believe that for clinicians or groups who report this measure, there will be a reduction in reporting burden compared to what would have been required to submit the measure without this change related to the elimination of the need to perform calculations prior to submitting a numerator and denominator. As data availability allows, we will reassess the inclusion of this burden in the Collection of Information in the future.

In sections III.K.3.g.(3)(a)(i) and III.K.3.g.(4)(a)(i) of this rule, beginning with the 2021 performance period and for future years, we require QCDRs and qualified registries to support three performance categories: Quality, improvement activities, and Promoting Interoperability. In the Collection of Information section, we discussed the potential burden reduction associated with simplifying MIPS reporting for clinicians who currently utilize qualified registries or QCDRs that have not previously offered the ability to report Promoting Interoperability or improvement activity data. We believe it is also possible that some MIPS eligible clinicians may elect to begin utilizing qualified registries or QCDRs as a result this policy and its potential for simplifying their MIPS reporting combined with the benefits of improving the quality of care provided to their patients. We do not have information with which to estimate the number of clinicians who may pursue this option, therefore we cannot quantify the associated costs, cost savings, and benefits consistent with the CY 2018 Quality Payment Program final rule (82 FR 53946).

(2) Potential Costs of Compliance With Improvement Activities Performance Category

In section III.K.3.c.(3)(d)(iii) of this final rule, we are: (1) Modifying the definition of rural area; (2) updating § 414.1380(b)(3)(ii)(A) and (C) removing the reference to the four listed accreditation organizations to be recognized as patient-centered medical homes and removing the reference to the specific accrediting organization for comparable specialty practices; (3) increasing the group reporting threshold to 50 percent; (4) establishing factors to consider for removal of improvement activities from the Inventory; (5) removing 15, modifying seven, and adding two new improvement activities for the 2020 performance period and future years; and (6) concluding and removing the CMS Study on Factors Associated with Reporting Quality Measures.

The finalized proposals to modify the definition of a rural area and to remove references to the four listed accreditation organizations to be recognized as patient-centered medical homes and to the specific accrediting organization for comparable specialty practices will have no financial impact due to the nature of the regulatory changes being finalized.

Given groups' familiarity with the improvement activities in the Improvement Activities Inventory, we believe that a group would find applicable and meaningful activities to complete that are not specific to practice size, specialty, or practice setting and would apply to at least 50 percent of individual MIPS eligible clinicians in the group. Therefore, an increase in the minimum threshold for a group to receive credit for the improvement activities performance category should not present additional complexity or burden. We also anticipate that the vast majority of clinicians performing improvement activities, to comply with existing MIPS policies, would continue to perform the same activities under the policies established in this final rule because previously finalized improvement activities continue to apply for the current and future years unless otherwise modified per rule-making (82 FR 54175). Most of the improvement activities in the Inventory remain unchanged for the 2020 MIPS performance period. Of the activities that are being removed, or modified, many were duplicative which means many clinicians or groups would be able to continue the activity, but it would be reported under a different activity in the Improvement Activities Inventory.

Our provision to establish removal factors for consideration when removing improvement activities from the Improvement Activities Inventory would provide guidance for clinicians or groups on the considerations for the removal of improvement activities and would not present additional burden. The changes to the Improvement Activities Inventory that include the modification, removal, and addition of improvement activities provide clarity, avoid duplication, and provide more options for clinicians to select improvement activities that are appropriate for their clinical practice and would not present additional burden. Furthermore, in this final rule, we end and remove the Study on Factors Associated with Reporting Quality Measures beginning with the 2020 MIPS performance period. In the CY 2019 PFS final rule, we finalized a sample size of 200 clinicians, each of which completed a 15-minute survey both prior to and after submitting MIPS data (83 FR 60058). As a result of ending the study, we estimate a reduction in burden of 100 hours and $20,286 (200 clinicians × 0.5 hours × $202.86).

(3) Potential Costs of Compliance With the Cost Performance Category

We state in section VI.B.7.j of the CY 2020 PFS final rule that there were no submissions required for the cost performance categories, therefore, we did not include any compliance cost associated with that performance category; however, we received the following comments on administrative costs for the cost performance category proposals.

Comment: One commenter noted that in a large multi-specialty organization the number of cost measures could increase administrative burden on clinicians and organizations, to track measures and work to improve performance.

Response: We acknowledge there are administrative burdens and related financial costs associated with each administrative claims measure clinicians, groups, and organizations may choose to monitor. However, because these costs can vary significantly due to organizational size, number of administrative claims measures being reported, volume of clinicians reporting each measure, and the specific methods employed to improve performance, we are unable to provide an estimate of the financial impact each clinician, group, or organization may experience.

As a result of these comments, we are acknowledging that while there is no data collection burden, there may be associated costs for clinicians and group practices to monitor new cost measures; however, we are unable to quantify that impact.

f. Potential Costs of Compliance for Third Party Intermediaries

Based on previously finalized policies in the CY 2017 Quality Payment Program final rule (81 FR 77363 through 77364) and as further revised in the CY 2019 PFS final rule at § 414.1400(a)(2) (83 FR 60088), the current policy is that all third party intermediaries may submit data for any of the three MIPS performance categories quality (except for data on the CAHPS for MIPS survey); improvement activities; and Promoting Interoperability. As previously discussed in section III.K.3.g.(3)(a)(i) and III.K.3.g.(4)(a)(i) of this final rule, we are finalizing changes to § 414.1400(a)(2) to state that beginning with the 2023 MIPS payment year (2021 performance period), QCDRs and qualified registries must be able to submit data for all the MIPS performance categories identified in the regulation. In section III.K.3.g.(1) of this final rule, we further state that we anticipate using the QCDR and qualified registry self-nomination vetting process to assess which of these entities will be subject to the requirement to support reporting the Promoting Interoperability performance category and which third parties could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(1) through (7) or (9). Based on our review of qualified registries and QCDRs approved to submit data for the 2019 MIPS performance period, 70 percent of qualified registries and 72 percent of QCDRs are already able to submit data for the quality, improvement activities, and Promoting Interoperability performance categories. We believe this provision could result in the remaining qualified registries and QCDRs incurring additional costs to upgrade information technology systems in order to make this ability available to clinicians, with less cost incurred by entities who would be subject to an exception for the Promoting Interoperability performance category. However, given that each of these entities and their information technology systems are unique, and there is no method of determining which entities may have already begun the process of developing this ability, we are unable to determine the impact of transitioning from allowing this ability as an option to requiring it. Also, given that the majority of these entities have already begun offering the ability to submit data on behalf of the improvement activities and Promoting Interoperability performance categories, we assume they have done so because they believe the benefits outweigh the costs and is therefore, in their best financial interests to do so.

In section III.K.3.g.(3)(a)(iii) of this final rule, beginning with the 2021 performance period, we require qualified registries and QCDRs to provide the following as part of the performance feedback given at least 4 times a year: Feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure (MIPS quality measure and/or QCDR measure) within the QCDR. We understand that QCDRs can only provide feedback on data they have collected on their clinicians and groups, and realize the comparison would be limited to that data and not reflect the larger sample of those that have submitted on the measure for MIPS, which the QCDR does not have access to. As finalized in the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77367 through 77386 and 82 FR 53812), qualified registries and QCDRs are required to provide feedback on all of the MIPS performance categories that the qualified registry or QCDR reports at least 4 times a year. Given that we did not propose a significant change but are instead modifying and strengthening the existing policy, we do not anticipate a significant increase in cost or effort for Third Party Intermediaries to comply with this provision.

In section III.K.3.g.(3)(c)(i)(B)(cc), we require that in order for a QCDR measure to be considered for use in the program beginning with the 2021 performance period and future years, all QCDR measures submitted for self-nomination must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System, as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures. Beginning with the 2021 performance period and future years, we also require QCDRs to collect data on the potential QCDR measure, appropriate to the measure type, as defined in the CMS Blueprint for the CMS Measures Management System, prior to self-nomination. The testing process for quality measures is dependent on the measure type (for example, a measure that is specified as an eCQM measure has additional steps it must undergo when compared to other measure types). The National Quality Forum (NQF) has developed guides for measure testing criteria and standards which further illustrate these differences based on measure type.[134] Additionally, the costs associated with testing vary based on the complexity of the measure and the developing organization. The Journal of the American Medical Association states that the costs associated with quality measures are generally unknown or unreported.[135] While we understand the policy will result in additional costs for QCDRs to develop measures, given the uncertainty regarding the number and types of measures that will be proposed in future performance periods coupled with the lack of available cost data on measure development and testing, we are unable to determine the financial impact of this provision on QCDRs beyond the likelihood of it being more than trivial. Likewise, we understand that some QCDRs already perform measure testing prior to submission for approval while others do not. This variability makes it difficult to estimate the incremental impact of this regulation.

In section III.K.3.g.(3)(c)(i)(A)(bb)(AA) of this rule, we amend § 414.1400 to state that CMS may consider the extent

[134] *http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx.*

[135] Schuster, Onorato, and Meltzer. ''Measuring the Cost of Quality Measurement: A Missing Link in Quality Strategy'', Journal of the American Medical Association. 2017; 318(13):1219–1220. *https://jamanetwork.com/journals/jama/fullarticle/2653111?resultClick=1.*

to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. Because the choice to license a QCDR measure is an elective business decision made by individual QCDRs and we have little insight into both the specific terms and frequency of agreements made between entities, we are unable to account for the financial impact of licensing QCDR measures for each QCDR. In aggregate across all QCDRs, the financial impact would be zero as fees paid by one QCDR will be collected by another QCDR.

In section III.K.3.g.(3)(c)(i)(B)(ee) of this rule, we discuss, beginning with the 2020 performance period, that after the self-nomination period closes each year, we will review newly self-nominated and previously approved QCDR measures based on considerations as described in the CY 2019 PFS final rule (83 FR 59900 through 59902). In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. The QCDR could do so by harmonizing its measure with, or significantly differentiating its measure from, other similar QCDR measures. QCDR measure harmonization may require two or more QCDRs to work collaboratively to develop one cohesive QCDR measure that is representative of their similar yet, individual measures. We are unable to account for the financial impact of measure harmonization, as the process and outcomes will likely vary substantially depending on a number of factors, including: Extent of duplication with other measures, number of QCDRs involved in harmonizing toward a single measure, and number of measures being harmonized among the same QCDRs. We intend to identify only those QCDR measures which are duplicative to such an extent as to assume harmonization will not be overly burdensome, however, because the harmonization process will occur between QCDRs without our involvement, we are unable to predict or quantify the associated effort.

We understand that some QCDRs may believe the provisions to require measure harmonization and encourage QCDRs to license their measures to other QCDRs as a consideration for measure approval may result in a reduced ability for QCDRs to differentiate themselves in the marketplace. We note that in addition to the suite of measures offered by a QCDR and their relevance to individual clinicians and groups, ease of incorporating a QCDR's measures into existing practice workflows, as well as integration into broader quality improvement programs are two examples of distinguishing characteristics for clinicians to consider when selecting a QCDR. In addition, clinicians may also consider cost (if any); recommendations, support, or endorsements from specialty societies; the number of other users submitting data to the QCDR; the specific educational services and quality improvement initiatives offered; and the specific performance feedback information provided as part of the required reports provided at least 4 times a year. We believe that the impact these provisions may have on the perceived differentiated value of certain QCDRs is counterbalanced by the need to promote more focused quality measure development towards outcomes that are meaningful to patients, families and their providers.

In this final rule, we discussed our policy to formalize a number of factors we would take into consideration for approving and rejecting QCDR measures for the MIPS program beginning with the 2020 performance period and future years. With regard to approving QCDR measures, we are implementing the following: (1) 2-year QCDR measure approval process, and (2) participation plan for existing QCDR measures that have failed to reach benchmarking thresholds.

As discussed in section III.K.3.g.(3)(c)(ii)(B), we are implementing, beginning with the 2021 performance period, 2-year QCDR measure approvals (at our discretion) for QCDR measures that attain approval status by meeting the QCDR measure considerations and requirements described in section III.K.3.g.(3)(c). The 2-year approvals would be subject to the following conditions whereby the multi-year approval will no longer apply if the QCDR measure is identified as: Topped out; duplicative of a new, more robust measure; reflects an outdated clinical guideline; requires measure harmonization, or if the QCDR self-nominating the measure is no longer in good standing. We believe this will result in reduced burden for QCDRs as they will no longer be required to submit each measure for approval annually. However, because we are unable to predict which previously approved QCDR measures will be removed or retained in future years, we are likewise unable to predict the impact on future burden associated with QCDRs submitting measures for approval. Beginning with the 2021 performance period, we require that in instances where an existing QCDR measure has been in MIPS for 2 years and has failed to reach benchmarking thresholds due to low adoption, where the QCDR believes the low-reported QCDR measure is still important and relevant to a specialist's practice, that the QCDR may submit to CMS a QCDR measure participation plan, to be submitted as part of their self-nomination. Because we are unable to predict the frequency with which existing QCDR measures will meet the criteria for allowing QCDRs to submit a measure participation plan or the likelihood of QCDRs electing to submit a plan, we are unable to estimate the impact associated with this provision.

As discussed in section III.K.3.g.(3)(c)(i)(B)(bb) of this final rule, beginning with the 2021 performance period and future years, QCDRs must link their QCDR measures as feasible to the following, at the time of self-nomination: (a) Cost measures (as found in section III.K.3.c.(3) of this final rule), (b) improvement activities (as found in Appendix 2: Improvement Activities Tables), or (c) CMS developed MIPS Value Pathways (as described in section III.K.3.a. of this final rule). We do not assume any additional impact beyond the 1 hour per QCDR measure as discussed in section VI.B.7 of the Collection of Information section of this final rule.

We are also finalizing in section III.K.3.g.(2) of this final rule and at § 414.1400(a)(4) to establish that a condition of approval is for the third party intermediary to agree that prior to discontinuing services to any MIPS eligible clinician, group or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved transition plan. Historically, less than 10 third party intermediaries have elected to discontinue services during a performance period and we have no basis to assume this is likely to change in future years. We do not assume any additional impact beyond the 10 hours per transition plan discussed in section VI.B.7 of this final rule.

We are finalizing in section III.K.3.g.3(c)(i)(A)(bb)(BB) of this final rule to amend § 414.1400 to add paragraph (b)(3)(iv)(I) to state that we would give greater consideration to measures for which QCDRs: (a) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development. We are also finalizing in section III.K.3.g.3(c)(i)(A)(bb)(CC) of this final rule and § 414.1400 to add paragraph (b)(3)(iv)(J), to state that, beginning with the 2020 performance period, we place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. Those that do not meet this requirement, may not continue to be approved. Lastly, we are finalizing in section III.K.3.g.3(c)(i)(B)(aa) of this final rule, beginning with the 2020 performance period, to change both of the below listed considerations into requirements and add paragraph (b)(3)(v) to include the following for QCDR measure requirements for approval: Measures that are beyond the measure concept phase of development; and measures that address significant variation in performance. We do not assume any additional impacts beyond those previously discussed in this section or in the Collection of Information section.

We received public comments on the compliance costs for third party intermediaries. The following is a summary of the comments we received and our responses.

Comment: A few commenters expressed their opinion that the scope of proposals in the proposed rule increases cost and burden to the point where some third-party vendors may end their participation in MIPS. One commenter stated that several provisions would additionally require it to alter business plans, missions, and customer service priorities while another commenter cited their belief that CMS is attempting to shift costs and burden of administering the MIPS program onto specialty societies that create measures and operate QCDRs.

Response: We disagree. We believe that our policies are intended to standardize and raise the bar on the services and the quality of the third-party intermediaries we have in the MIPS program. Similar to years past, the standards and requirements of QCDRs are higher when compared to that of qualified registries, as we expect QCDRs to have extensive experience in quality reporting, quality measure development, and clinical expertise to not just facilitate reporting, but to also help address measurement gaps found within the program. We believe that QCDRs and qualified registries should further clinician goals of quality improvement by providing meaningful information and services. We believe that the increased cost and burden are significantly outweighed by the positive impact of the policies for MIPS eligible clinicians. As a result of the comments, we have not updated our estimates.

g. Assumptions & Limitations

We note several limitations to our estimates of MIPS eligible clinicians' eligibility and participation, negative MIPS payment adjustments, and positive payment adjustments for the 2022 MIPS payment year. We based our analyses on the data prepared to support the 2018 performance period initial determination of clinician and special status eligibility (available via the NPI lookup on *qpp.cms.gov*),[136] APM Participant List for the first snapshot date for the 2019 QP performance period, CY 2018 Quality Payment Program Year 2 data and CAHPS for ACOs. The scoring model results presented in this rule assume that CY 2018 Quality Payment Program Year 2 data submissions and performance are representative of CY 2020 Quality Payment Program data submissions and performance. The estimated performance for CY 2020 MIPS performance period using Quality Payment Program Year 2 data may be underestimated because the performance threshold to avoid a negative payment adjustment for the 2018 MIPS performance period/2019 MIPS payment year was significantly lower (15 out of 100 points) than the performance threshold for the 2020 MIPS performance period/2022 MIPS payment year (45 out of 100). We anticipate clinicians may submit more performance categories to meet the higher performance threshold to avoid a negative payment adjustment.

In our MIPS eligible clinician assumptions, we assumed that 33 percent of the opt-in eligible clinicians that participated in the CY 2018 Quality Payment Program Year 2 would elect to opt-in to the MIPS program. It is difficult to predict whether clinicians will elect to opt-in to participate in MIPS with the finalized policies.

A limitation of our cost data is that it does not overlap with the 2018 calendar year so we may not be capturing performance for all clinicians.

There are additional limitations to our estimates: (1) Because we used historic data, we assumed participation in the three performance categories in MIPS Year 2 would be similar to MIPS Year 4 performance; and (2) to the extent that there are year-to-year changes in the data submission, volume and mix of services provided by MIPS eligible clinicians, the actual impact on total Medicare revenues will be different from those shown in Table 123. Due to the limitations described, there is considerable uncertainty around our estimates that is difficult to quantify in detail.

G. Alternatives Considered

This final rule contains a range of policies, including some provisions related to specific statutory provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our policies and, where relevant, alternatives that were considered. For purposes of the payment impact on PFS services of the policies contained in this final rule, we presented the estimated impact on total allowed charges by specialty. The alternatives we considered, as discussed in the preceding preamble sections, would result in different payment rates, and therefore, result in different estimates than those shown in Table 119 (CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty).

1. Alternatives Considered Related to Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

We considered several possibilities for pricing the oral medications, namely methadone and buprenorphine (oral), included in the OTP payment bundles. As described in section II.G. of this final rule, we finalized the use of ASP-based payment to set the payment rates for the oral OTP drug product categories when we receive manufacturer-submitted ASP data for these drugs and to limit the payment amounts for oral drugs to 100 percent of the ASP instead of 106 percent of the ASP. When ASP data are not available for the oral OTP drugs, we finalized use of the TRICARE rate to set the drug portion of the payment for

[136] The time period for this eligibility file (September 1, 2016 to August 31, 2017) maximizes the overlap with the performance data in our model.

methadone and the NADAC data to set the drug portion of the payment for oral buprenorphine. We note that, for the CY 2020 payments, we were able to calculate an ASP for methadone because of manufacturer reporting. However, we did not receive ASP data from any of the buprenorphine oral manufacturers. Therefore, this drug category was priced using NADAC survey data.

In developing the policies for this final rule, we also considered several other options for pricing of oral drugs as described in the proposed rule, including the methodology under section 1847A of the Act; Medicare Part D Prescription Drug Plan Finder data; WAC; and NADAC data. In determining which alternative data source to finalize for pricing the oral OTP drugs, in the event we did not receive manufacturer-submitted ASP pricing data, we considered commenters' varied responses to the options presented in the proposed rule. We also considered the possibility of using the TRICARE rate for methadone as the primary pricing methodology and increasing the payment limits to 106 percent of the ASP, instead of 100 percent of the ASP, as suggested by commenters.

We did not receive comments that would significantly alter our assumptions regarding estimated impacts of these alternatives. For methadone, using the methodology under section 1847A of the Act, Medicare Part D Prescription Drug Plan Finder data, WAC, TRICARE rates, and NADAC data methodologies would have resulted in a slightly decreased impact when compared to the reported ASP. For buprenorphine (oral), the Medicare Part D Prescription Drug Plan Finder data is very similar to NADAC pricing. Therefore, we believe there would be minimal changes in the estimated impacts from using this alternative data source. Since WAC-based pricing is slightly higher than NADAC pricing, we note that using WAC-based pricing would increase the estimated impacts marginally. For both oral product categories, increasing the payment limit to 106 percent of the ASP, instead of 100 percent of the ASP, would have resulted in a correspondingly higher impact.

While considering whether to finalize the rates that were proposed for the non-drug component, we explored a number of alternative scenarios based on commenters' responses to our proposals. For example, we considered whether to finalize the proposed rate that was based on a crosswalk to TRICARE's bundled weekly rate for methadone, whether to base the Medicare rate on the rates set by state Medicaid programs, or whether to calculate the rate using a building block methodology which sums the payment rates for similar services paid under Medicare currently. Were we to have finalized the proposed rates that were based on a crosswalk to TRICARE's weekly bundled rate, that would have resulted in a lower impact compared to the estimated impact of the rates we are finalizing, which were calculated using a building block methodology, as the TRICARE rate for non-drug services is lower than the rate we have finalized using the building block approach. Were we to have finalized rates equal to those set by some state Medicaid programs, the estimated impact would vary depending on which state Medicaid programs were used.

We note that there is significant variability across the state Medicaid programs in terms of the payment rates and what services are included in the bundle or billed separately, and that some states have payment rates that are higher than our finalized rate. Additionally, we considered whether to finalize partial episodes for each of the bundled payments. Were we to have finalized partial episodes that would have likely resulted in a lower overall impact compared to the rates we are finalizing, as the rates that were proposed for the partial episodes were calculated by taking one half of the value of the non-drug component for the full episodes. As noted in section II.G of this rule, we are not finalizing our proposal to create partial episodes for CY 2020.

We also considered several alternatives for the update factor used in updating the payment rates for the non-drug component of the bundled payment for OUD treatment services, including the Bureau of Labor Statistics Consumer Price Index for All Items for Urban Consumers (CPI–U) (Bureau of Labor Statistics #CUUR0000SA0 (*https://www.bls.gov/cpi/data.htm*)) and the IPPS hospital market basket reduced by the multifactor productivity adjustment. Based on a CMS forecast of projected rates, we believe that the projected MEI and CPI–U rates are anticipated to be similar, and thus using the CPI–U as an update factor would have minimal effect on estimated impacts. Since the projected IPPS hospital market basket rate is generally higher than the projected MEI rate, using the IPPS hospital market basket rate would result in higher estimated impacts. We received one comment which stated that an OTP's cost structure is more similar to a hospital outpatient department than a physician's office, so the IPPS annual update factor should be used instead of the MEI rate. In considering the appropriate update factor to finalize, we considered the medical services being provided by the OTP facilities and we believe that conceptually physician office services more closely align to OTP services, and compositionally the MEI more closely aligns with the services associated with the OTP payment system.

2. Alternatives Considered Related to Payment for E/M Services

In developing our policies for office/outpatient E/M visits effective January 1, 2021, we considered a number of alternatives. For reasons discussed in section II.P. of this final rule, we did not include either the extended office/outpatient E/M HCPCS code GPR01 or the single blended payment rates for combined visit levels 2 through 4 that were finalized in the CY 2019 final rule for CY 2021 in our considerations. Our alternatives also did not include the revaluation of global surgical services, as recommended by the AMA RUC, which incorporated the revised office/outpatient E/M code values. We note that in all of the alternatives we considered, the valuation for all codes in the office/outpatient E/M code set would increase. Therefore, all specialties for whom the office/outpatient codes represent a significant portion of their billing would also see payment increases while those specialties who do not report those codes would see overall payment decreases. Any variation in the magnitude of the increases or decreases are a result of a specialties overall billing patterns.

We did, however, consider proposing to eliminate both add-on codes, HCPCS code GCG0X and HCPCS code GPC1X, that were finalized in the CY 2019 final rule for CY 2021. Our stated rationale in the CY 2019 final rule for developing HCPCS code GPC1X (83 FR 59625 through 59653) was to more accurately account for the type and intensity of E/M work performed in primary care-focused visits beyond the typical resources reflected in the single payment rate for the levels 2 through 4 visits. The reason for finalizing HCPCS code GCG0X, as stated in the CY 2019 FR (83 FR 59625 through 59653) GCG0X was to reflect additional resource costs for inherently complex services that are non-procedural. We considered whether these two add-on codes would still be necessary in the context of the revised descriptors and valuations for office/outpatient E/M services. We considered an alternative, therefore, in which we adopted the RUC's recommended values

but excluded the two HCPCS add-on G-codes. In reviewing the results of this policy option, we observed that our concerns about capturing the work associated with visits that are part of ongoing, comprehensive primary care and/or care management for patients having a single, serious, or complex chronic condition were still present. The specialty level impacts associated with this alternative are displayed in Table 124. The specialties that benefited most from this alternative, such as Endocrinology and Rheumatology, are those that primarily bill levels 3–5 established patient office/outpatient E/M visits, as those visit levels had the greatest increases in valuation among the overall office/outpatient E/M code set.

BILLING CODE 4120–01–P

TABLE 124: Estimated Specialty Specific Impacts of Accepting the RUC Recommended Values but Deleting Both HCPCS G codes GCG0X and GPC1X if Implemented in CY 2020

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	3%	3%	0%	6%
Anesthesiology	$1,993	-3%	-1%	0%	-4%
Audiologist	$70	-3%	-1%	0%	-4%
Cardiac Surgery	$279	-4%	-1%	-1%	-5%
Cardiology	$6,595	1%	1%	0%	1%
Chiropractor	$750	-4%	-2%	-1%	-7%
Clinical Psychologist	$787	-4%	0%	0%	-4%
Clinical Social Worker	$781	-4%	1%	0%	-4%
Colon And Rectal Surgery	$162	-1%	0%	0%	-1%
Critical Care	$346	-3%	-1%	0%	-3%
Dermatology	$3,541	1%	2%	-1%	2%
Diagnostic Testing Facility	$697	0%	-3%	0%	-3%
Emergency Medicine	$3,021	-3%	-1%	1%	-4%
Endocrinology	$488	7%	3%	1%	10%
Family Practice	$6,019	5%	2%	0%	7%
Gastroenterology	$1,713	0%	0%	-1%	-1%
General Practice	$405	3%	1%	0%	5%
General Surgery	$2,031	-1%	0%	0%	-2%
Geriatrics	$187	1%	1%	0%	2%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,673	5%	2%	1%	8%
Independent Laboratory	$592	-2%	0%	0%	-2%
Infectious Disease	$640	-2%	-1%	0%	-3%
Internal Medicine	$10,507	1%	1%	0%	2%
Interventional Pain Mgmt	$885	2%	2%	0%	4%
Interventional Radiology	$432	-2%	-2%	0%	-4%
Multispecialty Clinic/Other Phys	$148	0%	0%	0%	0%
Nephrology	$2,164	-1%	0%	0%	-1%
Neurology	$1,503	1%	4%	0%	6%
Neurosurgery	$802	-2%	0%	-1%	-3%
Nuclear Medicine	$50	-2%	0%	0%	-2%
Nurse Anes / Anes Asst	$1,291	-5%	-1%	0%	-6%
Nurse Practitioner	$4,503	2%	1%	0%	4%
Obstetrics/Gynecology	$620	2%	2%	0%	4%
Ophthalmology	$5,398	-3%	-4%	0%	-7%
Optometry	$1,325	0%	-2%	0%	-2%
Oral/Maxillofacial Surgery	$71	0%	0%	-1%	-1%
Orthopedic Surgery	$3,734	0%	1%	0%	1%
Other	$34	-1%	-1%	0%	-2%
Otolaryngology	$1,225	2%	1%	0%	3%
Pathology	$1,203	-3%	-2%	0%	-5%
Pediatrics	$62	2%	1%	0%	3%
Physical Medicine	$1,110	0%	0%	0%	0%
Physical/Occupational Therapy	$4,248	-3%	-2%	0%	-5%
Physician Assistant	$2,637	2%	1%	0%	4%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Plastic Surgery	$369	-1%	0%	-1%	-2%
Podiatry	$1,998	2%	2%	0%	4%
Portable X-Ray Supplier	$94	-1%	-1%	0%	-3%
Psychiatry	$1,120	2%	1%	0%	3%
Pulmonary Disease	$1,658	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-1%	-1%	0%	-2%
Radiology	$4,971	-3%	-2%	0%	-5%
Rheumatology	$534	6%	3%	1%	9%
Thoracic Surgery	$352	-3%	-1%	0%	-5%
Urology	$1,739	2%	2%	0%	5%
Vascular Surgery	$1,203	-1%	-2%	0%	-3%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

We also considered, as an alternative, proposing CMS refinements to the RUC recommendations for two of the CPT codes. Consistent with our generally established policies for reviewing work RVUs recommended by the RUC, we observed that the increase in work RVU for CPT codes 99212 and 99214 (levels 2 and 4 for established patients) seemed disproportionate to the increase in total time for these services, particularly in comparison with the work to time relationships among the other seven E/M code revaluations. For CPT code 99212, we observed that the total time for furnishing this service increased by 2 minutes (13 percent increase), but that the recommended work RVU increased by nearly 50 percent from 0.48 to 0.70. We reviewed other CPT codes with similar times as the survey code and identified a potential crosswalk to CPT code 76536 (*Ultrasound, soft tissues of head and neck e.g., thyroid, parathyroid, parotid), real time with image documentation*), with a work RVU of 0.56. We therefore considered decreasing the work RVU for CPT code 99212 to 0.56. For CPT code 99214, the total time increased from 40 to 49 minutes, which is a 23 percent change, while the work RVU increased from 1.50 to 1.92 (28 percent increase). We considered a crosswalk to CPT code 73206 (*Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing*), with a work RVU of 1.81 and total time of 50 minutes. The refinements we considered for the RUC recommendations are shown in Table 125.

TABLE 125: Current, RUC recommended and CMS Refined Office/Outpatient E/M Work RVUs

CPT/HCPCS	Current Work RVU (Current)	RUC-Recommended Work RVU	Alternative: CMS-Refined Work RVU
99201	0.48	NA	NA
99202	0.93	0.93	0.93
99203	1.42	1.6	1.6
99204	2.43	2.6	2.6
99205	3.17	3.5	3.5
99211	0.18	0.18	0.18
99212	0.48	0.7	0.56
99213	0.97	1.3	1.3
99214	1.5	1.92	1.81
99215	2.11	2.8	2.8
99XXX	NA	0.61	0.5
GPC1X	0.25	NA	0.33
GCG0X	0.25	NA	0.33

Table 126 illustrates the specialty level impacts of refining the RUC recommendations. Under this alternative those specialties who frequently bill CPT code 99212 or CPT code 99214, such as dermatology and family practice, respectively, experience more modest increases relative to other alternatives.

TABLE 126: Estimated Specialty Specific Impacts of CMS Refined Values if Implemented in CY 2020

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	3%	3%	0%	6%
Anesthesiology	$1,993	-3%	-1%	0%	-4%
Audiologist	$70	-2%	-1%	0%	-4%
Cardiac Surgery	$279	-3%	-1%	0%	-5%
Cardiology	$6,595	1%	1%	0%	1%
Chiropractor	$750	-3%	-2%	-1%	-6%
Clinical Psychologist	$787	-4%	0%	0%	-3%
Clinical Social Worker	$781	-4%	1%	0%	-3%
Colon And Rectal Surgery	$162	-1%	0%	0%	-1%
Critical Care	$346	-2%	-1%	0%	-3%
Dermatology	$3,541	1%	2%	-1%	2%
Diagnostic Testing Facility	$697	0%	-3%	0%	-3%
Emergency Medicine	$3,021	-3%	-1%	1%	-3%
Endocrinology	$488	5%	2%	1%	8%
Family Practice	$6,019	4%	2%	1%	6%
Gastroenterology	$1,713	0%	0%	-1%	-1%
General Practice	$405	3%	1%	0%	4%
General Surgery	$2,031	-1%	0%	0%	-2%
Geriatrics	$187	1%	1%	0%	2%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,673	5%	2%	1%	8%
Independent Laboratory	$592	-2%	0%	0%	-2%
Infectious Disease	$640	-2%	0%	0%	-2%
Internal Medicine	$10,507	1%	1%	0%	2%
Interventional Pain Mgmt	$885	2%	2%	1%	4%
Interventional Radiology	$432	-1%	-2%	0%	-4%
Multispecialty Clinic/Other Phys	$148	0%	0%	0%	0%
Nephrology	$2,164	-1%	0%	0%	-1%
Neurology	$1,503	1%	4%	0%	5%
Neurosurgery	$802	-1%	0%	-1%	-3%
Nuclear Medicine	$50	-2%	0%	0%	-2%
Nurse Anes / Anes Asst	$1,291	-4%	-1%	0%	-5%
Nurse Practitioner	$4,503	2%	1%	0%	4%
Obstetrics/Gynecology	$620	2%	2%	0%	4%
Ophthalmology	$5,398	-3%	-4%	0%	-7%
Optometry	$1,325	0%	-2%	0%	-2%
Oral/Maxillofacial Surgery	$71	0%	0%	-1%	-1%
Orthopedic Surgery	$3,734	0%	1%	0%	1%
Other	$34	-1%	-1%	0%	-2%
Otolaryngology	$1,225	2%	2%	0%	3%
Pathology	$1,203	-3%	-2%	0%	-5%
Pediatrics	$62	2%	1%	0%	3%
Physical Medicine	$1,110	0%	0%	0%	1%
Physical/Occupational Therapy	$4,248	-3%	-2%	0%	-5%
Physician Assistant	$2,637	2%	1%	0%	4%
Plastic Surgery	$369	-1%	0%	-1%	-2%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Podiatry	$1,998	2%	2%	0%	4%
Portable X-Ray Supplier	$94	-1%	-1%	0%	-2%
Psychiatry	$1,120	1%	1%	0%	3%
Pulmonary Disease	$1,658	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-1%	-1%	0%	-2%
Radiology	$4,971	-3%	-2%	-1%	-5%
Rheumatology	$534	5%	2%	1%	8%
Thoracic Surgery	$352	-3%	-1%	0%	-4%
Urology	$1,739	2%	2%	0%	5%
Vascular Surgery	$1,203	-1%	-2%	0%	-3%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

We also considered an alternative that reflected CMS refinements to the three CPT codes as described above and also included the consolidated, redefined and revalued HCPCS add-on G code, GPC1X.

Table 127 illustrates the specialty level impacts associated with making refinements to the RUC recommended values for the office/outpatient E/M code set and also making separate payment for HCPCS add-on code GPC1X. These impacts are similar to what we proposed, with slight less positive impacts for those specialties who bill CPT codes 99212 or 99214.

TABLE 127: Estimated Specialty Specific Impacts of CMS Refined Values with HCPCS add-on G code GPC1X if Implemented in CY 2020

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	3%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-6%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-7%
Cardiology	$6,595	1%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-6%	0%	0%	-6%
Clinical Social Worker	$781	-6%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	0%	0%	-3%
Critical Care	$346	-4%	-1%	0%	-5%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	0%	-3%	0%	-4%
Emergency Medicine	$3,021	-5%	-2%	1%	-6%
Endocrinology	$488	10%	4%	1%	15%
Family Practice	$6,019	7%	3%	1%	11%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	7%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	1%	2%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	7%	4%	1%	12%
Independent Laboratory	$592	-2%	-1%	0%	-4%
Infectious Disease	$640	-2%	0%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-2%	-3%	0%	-5%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-3%	0%	0%	-4%
Nurse Anes / Anes Asst	$1,291	-6%	-2%	0%	-8%
Nurse Practitioner	$4,503	4%	3%	0%	7%
Obstetrics/Gynecology	$620	4%	3%	0%	7%
Ophthalmology	$5,398	-4%	-5%	0%	-9%
Optometry	$1,325	-2%	-3%	0%	-5%
Oral/Maxillofacial Surgery	$71	-1%	-1%	-1%	-3%
Orthopedic Surgery	$3,734	-1%	0%	0%	-2%
Other	$34	-3%	-2%	0%	-5%
Otolaryngology	$1,225	3%	2%	0%	5%
Pathology	$1,203	-4%	-3%	-1%	-8%
Pediatrics	$62	3%	2%	0%	5%
Physical Medicine	$1,110	-2%	0%	0%	-2%
Physical/Occupational Therapy	$4,248	-4%	-4%	0%	-8%
Physician Assistant	$2,637	4%	2%	0%	7%
Plastic Surgery	$369	-2%	-1%	-1%	-4%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Podiatry	$1,998	0%	1%	0%	1%
Portable X-Ray Supplier	$94	-1%	-3%	0%	-4%
Psychiatry	$1,120	4%	3%	0%	7%
Pulmonary Disease	$1,658	0%	1%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-2%	-2%	0%	-4%
Radiology	$4,971	-4%	-3%	0%	-8%
Rheumatology	$534	8%	4%	1%	13%
Thoracic Surgery	$352	-4%	-2%	-1%	-7%
Urology	$1,739	4%	4%	0%	8%
Vascular Surgery	$1,203	-2%	-3%	0%	-4%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

BILLING CODE 4120–01–C

Comment: As discussed previously, some commenters questioned the necessity of additional coding to describe medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. Some commenters encouraged CMS to work with CPT and the RUC, rather than utilize Medicare specific G-codes, to address concerns regarding payment for these services. Other commenters rejected the necessity of additional payment all together.

Response: Please see the full discussion in section II.P. of this final rule. We continue to believe that the revalued office/outpatient E/M visits do not accurately account for the resources associated with furnishing primary care and certain types of specialty visits.

Comment: Overall, commenters did not support CMS' refinements to the valuation of CPT codes 99212 and 99214 as reflected in alternatives considered, stating that the values recommended to CMS by the RUC were more accurate as they were part of a rigorous survey and represented a consensus by the medical community.

Response: As discussed in section II.P. of this final rule, we agree with commenters and are finalizing as proposed.

3. Alternatives Considered for the Quality Payment Program

For purposes of the payment impact on the Quality Payment Program, we view the performance threshold and the additional performance threshold, as the critical factors affecting the distribution of payment adjustments. We ran two separate models with performance thresholds of 35 and 50 respectively (as an alternative to the proposed performance threshold of 45) to estimate the impact of a more moderate and a more aggressive increase in the performance threshold. A lower performance threshold would be a more gradual transition and could potentially allow more clinicians to meet or exceed the performance threshold. The lower performance threshold would lower the amount of budget neutral dollars to redistribute and increase the number of clinicians with a positive payment adjustment, but the scaling factor would be lower. In contrast, a more aggressive increase would likely lead to higher positive payment adjustments for clinicians that exceed the performance threshold because the budget neutral pool would be redistributed among fewer clinicians. We ran each of these models using the proposed additional performance threshold of 85. In the model with a performance threshold of 35, we estimate that $360 million would be redistributed through budget neutrality. There would be a maximum payment adjustment of 6.0 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance. In addition, 5.2 percent of MIPS eligible clinicians would receive a negative payment adjustment among those that submit data. In the model with a performance threshold of 50, we estimate that $470 million would be redistributed through budget neutrality, and that there would be a maximum payment adjustment of 6.4 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance. In addition, 9.6 percent of MIPS eligible clinicians would receive a negative payment adjustment among those that submit data. We proposed a performance threshold of 45 because we believe increasing the performance threshold to 45 points was not unreasonable or too steep, but rather a moderate step that encourages clinicians to gain experience with all MIPS performance categories. We refer readers to section III.K.3.e.(2) of this final rule for additional rationale on the selection of the performance threshold.

To evaluate the impact of modifying the additional performance threshold, we ran two models with additional performance thresholds of 75 and 80 as an alternative to the 85 points. We ran each of these models using a performance threshold of 45. The benefit of the model with the additional performance threshold of 75 would maintain the additional performance threshold that was in year 3. In the model with the additional performance threshold of 75, we estimate that $433 million would be redistributed through budget neutrality, and there would be a maximum payment adjustment of 3.8 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance. In addition, 7.5 percent of MIPS eligible clinicians would receive a negative payment adjustment among those that submit data. In the model with an additional performance threshold of 80, we estimate that $433 million would be redistributed through budget neutrality, and that there would be a maximum payment adjustment of 4.5 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance among those that submit data. Also, that 7.5 percent of MIPS eligible clinicians will receive a negative payment adjustment among those that submit data. We proposed the additional performance threshold at 85 points because we believe raising the additional performance threshold would

incentivize continued improved performance while accounting for policy changes in the fourth year of the program. We refer readers to section III.K.3.e.(3) of this final rule for additional rationale on the selection of additional performance threshold.

In addition, we ran a model with a weight of 20 percent for the cost performance category and of 40 percent for the quality performance category as an alternate to our finalized weight of 15 percent for the cost performance category. The 20 percent weight for the cost performance category has a mean score of 76.34 and a median score of 82.88 where our primary model has a mean score of 76.67 and a median score of 83.57.

H. Impact on Beneficiaries

1. Medicare PFS

There are a number of changes in this final rule that will have an effect on beneficiaries. In general, we believe that many of these changes, including those intended to improve accuracy in payment through regular updates to the inputs used to calculate payments under the PFS, will have a positive impact and improve the quality and value of care provided to Medicare providers and beneficiaries.

2. Quality Payment Program

There are several changes in this rule that would have an effect on beneficiaries. In general, we believe that many of these changes, including those intended to improve accuracy in payment through regular updates to the inputs used to calculate payments under the PFS, would have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. For example, several of the new measures include patient-reported outcomes, which may be used to help patients make more informed decisions about treatment options. Patient-reported outcome measures provide information on a patient's health status from the patient's point of view and may also provide valuable insights on factors such as quality of life, functional status, and overall disease experience, which may not otherwise be available through routine clinical data collection. Patient-reported outcomes are factors frequently of interest to patients when making decisions about treatment. Similarly, our provisions in section III.K.3.g.(3) of this rule will improve the caliber and value of QCDR measures.

I. Burden Reduction Estimates: Payment for E/M Services

In the CY 2019 PFS final rule, we finalized proposals that we made in response to comments received from RFIs released to the public under our Patients Over Paperwork Initiative. Specifically, we finalized provisions that focused on simplifying the medical documentation payment framework for office/outpatient E/M services and allowing greater flexibility on the components practitioners could choose to document when billing Medicare for office/outpatient E/M visits. In that rule we discussed the specific changes to documentation requirements and estimated significant reductions in the amount of time that practitioners would spend documenting office/outpatient E/M visits, furthering our goal of allowing practitioners more time spent with patients. As discussed earlier in section II.P. of this final rule, we proposed to adopt the revised office/outpatient E/M code set. The proposals reflected our ongoing dialog with the practitioner community and took into account the significant revisions the AMA/CPT Editorial Panel has made to the guidelines for the office/outpatient E/M code set. We note that as part of its efforts to revise the guidelines, the AMA has also estimated a reduction in the amount of time practitioners would spend documenting office/outpatient E/M visits. The AMA asserts that its revisions to the office/outpatient E/M code set will accomplish similar, albeit greater burden reduction in comparison with CMS' approach, as finalized in the CY 2019 PFS final rule, and is more intuitive and in line with the current practice of medicine. We reviewed the AMA's estimates and acknowledge that overall the AMA's approach does result in burden reduction that are consistent with our broader goals discussed above. In comparison to our estimates of burden reduction, as discussed in the CY 2019 final rule, the AMA's estimates show less documentation burden to practitioners, the difference resulting from CMS' finalized policies that allow use of add-on codes to reflect additional resource costs inherent in furnishing some kinds of office/outpatient E/M visits that the current E/M coding and visit levels do not fully recognize (FR 83 59638). The AMA estimates reflect assumptions that the time spent documenting appropriate application of the add-on codes may result in additional burden to practitioners. We disagree with this assumption. In addition to proposing to redefine and revalue HCPCS G code add-on GPC1X to be more understandable and easy to report for purposes of medical documentation and billing, and proposing to delete HCPCS G-code add-on GCG0X, we discussed that we believe that while an initial setup period is expected for practices to establish workflows that incorporate appropriate use of the add-on code, practices should be able to automate the appropriate use of the add-on code in a short period of time. Even so, our proposal to adopt the AMA's revised office/outpatient E/M code set was consistent with our goal of burden reduction and aligns with the policy principles that underlay what we finalized in the CY 2019 PFS final rule. The AMA's estimates of burden reduction as related to office/outpatient E/M documentation and other materials pertinent to the AMA/CPT and AMA/RUC's recent efforts to revise the office/outpatient E/M code set are available at *https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management.* The burden estimates as discussed above remain the same because we made no refinements to our proposals to adopt the AMA's revised office/outpatient E/M code set.

J. Estimating Regulatory Familiarization Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcomed any comments on the approach in estimating the number of entities which will review this rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We sought comments on this assumption.

Using the wage information from the May 2018 BLS for medical and health service managers (Code 11–9111), we

estimate that the cost of reviewing this rule is $109.36 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it would take approximately 8.0 hours for the staff to review half of this rule. For each facility that reviews the rule, the estimated cost is $874.88 (8.0 hours × $109.36). Therefore, we estimated that the total cost of reviewing this regulation is $37,997,788 ($874.88 × 43,432 reviewers).

K. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Tables 128 and 129 (Accounting Statements), we have prepared an accounting statement. This estimate includes growth in incurred benefits from CY 2019 to CY 2020 based on the FY 2020 President's Budget baseline.

TABLE 128—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Category	Transfers
CY 2020 Annualized Monetized Transfers	Estimated increase in expenditures of $0.3 billion for PFS CF update.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.

TABLE 129—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED COSTS, TRANSFER, AND SAVINGS

Category	Transfer
CY 2020 Annualized Monetized Transfers of beneficiary cost coinsurance.	$0.1 billion.
From Whom to Whom?	Beneficiaries to Federal Government.

L. Conclusion

The analysis in the previous sections, together with the remainder of this preamble, provided an initial Regulatory Flexibility Analysis. The previous analysis, together with the preceding portion of this preamble, provides an RIA. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 403

Grant programs—health, Health insurance, Hospitals, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Biologics, Drugs, Health facilities, Health professions, Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 425

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 403—SPECIAL PROGRAMS AND PROJECTS

■ 1. The authority citation for part 403 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 403.902 is amended—
■ a. By adding in alphabetical order the definitions of ''Certified nurse midwife'', ''Certified registered nurse anesthetist'', and ''Clinical nurse specialist'';
■ b. By revising the definition of ''Covered recipient'';
■ c. By adding in alphabetical order the definitions of ''Device identifier'', ''Long term medical supply or device loan'', ''Non-teaching hospital covered recipient'', ''Nurse practitioner'', ''Physician assistant'', ''Short term medical supply or device loan'', and ''Unique device identifier''.

The additions and revisions read as follows:

§ 403.902 Definitions.

* * * * *

Certified nurse midwife means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

Certified registered nurse anesthetist means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the

Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

* * * * *

Clinical nurse specialist means, an individual who—

(1) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(2) Holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

* * * * *

Covered recipient means—

(1) Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who is not a bona fide employee of the applicable manufacturer that is reporting the payment; or

Device identifier is the mandatory, fixed portion of a unique device identifier (UDI) that identifies the specific version or model of a device and the labeler of that device (as described at 21 CFR 801.3 in paragraph (1) of the definition of ''Unique device identifier'').

* * * * *

Long term medical supply or device loan means the loan of supplies or a device for 91 days or longer.

Non-teaching hospital covered recipient means a person who is one or more of the following: Physician; physician assistant; nurse practitioner; clinical nurse specialist; certified registered nurse anesthetist; or certified nurse-midwife.

* * * * *

Nurse practitioner means a nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * *

Physician assistant means a physician assistant who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * *

Short term medical supply or device loan means the loan of a covered device or a device under development, or the provision of a limited quantity of medical supplies for a short-term trial period, not to exceed a loan period of 90 days or a quantity of 90 days of average daily use, to permit evaluation of the device or medical supply by the covered recipient.

* * * * *

Unique device identifier means an identifier that adequately identifies a device through its distribution and use by meeting the requirements of 21 CFR 801.40 and 830.3.

■ 3. Section 403.904 is amended by—

■ a. Revising paragraphs (c)(1), (c)(3) introductory text, (c)(3)(ii) and (iii), (c)(8), (e)(2) introductory text and;

■ b. Adding paragraph (e)(2)(xi);

■ c. Revising paragraphs (e)(2)(xiv) and (xv);

■ d. Adding paragraph (e)(2)(xviii); and

■ e. Revising paragraphs (f)(1) introductory text, (f)(1)(i)(A) introductory text, (f)(1)(i)(A)(*1*),(*3*) and (5), (f)(1)(iv), (f)(1)(v), (h)(5), (h)(7), and (h)(13).

The revisions and addition read as follows:

§ 403.904 Reports of payments or other transfers of value to covered recipients.

* * * * *

(c)* * *

(1) *Name of the covered recipient.* For non-teaching hospital covered recipients, the name must be as listed in the National Plan & Provider Enumeration System (NPPES) (if applicable) and include first and last name, middle initial, and suffix (for all that apply).

* * * * *

(3*) Identifiers for non-teaching hospital covered recipients.* In the case of a covered recipient the following identifiers:

* * * * *

(ii) National Provider Identifier (if applicable and as listed in the NPPES). If a National Provider Identifier cannot be identified for a non-teaching hospital covered recipient, the field may be left blank, indicating that the applicable manufacturer could not find one.

(iii) State professional license number(s) (for at least one State where the non-teaching hospital covered recipient maintains a license), and the State(s) in which the license is held.

* * * * *

(8) *Related covered drug, device, biological or medical supply.* Report the marketed or brand name of the related covered drugs, devices, biologicals, or medical supplies, and therapeutic area or product category unless the payment or other transfer of value is not related to a particular covered drug, device, biological or medical supply.

(i) For drugs and biologicals—

(A) If the marketed name has not yet been selected, applicable manufacturers must indicate the name registered on *clinicaltrials.gov*.

(B) Any regularly used identifiers must be reported, including, but not limited to, national drug codes.

(ii) For devices, if the device has a unique device identifier (UDI), then the device identifier (DI) portions of it must be reported, as applicable.

(iii) Applicable manufacturers may report the marketed name and therapeutic area or product category for payments or other transfers of value related to a non-covered drug, device, biological, or medical supply.

(iv) Applicable manufacturers must indicate if the related drug, device, biological, or medical supply is covered or non-covered.

(v) Applicable manufacturers must indicate if the payment or other transfer of value is not related to any covered or non-covered drug, device, biological or medical supply.

* * * * *

(e) * * *

(2) *Rules for categorizing natures of payment.* An applicable manufacturer must categorize each payment or other transfer of value, or separable part of that payment or transfer of value, with one of the categories listed in paragraphs (e)(2)(i) through (xviii) of this section, using the designation that best describes the nature of the payment or other transfer of value, or separable part of that payment or other transfer of value. If a payment or other transfer of value could reasonably be considered as falling within more than one category, the applicable manufacturer should select one category that it deems to most accurately describe the nature of the payment or transfer of value.

* * * * *

(xi) Debt forgiveness.

* * * * *

(xiv) Compensation for serving as faculty or as a speaker for a medical education program.

(xv) Long term medical supply or device loan.

* * * * *

(xviii) Acquisitions.

(f) * * *

(1) Research-related payments or other transfers of value to covered recipients, including research-related

payments or other transfers of value made indirectly to a covered recipient through a third party, must be reported to CMS separately from other payments or transfers of value, and must include the following information (in lieu of the information required by § 403.904(c)):

(i) * * *

(A) If paid to a non-teaching hospital covered recipient, all of the following must be provided:

(*1*) The non-teaching hospital covered recipient's name as listed in the NPPES (if applicable).

* * * * *

(*3*) State professional license number(s) (for at least one State where the non-teaching hospital covered recipient maintains a license) and State(s) in which the license is held.

* * * * *

(*5*) Primary business address of the non-teaching hospital covered recipient(s).

* * * * *

(iv) Name(s) of any related covered drugs, devices, biologicals, or medical supplies (subject to the requirements specified in paragraph (c)(8) of this section); for drugs and biologicals, the relevant National Drug Code(s), if any; and for devices and medical supplies, the relevant device identifier, if any, and the therapeutic area or product category if a marketed name is not available.

(v) Information about each non-teaching hospital covered recipient principal investigator (if applicable) set forth in paragraph (f)(1)(i)(A) of this section.

* * * * *

(h) * * *

(5) Short term medical supply or device loan.

* * * * *

(7) A transfer of anything of value to a non-teaching hospital covered recipient when the covered recipient is a patient, research subject or participant in data collection for research, and not acting in the professional capacity of a covered recipient.

* * * * *

(13) In the case of a non-teaching hospital covered recipient, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to an administrative proceeding, legal defense, prosecution, or settlement or judgment of a civil or criminal action and arbitration.

* * * * *

■ 4. Section 403.908 is amended by revising paragraphs (g)(2)(ii) introductory text to read as follows:

§ 403.908 Procedures for electronic submission of reports.

* * * * *

(g) * * *

(2) * * *

(ii) Covered recipients—

* * * * *

PART 409—HOSPITAL INSURANCE BENEFITS

■ 5. The authority citation for part 409 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

§ 409.27 [Amended]

■ 6. Section 409.27 is amended in paragraph (c) by removing the reference ''§ 410.40(d)(1)'' and adding in its place the reference ''§ 410.40(e)(1)''.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 7. The authority citation for part 410 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

■ 8. Section 410.20 is amended by adding paragraph (e) to read as follows:

§ 410.20 Physicians' services.

* * * * *

(e) *Medical record documentation.* The physician may review and verify (sign/date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team including, as applicable, notes documenting the physician's presence and participation in the services.

■ 9. Section 410.40 is amended—

■ a. By redesignating paragraphs (a) through (f) as paragraphs (b) through (g), respectively;

■ b. By adding new paragraph (a);

■ c. In newly redesignated paragraph (b)(1) by removing the reference ''paragraphs (d) and (e)'' and adding in its place the reference ''paragraphs (e) and (f)''; and

■ d. By revising newly redesignated paragraphs (e)(2)(i), (e)(3)(i), and (e)(3)(iii) through (v).

The additions and revision reads as follows:

§ 410.40 Coverage of ambulance services.

(a) *Definitions.* As used in this section, the following definitions apply:

Non-physician certification statement means a statement signed and dated by an individual which certifies that the medical necessity provisions of paragraph (e)(1) of this section are met and who meets all of the criteria in paragraphs (i) through (iii) of this definition. The statement need not be a stand-alone document and no specific format or title is required.

(i) Has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished;

(ii) Who must be employed:

(A) By the beneficiary's attending physician; or

(B) By the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported;

(iii) Is among the following individuals, with respect to whom all Medicare regulations and all applicable State licensure laws apply:

(A) Physician assistant (PA).

(B) Nurse practitioner (NP).

(C) Clinical nurse specialist (CNS).

(D) Registered nurse (RN).

(E) Licensed practical nurse (LPN).

(F) Social worker.

(G) Case manager.

(H) Discharge planner.

Physician certification statement means a statement signed and dated by the beneficiary's attending physician which certifies that the medical necessity provisions of paragraph (e)(1) of this section are met. The statement need not be a stand-alone document and no specific format or title is required.

* * * * *

(e) * * *

(2) * * *

(i) Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a physician certification statement dated no earlier than 60 days before the date the service is furnished.

* * * * *

(3) * * *

(i) For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a physician certification statement within 48 hours after the transport.

* * * * *

(iii) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a non-physician certification statement must be obtained.

(iv) If the ambulance provider or supplier is unable to obtain the required physician or non-physician certification statement within 21 calendar days following the date of the service, the ambulance provider or supplier must document its attempts to obtain the

requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (e)(3)(iii) of this section.

(v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the physician or non-physician certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

* * * * *

■ 10. Section 410.41 is amended by revising the section heading and paragraph (c)(1) to read as follows:

§ 410.41 Requirements for ambulance providers and suppliers.

* * * * *

(c) * * *

(1) Bill for ambulance services using CMS-designated procedure codes to describe origin and destination and indicate on claims form that the physician certification statement or non-physician certification statement is on file, if required.

* * * * *

■ 11. Section 410.49 is amended by revising paragraph (b)(1)(vii) and adding paragraph (b)(1)(viii) to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

* * * * *

(b) * * *

(1) * * *

(vii) Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 18, 2014 for cardiac rehabilitation and on or after February 9, 2018 for intensive cardiac rehabilitation; or

(viii) Other cardiac conditions as specified through a national coverage determination (NCD). The NCD process may also be used to specify non-coverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

* * * * *

■ 12. Section 410.59 is amended by—

■ a. Adding paragraphs (a)(4) and (e)(1)(v); and

■ b. Revising paragraphs (e)(2) introductory text, (e)(2)(i) and (v), and (e)(3).

The additions and revisions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) * * *

(4) Effective for dates of service on and after January 1, 2020, for occupational therapy services described in paragraph (a)(3)(i) or (ii) of this section, as applicable—

(i) Claims for services furnished in whole or in part by an occupational therapy assistant must include the prescribed modifier; and

(ii) Effective for dates of service on or after January 1, 2022, claims for such services that include the modifier and for which payment is made under sections 1848 or 1834(k) of the Act are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service.

(iii) For purposes of this paragraph, ''furnished in whole or in part'' means when the occupational therapy assistant either:

(A) Furnishes all the minutes of a service exclusive of the occupational therapist; or

(B) Furnishes a portion of a service separately from the part furnished by the occupational therapist such that the minutes for that portion of a service furnished by the occupational therapy assistant exceed 10 percent of the total minutes for that service.

* * * * *

(e) * * *

(1) * * *

(v) Beginning in 2018 and for each successive calendar year, the amount described in paragraph (e)(1)(ii) of this section is no longer applied as a limitation on incurred expenses for outpatient occupational therapy services, but, is instead applied as a threshold above which claims for occupational therapy services must include the KX modifier (the KX modifier threshold) to indicate that the service is medically necessary and justified by appropriate documentation in the medical record and claims for services above the KX modifier threshold that do not include the KX modifier are denied.

(2) For purposes of applying the KX modifier threshold, outpatient occupational therapy includes:

(i) Outpatient occupational therapy services furnished under this section;

* * * * *

(v) Outpatient occupational therapy services furnished by a CAH directly or under arrangements, included in the amount of annual incurred expenses as if such services were furnished under section 1834(k)(1)(B) of the Act.

* * * * *

(3) A process for medical review of claims for outpatient occupational therapy services applies as follows:

(i) For 2012 through 2017, medical review applies to claims for services at or in excess of $3,700 of recognized incurred expenses as described in paragraph (e)(1)(i) of this section.

(A) For 2012, 2013, and 2014 all claims at and above the $3,700 medical review threshold are subject to medical review; and

(B) For 2015, 2016, and 2017 claims at and above the $3,700 medical review threshold are subject to a targeted medical review process.

(ii) For 2018 and subsequent years, a targeted medical review process applies when the accrued annual incurred expenses reach the following medical review threshold amounts:

(A) Beginning with 2018 and before 2028, $3,000;

(B) For 2028 and each year thereafter, the applicable medical review threshold is determined by increasing the medical review threshold in effect for the previous year (starting with $3,000 in 2027) by the increase in the Medicare Economic Index for the current year.

■ 13. Section 410.60 is amended by—

■ a. Adding paragraphs (a)(4) and (e)(1)(v); and

■ b. Revising paragraphs (e)(2) introductory text, (e)(2)(i), (ii) and (vi), and (e)(3).

The additions and revisions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) * * *

(4) Effective for dates of service on and after January 1, 2020, for physical therapy services described in paragraphs (a)(3)(i) or (ii) of this section, as applicable—

(i) Claims for services furnished in whole or in part by a physical therapist assistant must include the prescribed modifier; and

(ii) Effective for dates of service on or after January 1, 2022, claims for such services that include the modifier and for which payment is made under sections 1848 or 1834(k) of the Act are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service.

(iii) For purposes of this paragraph, ''furnished in whole or in part'' means when the physical therapist assistant either:

(A) Furnishes all the minutes of a service exclusive of the physical therapist; or

(B) Furnishes a portion of a service separately from the part furnished by the physical therapist such that the minutes for that portion of a service furnished by the physical therapist assistant exceed 10 percent of the total minutes for that service.

* * * * *

(e) * * *

(1) * * *

(v) Beginning in 2018 and for each successive calendar year, the amount described in paragraph (e)(1)(ii) of this section is not applied as a limitation on incurred expenses for outpatient physical therapy and outpatient speech-language pathology services, but is instead applied as a threshold above which claims for physical therapy and speech-language pathology services must include the KX modifier (the KX modifier threshold) to indicate that the service is medically necessary and justified by appropriate documentation in the medical record; and claims for services above the KX modifier threshold that do not include the KX modifier are denied.

(2) For purposes of applying the KX modifier threshold, outpatient physical therapy includes:

(i) Outpatient physical therapy services furnished under this section;

(ii) Outpatient speech-language pathology services furnished under § 410.62;

* * * * *

(vi) Outpatient physical therapy and speech-language pathology services furnished by a CAH directly or under arrangements, included in the amount of annual incurred expenses as if such services were furnished and paid under section 1834(k)(1)(B) of the Act.

(3) A process for medical review of claims for physical therapy and speech-language pathology services applies as follows:

(i) For 2012 through 2017, medical review applies to claims for services at or in excess of $3,700 of recognized incurred expenses as described in paragraph (e)(1)(i) of this section.

(A) For 2012, 2013, and 2014 all claims at and above the $3,700 medical review threshold are subject to medical review; and

(B) For 2015, 2016, and 2017 claims at and above the $3,700 medical review threshold are subject to a targeted medical review process.

(ii) For 2018 and subsequent years, a targeted medical review process when the accrued annual incurred expenses reach the following medical review threshold amounts:

(A) Beginning with 2018 and before 2028, $3,000;

(B) For 2028 and each year thereafter, the applicable medical review threshold is determined by increasing the medical review threshold in effect for the previous year (starting with $3,000 for 2017) by the increase in the Medicare Economic Index for the current year.

■ 14. Section 410.67 is added to read as follows:

§ 410.67 Medicare coverage and payment of Opioid use disorder treatment services furnished by Opioid treatment programs.

(a) *Basis and scope.* (1) *Basis.* This section implements sections 1861(jjj), 1861(s)(2)(HH), 1833(a)(1)(CC) and 1834(w) of the Act which provide for coverage of opioid use disorder treatment services furnished by an opioid treatment program and the payment of a bundled payment under Part B to an opioid treatment program for opioid use disorder treatment services that are furnished to a beneficiary during an episode of care beginning on or after January 1, 2020.

(2) *Scope.* This section sets forth the criteria for an opioid treatment program, the scope of opioid use disorder treatment services, and the methodology for determining the bundled payments to opioid treatment programs for furnishing opioid use disorder treatment services.

(b) *Definitions.* For purposes of this section, the following definitions apply:

Episode of care means a one-week (contiguous 7-day) period.

Opioid treatment program means an entity that is an opioid treatment program (as defined in § 8.2 of this title, or any successor regulation) that meets the requirements described in paragraph (c) of this section.

Opioid use disorder treatment service means one of the following items or services for the treatment of opioid use disorder that is furnished by an opioid treatment program that meets the requirements described in paragraph (c) of this section.

(1) Opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 505 of the Federal, Food, Drug, and Cosmetic Act for use in treatment of opioid use disorder.

(2) Dispensing and administration of opioid agonist and antagonist treatment medications, if applicable.

(3) Substance use counseling by a professional to the extent authorized under State law to furnish such services including services furnished via two-way interactive audio-video communication technology, as clinically appropriate, and in compliance with all applicable requirements.

(4) Individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law), including services furnished via two-way interactive audio-video communication technology, as clinically appropriate, and in compliance with all applicable requirements.

(5) Toxicology testing.

(6) Intake activities, including initial medical examination services required under § 8.12(f)(2) of this title and initial assessment services required under § 8.12(f)(4) of this title.

(7) Periodic assessment services required under § 8.12(f)(4) of this title.

(c) *Requirements for opioid treatment programs.* To participate in the Medicare program and receive payment, an opioid treatment program must meet all of the following:

(1) Be enrolled in the Medicare program.

(2) Have in effect a certification by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the opioid treatment program.

(3) Be accredited by an accrediting body approved by the SAMHSA.

(4) Have in effect a provider agreement under part 489 of this title.

(d) *Bundled payments for opioid use disorder treatment services furnished by opioid treatment programs.*

(1) CMS will establish categories of bundled payments for opioid treatment programs for an episode of care as follows:

(i) Categories for each type of opioid agonist and antagonist treatment medication;

(ii) A category for medication not otherwise specified, which will be used for new FDA-approved opioid agonist or antagonist treatment medications for which CMS has not established a category; and

(iii) A category for episodes of care in which no medication is provided.

(2) The bundled payment for episodes of care in which a medication is provided consists of payment for a drug component, reflecting payment for the applicable FDA-approved opioid agonist or antagonist medication in the patient's treatment plan, and a non-drug component, reflecting payment for all other opioid use disorder treatment services reflected in the patient's treatment plan (including dispensing/administration of the medication, if applicable). The payments for the drug component and non-drug component are added together to create the bundled payment amount. The bundled payment

for episodes of care in which no medication is provided consists of a single payment amount for all opioid use disorder treatment services reflected in the patient's treatment plan (excluding medication and dispensing/administration of medication).

(i) *Drug component.* The payment for the drug component for an episode of care will be determined as follows, using the most recent data available at time of ratesetting for the applicable calendar year:

(A) For implantable and injectable medications, the payment is determined using the methodology set forth in section 1847A of the Act, except that the payment amount shall be 100 percent of the ASP, if ASP is used.

(B) For oral medications, if ASP data are available, the payment amount is 100 percent of ASP, which will be determined based on ASP data that have been calculated consistent with the provisions in part 414, subpart 800 of this chapter and voluntarily submitted by drug manufacturers. If ASP data are not available, the payment amount for methadone will be based on the TRICARE rate and for buprenorphine will be calculated using the National Average Drug Acquisition Cost.

(C) *Exception.* For the drug component of bundled payments in the medication not otherwise specified category under paragraph (d)(1)(iii) of this section, the payment amount is be based on the applicable methodology under paragraphs (d)(2)(i)(A) and (B) of this section (applying the most recent available data for such new medication), or invoice pricing until the necessary data become available.

(ii) *Non-drug component.* The payment for CY 2020 for the non-drug component of the bundled payment for an episode of care is the sum of:

(A) The CY 2019 Medicare physician fee schedule non-facility rates for the following items and services:

(*1*) Psychotherapy, 30 minutes with patient

(*2*) Group psychotherapy

(*3*) Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention at the non-physician practitioner rate.

(*4*) For administration of an injectable medication, if applicable, drug administration (Therapeutic, prophylactic).

(*5*) For the insertion, removal, or insertion and removal of the implantable medication, if applicable, the applicable rate.

(B) For dispensing oral medication, if applicable, an approximation of the average dispensing fees under state Medicaid programs.

(C) One fourth of the sum of the CY 2019 Clinical Laboratory Fee Schedule rate for two drug tests, presumptive, capable of being read by direct optical observation only and for a drug test, definitive, 1–7 drug classes.

(iii) *No medication provided episodes of care.* The bundled payment amount for CY 2020 for an episode of care in which no medication is provided is based on the non-drug component rate for an episode of care in which a drug is dispensed or administered, not including any amounts reflecting the cost of dispensing or administration of a drug.

(3) At least one OUD treatment service described in paragraphs (b)(1) through (5) of this section must be furnished to bill for the bundled payment for an episode of care.

(4) Adjustments will be made to the bundled payment for the following:

(i) If the opioid treatment program furnishes:

(A) Counseling or therapy services in excess of the amount specified in the beneficiary's treatment plan and for which medical necessity is documented in the medical record, an adjustment will be made for each additional 30 minutes of counseling or individual therapy furnished during the episode of care.

(B) Intake activities described in paragraph (b)(6) of this section, an adjustment will be made when intake activities are furnished.

(C) Periodic assessments described in paragraph (b)(7) of this section, an adjustment will be made when this service is furnished.

(D) Additional take home supply of oral drugs of up to 21 days, in increments of 7 days, an adjustment will be made when oral medications are dispensed.

(ii) The payment amounts for the non-drug component of the bundled payment for an episode of care, and the adjustments for counseling or therapy, intake activities and periodic assessments will be geographically adjusted using the Geographic Adjustment Factor described in § 414.26 of this chapter.

(iii) The payment amounts for the non-drug component of the bundled payment for an episode of care, and the adjustments for counseling or therapy, intake activities and periodic assessments will be updated annually using the Medicare Economic Index described in § 405.504(d) of this chapter.

(5) Payment for medications delivered, administered or dispensed to a beneficiary as part of the bundled payment is considered a duplicative payment if a claim for delivery, administration or dispensing of the same medications for the same beneficiary on the same date of service was also separately paid under Medicare Part B or Part D. CMS will recoup the duplicative payment made to the opioid treatment program.

(e) *Beneficiary cost-sharing.* A beneficiary copayment amount of zero will apply.

■ 15. Section 410.69 is amended in paragraph (b) by adding paragraph (5) to the definition of ''Certified registered nurse anesthetist'' to read as follows:

§ 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

* * * * *

(b) * * *

Certified registered nurse anesthetist * * *

(5) For certified registered nurse anesthetist services, the certified registered nurse anesthetist may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the certified registered nurse anesthetist's presence and participation in the service.

* * * * *

■ 16. Section 410.74 is amended by revising paragraph (a)(2)(iv) and by adding paragraph (e) to read as follows:

§ 410.74 Physician assistants' services.

(a) * * *

(2) * * *

(iv) Performs the services in accordance with state law and state scope of practice rules for physician assistants in the state in which the physician assistant's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and physician assistants, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act. For states with no explicit state law and scope of practice rules regarding physician supervision of physician assistant's services, physician supervision is a process in which a physician assistant has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting at the

practice level the physician assistant's scope of practice and the working relationships the physician assistant has with the supervising physician/s when furnishing professional services.

* * * * *

(e) *Medical record documentation.* For physician assistants' services, the physician assistant may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the physician assistant's presence and participation in the service.

■ 17. Section 410.75 is amended by adding paragraph (f) to read as follows:

§ 410.75 Nurse practitioners' services.

* * * * *

(f) *Medical record documentation.* For nurse practitioners' services, the nurse practitioner may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the nurse practitioner's presence and participation in the service.

■ 18. Section 410.76 is amended by adding paragraph (f) to read as follows:

§ 410.76 Clinical nurse specialists' services.

* * * * *

(f) *Medical record documentation.* For clinical nurse specialists' services, the clinical nurse specialist may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the clinical nurse specialist's presence and participation in the service.

■ 19. Section 410.77 is amended by adding paragraph (e) to read as follows:

§ 410.77 Certified nurse-midwives' services: Qualifications and conditions.

* * * * *

(e) *Medical record documentation.* For certified nurse-midwives' services, the certified nurse-midwife may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the certified nurse-midwife's presence and participation in the service.

■ 20. Section 410.105 is amended by adding paragraph (d) to read as follows:

§ 410.105 Requirements for coverage of CORF services.

* * * * *

(d) *Claims.* Effective for dates of service on and after January 1, 2020 physical therapy or occupational therapy services covered as part of a rehabilitation plan of treatment described in paragraph (c) of this section, as applicable—

(1) Claims for such services furnished in whole or in part by a physical therapist assistant or an occupational therapy assistant must be identified with the inclusion of the respective prescribed modifier; and

(2) Effective for dates of service on and after January 1, 2022, such claims are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service as defined at section 1834(k) of the Act.

(3) For purposes of this paragraph, ''furnished in whole or in part'' means when the physical therapist assistant or occupational therapy assistant either—

(i) Furnishes all the minutes of a service exclusive of the respective physical therapist or occupational therapist; or

(ii) Furnishes a portion of a service separately from the part furnished by the physical or occupational therapist such that the minutes for that portion of a service exceed 10 percent of the total time for that service.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 21. The authority citation for part 411 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn.

■ 22. Section 411.370 is amended—

■ a. In paragraph (b) introductory text, by removing the phrase ''CMS determines'' and adding in its place the phrase ''CMS will determine''; and

■ b. By revising paragraphs (b)(1), (c) introductory text, (d), and (e).

The revisions read as follows:

§ 411.370 Advisory opinions relating to physician referrals.

* * * * *

(b) * * *

(1) The request must relate to an existing arrangement or one into which the requestor, in good faith, specifically plans to enter. The planned arrangement may be contingent upon the party or parties receiving a favorable advisory opinion. CMS does not consider, for purposes of an advisory opinion, requests that involve the activities of third parties.

* * * * *

(c) *Matters not subject to advisory opinions.* CMS will not address through an advisory opinion—

* * * * *

(d) *Facts subject to advisory opinions.* The requestor must include in the advisory opinion request a complete description of the arrangement that the requestor is undertaking, or plans to undertake, as described in § 411.372.

(e) *Acceptance of requests.* (1) CMS does not accept an advisory opinion request or issue an advisory opinion if—

(i) The request is not related to a named individual or entity;

(ii) The request does not describe the arrangement at issue with a level of detail sufficient for CMS to issue an opinion, and the requestor does not timely respond to CMS requests for additional information;

(iii) CMS is aware, after consultation with OIG and DOJ, that the same course of action is under investigation, or is or has been the subject of a proceeding involving the Department of Health and Human Services or another governmental agency;

(iv) CMS believes that it cannot make an informed opinion or could only make an informed opinion after extensive investigation, clinical study, testing, or collateral inquiry; or

(v) CMS determines that the arrangement or course of conduct at issue is or would be in violation of applicable State or Federal law or regulation.

(2) CMS may elect not to accept an advisory opinion request if it determines, after consultation with OIG and DOJ:

(i) The course of action described is substantially similar to a course of conduct that is under investigation or the subject of a proceeding involving the Department or other law enforcement agencies; and

(ii) Issuing an advisory opinion could interfere with the investigation or proceeding.

* * * * *

■ 23. Section 411.372 is amended by—

■ a. Revising paragraphs (b)(4)(i) and (ii), (5), (6), and (8)(ii);

■ b. Removing paragraph (b)(9); and

■ c. Adding paragraph (d).

The revisions and addition read as follows:

§ 411.372 Procedure for submitting a request.

* * * * *

(b) * * *

(4) * * *

(i) A complete description of the arrangement that the requestor is undertaking, or plans to undertake, including:

(A) The purpose of the arrangement; the nature of each party's (including each entity's) contribution to the arrangement; the direct or indirect relationships between the parties, with an emphasis on the relationships between physicians involved in the arrangement (or their immediate family members who are involved); and

(B) Any entities that provide designated health services; the types of services for which a physician wishes to refer, and whether the referrals will involve Medicare or Medicaid patients;

(ii) Complete copies of all relevant documents or relevant portions of documents that affect or could affect the arrangement, such as personal service or employment contracts, leases, deeds, pension or insurance plans, or financial statements (or, if these relevant documents do not yet exist, a complete description, to the best of the requestor's knowledge, of what these documents are likely to contain);

* * * * *

(5) The identity of all entities involved either directly or indirectly in the arrangement, including their names, addresses, legal form, ownership structure, nature of the business (products and services) and, if relevant, their Medicare and Medicaid provider numbers. The requestor must also include a brief description of any other entities that could affect the outcome of the opinion, including those with which the requestor, the other parties, or the immediate family members of involved physicians, have any financial relationships (either direct or indirect, and as defined in section 1877(a)(2) of the Act and § 411.354), or in which any of the parties holds an ownership or control interest as defined in section 1124(a)(3) of the Act.

(6) At the option of the requestor, a discussion of the specific issues or questions to be addressed by CMS including, if possible, a discussion of why the requestor believes the referral prohibition in section 1877 of the Act might or might not be triggered by the arrangement and which, if any, exceptions the requestor believes might apply. The requestor should attempt to designate which facts are relevant to each issue or question raised in the request and should cite the provisions of law under which each issue or question arises.

* * * * *

(8) * * *

(ii) The chief executive officer, or other authorized officer, of the requestor, if the requestor is a corporation;

* * * * *

(d) *Requests for expedited review.* Parties may seek expedited review of arrangements under § 411.380(c)(1)(i) for a determination as to whether the arrangement or course of conduct is indistinguishable in all material aspects from an arrangement or course of conduct that was the subject of a prior advisory opinion. Parties seeking such expedited review must identify the relevant advisory opinion and provide an explanation of why the subject arrangement is indistinguishable from the arrangement that was the subject of the prior relevant advisory opinion. Requestors should clearly and prominently indicate in their submission to CMS that they are seeking expedited review.

■ 24. Section 411.375 is amended by—

■ a. Revising paragraphs (a);

■ b. Removing paragraph (b); and

■ c. Redesignating paragraphs (c) and (d) as paragraphs (b) and (c).

The revision reads as follows:

§ 411.375 Fees for the cost of advisory opinions.

(a) *Hourly rate.* CMS will charge an hourly rate of $220. Parties may request an estimate from CMS after submitting a complete request. Before issuing the advisory opinion, CMS will calculate the final fee for responding to the request.

* * * * *

■ 25. Section 411.379 is amended by revising paragraphs (a), (b), (d) and (e) to read as follows:

§ 411.379 When CMS accepts a request.

(a) Upon receiving a request for an advisory opinion, CMS promptly makes an initial determination of whether the request contains a level of detail sufficient for CMS to process the request.

(b) If CMS determines that the request submitted lacks details necessary for CMS to process the request, CMS will provide notification to the requestor within 15 working days of receiving the request.

* * * * *

(d) CMS formally accepts a request when CMS determines that the request (inclusive of any supplemental submissions) describes the arrangement at issue with sufficient detail and that the grounds for rejection of a request listed at § 411.370(e) do not apply. Upon accepting the request, CMS notifies the requestor by regular U.S. mail of the date that CMS formally accepts the request.

(e) The applicable time period that CMS has to issue an advisory opinion set forth in § 411.380(c) does not begin until CMS formally accepts the request for an advisory opinion.

■ 26. Section 411.380 is amended by revising paragraph (c) to read as follows:

§ 411.380 When CMS issues a formal advisory opinion.

* * * * *

(c)(1) Except as set forth in paragraph (c)(2) of this section, CMS issues an advisory opinion in accordance with the provisions of this part within 60 working days after the date on which it formally accepts the advisory opinion request.

(i) In the case of a request for a determination that an arrangement or course of conduct is indistinguishable in all material aspects from another arrangement or course of conduct that was the subject of a prior opinion, CMS issues an advisory opinion within 30 working days after the date on which it formally accepts the advisory opinion request.

(ii) In the case of a request that CMS determines, in its discretion, involves complex legal issues or highly complicated fact patterns, CMS issues an advisory opinion within a reasonable time period after the date on which it formally accepts the advisory opinion request.

(iii) If the last day of the 60-working day or 30-working day time period falls on a Saturday, Sunday, or Federal holiday, CMS may issue the advisory opinion at the close of business on the first business day following the weekend or holiday.

(2) The applicable time period for issuing an advisory opinion is suspended from the time CMS;

(i) Notifies the requestor that the costs have reached or are likely to exceed the triggering amount as described in § 411.375(c)(2) until CMS receives written notice from the requestor to continue processing the request;

(ii) Requests additional information from the requestor until CMS receives the additional information;

(iii) Notifies the requestor of the full amount due until CMS receives payment of this amount; and

(iv) Notifies the requestor of the need for expert advice until CMS receives the expert advice.

* * * * *

■ 27. Section 411.382 is revised to read as follows:

§ 411.382 CMS' right to rescind advisory opinions.

(a)(1) Any advice CMS gives in an advisory opinion does not prejudice its right to reconsider the questions involved in the opinion, and CMS may rescind or revoke the opinion if it determines that there is good cause to rescind or revoke the opinion.

(2) Good cause shall exist where—

(i) There is a material change in the law that affects the conclusions reached in an opinion; or

(ii) A party that has received a negative advisory opinion seeks reconsideration based on new facts or law.

(b) CMS provides advance notice to the requestor and to the public of its decision to rescind or revoke the opinion so that the requestor and other parties may discontinue any course of action they have taken in accordance with, or in good faith reliance on, the advisory opinion.

(c) CMS does not proceed against the requestor with respect to any action the requestor and the involved parties have taken in good faith reliance upon CMS' advice under this part, provided—

(1) The requestor presented to CMS a full, complete and accurate description of all the relevant facts; and

(2) The parties promptly discontinue the action upon receiving notice that CMS had rescinded or revoked its approval, or discontinue the action within a reasonable ''wind down'' period, as determined by CMS.

§ 411.384 [Amended]

■ 28. Section 411.384 is amended in paragraph (b) by removing the phrase ''for public inspection during its normal hours of operation and''.

■ 29. Section 411.387 is revised to read as follows:

§ 411.387 Effect of an advisory opinion.

(a) An advisory opinion is binding on the Secretary, and a favorable advisory opinion shall preclude imposition of sanctions under section 1877(g) of the Act with respect to:

(1) The individuals or entities requesting the opinion; and

(2) Individuals or entities that are parties to the specific arrangement with respect to which such advisory opinion has been issued.

(b) The Secretary will not pursue sanctions under section 1877(g) of the Act against any party to an arrangement that CMS determines is indistinguishable in all its material aspects from an arrangement with respect to which CMS issued a favorable advisory opinion.

(c) Individuals and entities may rely on an advisory opinion as non-binding guidance that illustrates the application of the physician self-referral law and regulations to the specific facts and circumstances described in the advisory opinion.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 30. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

■ 31. Section 414.601 is amended by adding the following sentence to the end of the section:

§ 414.601 Purpose.

* * * Section 1834(l)(17) of the Act requires the development of a data collection system to collect cost, revenue, utilization, and other information determined appropriate from providers of services and suppliers of ground ambulance services.

■ 32. Section 414.605 is amended by—

■ a. Adding the definition of ''Ground ambulance organization'' in alphabetical order; and

■ b. In the definition of ''Paramedic ALS intercept (PI)'' by removing the reference ''§ 410.40(c)'' and adding in its place the reference ''§ 410.40(d)''.

The addition reads as follows:

§ 414.605 Definitions.

* * * * *

Ground ambulance organization means a Medicare provider or supplier of ground ambulance services.

* * * * *

■ 33. Section 414.610 is amended by adding paragraph (c)(9) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(9) *Payment reduction for failure to report data.* In the case of a ground ambulance organization (as defined at § 414.605) that is selected by CMS under § 414.626(c) for a year that does not sufficiently submit data under § 414.626(b) and is not granted a hardship exemption under § 414.626(d), the payments made under this section are reduced by 10 percent for the applicable period. For purposes of this paragraph, the applicable period is the calendar year that begins following the date that CMS provided written notification to the ground ambulance organization under § 414.626(e)(1) that the ground ambulance did not sufficiently submit the required data.

* * * * *

■ 34. Section 414.626 is added to subpart H to read as follows:

§ 414.626 Data reporting by ground ambulance organizations.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Data collection period means, with respect to a year, the 12-month period that reflects the ground ambulance organization's annual accounting period.

Data reporting period means, with respect to a year, the 5-month period that begins the day after the last day of the ground ambulance organization's data collection period.

For a year means one of the calendar years from 2020 through 2024.

Medicare Ground Ambulance Data Collection Instrument means the single survey-based data collection instrument that can be accessed by sampled ambulance organizations under this section via a secure web-based system for reporting data under this section.

(b) *Data collection and submission requirement.* Except as provided in paragraph (d) of this section, a ground ambulance organization selected by CMS under paragraph (c) of this section must do the following:

(1) Within 30 days of the date that CMS notifies a ground ambulance organization under paragraph (c)(3) of this section that it has selected the ground ambulance organization to report data under this section, the ground ambulance must select a data collection period that corresponds with its annual accounting period and provide the start date of that data collection period to the ground ambulance organization's Medicare Administrative Contractor.

(2) Collect during its selected data collection period the data necessary to complete the Medicare Ground Ambulance Data Collection Instrument.

(3) Submit to CMS a completed Medicare Ground Ambulance Data Collection Instrument during the data reporting period that corresponds to the ground ambulance organization's selected data collection period.

(c) *Representative sample.* (1) *Random sample.* For purposes of the data collection described in paragraph (b) of this section, and for a year, CMS will select a random sample of 25 percent of eligible ground ambulance organizations that is stratified based on:

(i) Provider versus supplier status and ownership (for-profit, non-profit, and government);

(ii) Service area population density (transports originating in primarily urban, rural, and super rural zip codes); and

(iii) Medicare-billed transport volume categories.

(2) *Selection eligibility.* A ground ambulance organization is eligible to be selected for data reporting under this section for a year if it is enrolled in Medicare and has submitted to CMS at least one Medicare ambulance transport claim during the year prior to the selection under paragraph (b)(1) of this section.

(3) *Notification of selection for a year.* CMS will notify an eligible ground ambulance organization that it has been selected to report data under this section for a year at least 30 days prior to the beginning of the calendar year in which the ground ambulance organization must begin to collect data by posting a list of selected organizations on the CMS web page and providing written notification to each selected ground ambulance organization via email or U.S. mail.

(4) *Limitation.* CMS will not select the same ground ambulance organization under this paragraph (c) in 2 consecutive years, to the extent practicable.

(d) *Hardship exemption.* A ground ambulance organization selected under paragraph (c) of this section may request and CMS may grant an exception to the reporting requirements under paragraph (b) of this section in the event of a significant hardship, such as a natural disaster, bankruptcy, or similar situation that the Secretary determines interfered with the ability of the ground ambulance organization to submit such information in a timely manner for the data collection period selected by the ground ambulance organization.

(1) To request a hardship exemption, the ground ambulance organization must submit a request form (accessed on the Ambulances Services Center website (*https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html*) to CMS within 90 calendar days of the date that CMS notified the ground ambulance organization that it would receive a 10 percent payment reduction as a result of not submitting sufficient information under the data collection system. The request form must include all of the following:

(i) Ground ambulance organization name.

(ii) NPI number.

(iii) Ground ambulance organization address.

(iv) Chief executive officer and any other designated personnel contact information, including name, email address, telephone number and mailing address (must include a physical address, a post office box address is not acceptable).

(v) Reason for requesting a hardship exemption.

(vi) Evidence of the impact of the hardship (such as photographs, newspaper or other media articles, financial data, bankruptcy filing, etc.).

(vii) Date when the ground ambulance organization would be able to begin collecting data under paragraph (b) of this section.

(viii) Date and signature of the chief executive officer or other designated personnel of the ground ambulance organization.

(2) CMS will provide a written response to the hardship exemption request within 30 days of its receipt of the hardship exemption form.

(e) *Notification of non-compliance and informal review.* (1) *Notification of non-compliance.* A ground ambulance organization selected under paragraph (c) of this section for a year that does not sufficiently report data under paragraph (b) of this section, will receive written notification from CMS that it will receive a payment reduction under § 414.610(c)(9).

(2) *Informal review.* A ground ambulance organization that receives a written notification under paragraph (e)(1) of a payment reduction under § 414.610(c)(9) may submit a request for an informal review within 90 days of the date it received the notification by submitting all of the following information:

(i) Ground ambulance organization name.

(ii) NPI number.

(iii) Chief executive officer and any other designated personnel contact information, including name, email address, telephone number and mailing address with the street location of the ground ambulance organization.

(iv) Ground ambulance organization's selected data collection period and data reporting period.

(v) A statement of the reasons why the ground ambulance organization does not agree with CMS' determination and any supporting documentation.

(f) *Public availability of data.* Beginning in 2022, and at least once every 2 years thereafter, CMS will post on its website data that it collected under this section, including but not limited to summary statistics and ground ambulance organization characteristics.

(g) *Limitations on review.* There is no administrative or judicial review under section 1869 or section 1878 of the Act, or otherwise of the data required for submission under paragraph (b) of this section or the selection of ground ambulance organizations under paragraph (c) of this section.

■ 35. Section 414.1305 is amended by—

■ a. Adding the definition of ''Aligned Other Payer Medical Home Model'' in alphabetical order;

■ b. Revising the definition of ''Hospital-based MIPS eligible clinician'';

■ c. Adding the definition of ''MIPS Value Pathway'' in alphabetical order; and

■ d. Revising the definition of ''Rural area''.

The additions and revision read as follows:

§ 414.1305 Definitions.

* * * * *

Aligned Other Payer Medical Home Model means an aligned other payer payment arrangement (not including a Medicaid payment arrangement) operated by a payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU) with CMS, and is determined by CMS to have the following characteristics:

(1) The other payer payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;

(2) Empanelment of each patient to a primary clinician; and

(3) At least four of the following:

(i) Planned coordination of chronic and preventive care.

(ii) Patient access and continuity of care.

(iii) Risk-stratified care management.

(iv) Coordination of care across the medical neighborhood.

(v) Patient and caregiver engagement.

(vi) Shared decision-making.

(vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

* * * * *

Hospital-based MIPS eligible clinician means:

(1) For the 2019 and 2020 MIPS payment years, a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus-outpatient hospital, or emergency room setting based on claims for a period prior to the performance period as specified by CMS; and

(2) For the 2021 MIPS payment year, a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period; and

(3) Beginning with the 2022 MIPS payment year, an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.

* * * * *

MIPS Value Pathway means a subset of measures and activities established through rulemaking.

* * * * *

Rural area means a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP), using the most recent FORHP Eligible ZIP Code file available.

* * * * *

■ 36. Section 414.1310 is amended by—

■ a. Revising paragraph (e)(2)(ii); and

■ b. Removing paragraphs (e)(3) through (5).

The revision reads as follows:

§ 414.1310 Applicability.

* * * * *

(e) * * *

(2) * * *

(ii) Individual eligible clinicians that elect to participate in MIPS as a group must aggregate their performance data across the group's TIN, and for the Promoting Interoperability performance category, must aggregate the performance data of all of the MIPS eligible clinicians in the group's TIN for whom the group has data in CEHRT.

* * * * *

■ 37. Section 414.1315 is amended by revising paragraph (d)(2) to read as follows:

§ 414.1315 Virtual groups.

* * * * *

(d) * * *

(2) Solo practitioners and groups of 10 or fewer eligible clinicians that elect to participate in MIPS as a virtual group must aggregate their performance data across the virtual group's TINs, and for the Promoting Interoperability performance category, must aggregate the performance data of all of the MIPS eligible clinicians in the virtual group's TINs for whom the virtual group has data in CEHRT.

* * * * *

■ 38. Section 414.1320 is amended by adding paragraph (f) to read as follows:

§ 414.1320 MIPS performance period.

* * * * *

(f) For purposes of the 2023 MIPS payment year, the performance period for:

(1) The Promoting Interoperability performance category is a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

(2) [Reserved]

■ 39. Section 414.1330 is amended by revising paragraphs (b)(3) to read as follows:

§ 414.1330 Quality performance category.

* * * * *

(b) * * *

(3) 45 percent of a MIPS eligible clinician's final score for MIPS payment years 2021 and 2022.

■ 40. Section 414.1335 is amended by revising paragraph (a)(3)(i) to read as follows:

§ 414.1335 Data submission criteria for the quality performance category.

(a) * * *

(3) * * *

(i) For the 12-month performance period, a group that participates in the CAHPS for MIPS survey must use a survey vendor that is approved by CMS for the applicable performance period to transmit survey measures data to CMS.

* * * * *

■ 41. Section 414.1340 is amended by revising paragraphs (a)(1) and (2) and adding paragraphs (a)(3), (b)(3), and (d) to read as follows:

§ 414.1340 Data completeness criteria for the quality performance category.

(a) * * *

(1) At least 50 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment year 2019.

(2) At least 60 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment years 2020 and 2021.

(3) At least a 70 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the 2022 MIPS payment year.

(b) * * *

(3) At least a 70 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the 2022 MIPS payment year.

* * * * *

(d) If quality data are submitted selectively such that the submitted data are unrepresentative of a MIPS eligible clinician or group's performance, any such data would not be true, accurate, or complete for purposes of § 414.1390(b) or § 414.1400(a)(5).

■ 42. Section 414.1350 is amended by revising paragraphs (b), (c)(2) and (d)(3) to read as follows:

§ 414.1350 Cost performance category.

* * * * *

(b) *Attribution.* (1) Cost measures are attributed at the TIN/NPI level for the 2017 thorough 2019 performance periods.

(2) For the total per capita cost measure specified for the 2017 through 2019 performance periods, beneficiaries are attributed using a method generally consistent with the method of assignment of beneficiaries under § 425.402 of this chapter.

(3) For the Medicare Spending per Beneficiary clinician (MSPB clinician) measure specified for the 2017 through 2019 performance periods, an episode is attributed to the MIPS eligible clinician who submitted the plurality of claims (as measured by allowed charges) for Medicare Part B services rendered during an inpatient hospitalization that is an index admission for the MSPB clinician measure during the applicable performance period.

(4) For the acute condition episode-based measures specified for the 2017 performance period, an episode is attributed to each MIPS eligible clinician who bills at least 30 percent of

inpatient evaluation and management (E/M) visits during the trigger event for the episode.

(5) For the procedural episode-based measures specified for the 2017 performance period, an episode is attributed to each MIPS eligible clinician who bills a Medicare Part B claim with a trigger code during the trigger event for the episode.

(6) For the acute inpatient medical condition episode-based measures specified for the 2019 performance period, an episode is attributed to each MIPS eligible clinician who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E/M claim lines in that hospitalization.

(7) For the procedural episode-based measures specified for the 2019 performance period, an episode is attributed to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes.

(8) Beginning with the 2020 performance period, each cost measure is attributed according to the measure specifications for the applicable performance period.

* * * * *

(c) * * *

(2) For the Medicare spending per beneficiary clinician measure, the case minimum is 35.

* * * * *

(d) * * *

(3) 15 percent of a MIPS eligible clinician's final score for MIPS payment years 2021 and 2022.

■ 43. Section 414.1360 is amended by adding paragraph (a)(2) to read as follows:

§ 414.1360 Data submission criteria for the improvement activities performance category.

(a) * * *

(2) *Groups and virtual groups.* Beginning with the 2020 performance year, each improvement activity for which groups and virtual groups submit a yes response in accordance with paragraph (a)(1) of this section must be performed by at least 50 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, and the NPIs must perform the same activity during any continuous 90-day period within the same performance year.

* * * * *

■ 44. Section 414.1370 is amended by adding paragraph (e)(2) and revising paragraph (g)(1) to read as follows:

§ 414.1370 APM scoring standard under MIPS.

* * * * *

(e) * * *

(2) For purposes of calculating the APM Entity group score under the APM scoring standard, MIPS scores submitted by virtual groups will not be included.

* * * * *

(g) * * *

(1) *Quality.* Beginning in the 2020 Performance year—

(i) *MIPS APMs that require APM Entities to submit quality data through a MIPS submission mechanism.* The MIPS quality performance category score for a performance period will be calculated for the APM Entity using the data submitted for the APM Entity through a MIPS submission mechanism in accordance with § 414.1335.

(ii) *MIPS APMs that do not require APM Entities to submit quality data through a MIPS submission mechanism.* The APM Entity will be assigned an APM Quality Reporting Credit worth 50 percent of the total quality performance category score. The APM Quality Reporting Credit will be added to the MIPS quality performance category score to generate an APM Entity quality performance category score, which in no case shall exceed 100. The MIPS quality performance category score for a performance period will be calculated for the APM Entity using the data submitted for the APM Entity through a MIPS submission mechanism in accordance with § 414.1335.

(iii) *Determination of score for each MIPS eligible clinician in an APM entity.* Regardless of whether a MIPS APM requires APM Entities to submit quality data through a MIPS submission mechanism, if data are not submitted for an APM Entity through a MIPS submission mechanism in accordance with § 414.1335, the score for each MIPS eligible clinician in such APM Entity is the higher of either:

(A) A TIN level score based on the measure data for the quality performance category reported by a TIN for the MIPS eligible clinician in accordance with § 414.1335; or

(B) An individual level score based on the measure data for the quality performance category reported by the MIPS eligible clinician in accordance with § 414.1335.

(iv) Quality improvement score. For an APM Entity for which CMS calculated a total quality performance category score for one or more participants in the APM Entity for the preceding MIPS performance period, CMS calculates a quality improvement score for the APM Entity group as specified in § 414.1380(b)(1)(xvi).

* * * * *

■ 45. Section 414.1380 is amended—

■ a. In paragraph (b)(1)(i) introductory text by removing the years ''2019, 2020, and 2021'' and adding in its place the years ''2019 through 2022'';

■ b. In paragraph (b)(1)(i)(A)(*1*) by removing the years ''2019, 2020, and 2021'' and adding in its place the years ''2019 through 2022'';

■ c. By revising paragraph (b)(1)(ii) introductory text;

■ d. By adding paragraph (b)(1)(ii)(C);

■ e. By revising paragraph (b)(1)(v)(A)(*1*)(*i*);

■ f. In paragraph (b)(1)(v)(A)(*1*)(*ii*) by removing the years ''2019, 2020, and 2021'' and adding in its place the years ''2019 through 2022'';

■ g. In paragraph (b)(1)(v)(B)(*1*)(*i*) by removing the years ''2019, 2020, and 2021'' and adding in its place the years ''2019 through 2022'';

■ h. In paragraph (b)(1)(vi)(C)(*4*) by removing the phrase ''2020 and 2021 MIPS payment year'' and adding in its place the phrase ''2020 through 2022 MIPS payment years'';

■ i. By revising paragraph (b)(3)(ii)(A) and (C);

■ j. In paragraph (c)(2)(i)(A)(*4*) by removing the phrase ''beginning with the 2021 MIPS payment year'' and adding in its place the phrase ''for the 2021 and 2022 MIPS payment years'';

■ k. In paragraph (c)(2)(i)(A)(*5*) by removing the years ''2019, 2020, and 2021'' and adding in its place the years ''2019, 2020, 2021, and 2022'';

■ l. By adding paragraph (c)(2)(i)(A)(*9*);

■ m. By revising paragraph (c)(2)(i)(C) introductory text;

■ n. By adding paragraphs (c)(2)(i)(C)(*10*) and (c)(2)(ii)(D);

■ o. By revising paragraph (c)(2)(iii) and (c)(3) introductory text; and

■ p. In paragraph (e)(2)(i)(C) by removing the phrase ''Can be attributed'' and adding in its place the phrase ''Can be assigned''.

The revisions and additions read as follows:

§ 414.1380 Scoring.

* * * * *

(b) * * *

(1) * * *

(ii) *Benchmarks.* Except as provided in paragraphs (b)(1)(ii)(B) and (C) of this section, benchmarks will be based on performance by collection type, from all available sources, including MIPS eligible clinicians and APMs, to the extent feasible, during the applicable baseline or performance period.

* * * * *

(C) Beginning with the 2022 MIPS payment year, for each measure that has a benchmark that CMS determines may have the potential to result in inappropriate treatment, CMS will set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the methodology at paragraph (b)(1)(ii) of this section.

* * * * *

(v) * * *

(A) * * *

(*1*) * * *

(*i*) Each high priority measure must meet the case minimum requirement at paragraph (b)(1)(iii) of this section, meet the data completeness requirement at § 414.1340, and have a performance rate that is greater than zero.

* * * * *

(3) * * *

(ii) * * *

(A) The practice has received accreditation from an accreditation organization that is nationally recognized.

* * * * *

(C) The practice is a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; or

* * * * *

(c) * * *

(2) * * *

(i) * * *

(A) * * *

(*9*) Beginning with the 2020 MIPS payment year, for the quality, cost, and improvement activities performance categories, CMS determines, based on information known to the agency prior to the beginning of the relevant MIPS payment year, that data for a MIPS eligible clinician are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician and its agents.

* * * * *

(C) Under section 1848(o)(2)(D) of the Act, a significant hardship exception or other type of exception is granted to a MIPS eligible clinician based on the following circumstances for the Promoting Interoperability performance category. Except as provided in paragraph (c)(2)(i)(C)(10) of this section, in the event that a MIPS eligible clinician submits data for the Promoting Interoperability performance category, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

* * * * *

(10) Beginning with the 2020 MIPS payment year, CMS determines, based on information known to the agency prior to the beginning of the relevant MIPS payment year, that data for a MIPS eligible clinician are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician and its agents.

* * * * *

(ii) * * *

(D) For the 2022 MIPS payment year:

Reweighting scenario	Quality (%)	Cost (%)	Improvement activities (%)	Promoting interoperability (%)
No Reweighting Needed:				
Scores for all four performance categories	45	15	15	25
Reweight One Performance Category:				
No Cost	55	0	15	30
No Promoting Interoperability	70	15	15	0
No Quality	0	15	15	70
No Improvement Activities	60	15	0	25
Reweight Two Performance Categories:				
No Cost and no Promoting Interoperability	85	0	15	0
No Cost and no Quality	0	0	15	85
No Cost and no Improvement Activities	70	0	0	30
No Promoting Interoperability and no Quality	0	50	50	0
No Promoting Interoperability and no Improvement Activities	85	15	0	0
No Quality and no Improvement Activities	0	15	0	85

(iii) For the Promoting Interoperability performance category to be reweighted in accordance with paragraph (c)(2)(ii) of this section for a MIPS eligible clinician who elects to participate in MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group or virtual group must qualify for reweighting based on the circumstances described in paragraph (c)(2)(i) of this section, or the group or virtual group must meet the definition of a hospital-based MIPS eligible clinician or a non-patient facing MIPS eligible clinician as defined in § 414.1305.

(3) *Complex patient bonus.* For the 2020, 2021 and 2022 MIPS payment years, provided that a MIPS eligible clinician, group, virtual group or APM entity submits data for at least one MIPS performance category for the applicable performance period for the MIPS payment year, a complex patient bonus will be added to the final score for the MIPS payment year, as follows:

* * * * *

■ 46. Section 414.1385 is amended by revising paragraph (a) to read as follows:

§ 414.1385 Targeted review and review limitations.

(a) *Targeted review.* A MIPS eligible clinician or group may request a targeted review of the calculation of the MIPS payment adjustment factor under section 1848(q)(6)(A) of the Act and, as applicable, the calculation of the additional MIPS payment adjustment factor under section 1848(q)(6)(C) of the Act (collectively referred to as the MIPS payment adjustment factors) applicable to such MIPS eligible clinician or group for a year. The process for targeted review is as follows:

(1) A MIPS eligible clinician or group (including their designated support staff), or a third party intermediary as defined at § 414.1305, may submit a request for a targeted review.

(2) All requests for targeted review must be submitted during the targeted review request submission period, which is a 60-day period that begins on the day CMS makes available the MIPS payment adjustment factors for the MIPS payment year. The targeted review request submission period may be extended as specified by CMS.

(3) A request for a targeted review may be denied if the request is duplicative of another request for a targeted review; the request is not

submitted during the targeted review request submission period; or the request is outside of the scope of the targeted review, which is limited to the calculation of the MIPS payment adjustment factors applicable to the MIPS eligible clinician or group for a year. If the targeted review request is denied, there will be no change to the MIPS final score or associated MIPS payment adjustment factors for the MIPS eligible clinician or group. If the targeted review request is approved, the MIPS final score and associated MIPS payment adjustment factors may be revised, if applicable, for the MIPS eligible clinician or group.

(4) CMS will respond to each request for a targeted review timely submitted and determine whether a targeted review is warranted.

(5) A request for a targeted review may include additional information in support of the request at the time it is submitted. If CMS requests additional information from the MIPS eligible clinician or group that is the subject of a request for a targeted review, it must be provided and received by CMS within 30 days of CMS' request. Non-responsiveness to CMS' request for additional information may result in a final decision based on the information available, although another non-duplicative request for a targeted review may be submitted before the end of the targeted review request submission period.

(6) If a request for a targeted review is approved, CMS may recalculate, to the extent feasible and applicable, the scores of a MIPS eligible clinician or group with regard to measures, activities, performance categories, and the final score, as well as the MIPS payment adjustment factors.

(7) Decisions based on the targeted review are final, and there is no further review or appeal. CMS will notify the individual or entity that submitted the request for a targeted review of the final decision.

(8) Documentation submitted for a targeted review must be retained by the submitter for 6 years from the end of the MIPS performance period.

* * * * *

■ 47. Section 414.1395 is amended by revising paragraph (a) to read as follows:

§ 414.1395 Public reporting.

(a) *General.* (1) CMS posts on Physician Compare, in an easily understandable format, the following:

(i) Information regarding the performance of MIPS eligible clinicians, including, but not limited to, final scores and performance category scores for each MIPS eligible clinician; and

(ii) The names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs.

(2) CMS periodically posts on Physician Compare aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians with respect to each performance category.

(3) The information made available under this section will indicate, where appropriate, that publicized information may not be representative of an eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated.

* * * * *

■ 48. Section 414.1400 is amended by—

■ a. Revising paragraphs (a)(2) introductory text and (a)(2)(iii);

■ b. Adding paragraphs (a)(4)(v) and (vi);

■ c. Revising paragraph (b)(1);

■ d. Adding paragraphs (b)(2)(iii), (b)(3)(iv) through (vii), ;

■ e. Revising paragraph (c)(1);

■ f. Adding paragraphs (c)(2)(i) and (ii); and

■ g. Revising paragraphs (f)(1) introductory text and (f)(3) introductory text.

The revision and addition reads as follows:

§ 414.1400 Third party intermediaries.

(a) * * *

(2) Beginning with the 2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all of the following MIPS performance categories, and Health IT vendors must be able to submit data for at least one of the following MIPS performance categories:

* * * * *

(iii) Promoting Interoperability, if the eligible clinician, group, or virtual group is using CEHRT; however, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(*4*) or (*5*) or § 414.1380(c)(2)(i)(C)(*1*) through (*7*) or § 414.1380(c)(2)(i)(C)(*9*)).

* * * * *

(4) * * *

(v) The third party intermediary must provide services throughout the entire performance period and applicable data submission period.

(vi) Prior to discontinuing services to any MIPS eligible clinician, group, or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved a transition plan.

* * * * *

(b) * * *

(1) *QCDR self-nomination.* For the 2020 and 2021 MIPS payment years, entities seeking to qualify as a QCDR must self-nominate September 1 until November 1 of the CY preceding the applicable performance period. For the 2022 MIPS payment year and future years, entities seeking to qualify as a QCDR must self-nominate during a 60-day period during the CY preceding the applicable performance period (beginning no earlier than July 1 and ending no later than September 1). Entities seeking to qualify as a QCDR for a performance period must provide all information required by CMS at the time of self-nomination and must provide any additional information requested by CMS during the review process. For the 2021 MIPS payment year and future years, existing 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. Beginning with the 2023 payment year, QCDRs are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at paragraph (b)(2)(iv) of this section), and if not, provide sufficient rationale as to why they do not believe they would be able to meet this requirement. Each QCDR would still be required to submit notification to CMS within the reporting period promptly within the month of realization of the impending deficiency in order to be considered for this exception, as discussed at paragraph (b)(2)(iv) of this section.

(2) * * *

(iii) Beginning with the 2023 MIPS payment year, require QCDRs to provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR. Exceptions to this requirement may occur if the QCDR does not receive the data from their clinician until the end of the performance period.

(3) * * *

(iv) QCDR measure considerations for approval include:

(A) Preference for measures that are outcome-based rather than clinical process measures.

(B) Measures that address patient safety and adverse events.

(C) Measures that identify appropriate use of diagnosis and therapeutics.

(D) Measures that address the domain of care coordination.

(E) Measures that address the domain for patient and caregiver experience.

(F) Measures that address efficiency, cost, and resource use.

(G) Beginning with the 2021 performance period—

(*1*) That QCDRs link their QCDR measures as feasible to at least one of the following at the time of self-nomination:

(*i*) Cost measure;

(*ii*) Improvement activity; or

(*iii*) An MVP.

(*2*) In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or an MVP, we would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure requirements and considerations.

(H) Beginning with the 2020 performance period CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure.

(I) We give greater consideration to measures for which QCDRs:

(*1*) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and

(*2*) Utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development.

(J) Beginning with the 2020 performance period, we place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. Those that do not, may not continue to be approved.

(*1*) Beginning with the 2020 performance period, in instances where a QCDR believes the low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist's practice, that the QCDR may develop and submit a QCDR measure participation plan for our consideration. This QCDR measure participation plan must include the QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program.

(*2*) [Reserved]

(v) QCDR measure requirements for approval include:

(A) QCDR Measures that are beyond the measure concept phase of development.

(B) QCDR Measures that address significant variation in performance.

(C) Beginning with the 2021 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination.

(D) Beginning with the 2021 performance period, QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

(E) Beginning with the 2022 MIPS payment year, CMS may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. If the QCDR measures are not harmonized, CMS may reject the duplicative QCDR measure.

(vi) Beginning with the 2021 performance period, QCDR measures may be approved for 2 years, at CMS discretion, by attaining approval status by meeting QCDR measure considerations and requirements. Upon annual review, CMS may revoke QCDR measure second year approval, if the QCDR measure is found to be: Topped out; duplicative of a more robust measure; reflects an outdated clinical guideline; requires QCDR measure harmonization; or if the QCDR self-nominating the QCDR measure is no longer in good standing.

(vii) Beginning with the 2020 performance period, QCDR measure rejection criteria considerations include, but are not limited to, the following factors:

(A) QCDR measures that are duplicative, or identical to other QCDR measures or MIPS quality measures that are currently in the program.

(B) QCDR measures that are duplicative or identical to MIPS quality measures that have been removed from MIPS through rulemaking.

(C) QCDR measures that are duplicative or identical to quality measures used under the legacy Physician Quality Reporting System (PQRS) program, which have been retired.

(D) QCDR measures that meet the topped out definition as described at § 414.1305.

(E) QCDR measures that are process-based, with consideration to whether the removal of the process measure impacts the number of measures available for a specific specialty.

(F) Whether the QCDR measure has potential unintended consequences to a patient's care.

(G) Considerations and evaluation of the measure's performance data, to determine whether performance variance exists.

(H) Whether the previously identified areas of duplication have been addressed as requested.

(I) QCDR measures that split a single clinical practice or action into several QCDR measures.

(J) QCDR measures that are ''check-box'' with no actionable quality action.

(K) QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years.

(L) Whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality actions, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization.

(M) QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician.

(N) QCDR measures that focus on rare events or ''never events'' in the measurement period.

(c) * * *

(1) *Qualified registry self-nomination.* For the 2020 and 2021 MIPS payment years, entities seeking to qualify as a qualified registry must self-nominate from September 1 until November 1 of the CY preceding the applicable performance period. For the 2022 MIPS payment year and future years, entities seeking to qualify as a qualified registry must self-nominate during a 60-day period during the CY preceding the applicable performance period (beginning no earlier than July 1 and ending no later than September 1). Entities seeking to qualify as a qualified registry for a performance period must provide all information required by CMS at the time of self-nomination and must provide any additional

information requested by CMS during the review process. For the 2021 MIPS payment year and future years, existing qualified registries 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. Beginning with the 2023 payment year, qualified registries are required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year (as specified at § 414.1400(c)(2)(ii)), and if not, provide sufficient rationale as to why they do not believe they would be able to meet this requirement. Each qualified registry would still be required to submit notification to CMS within the reporting period promptly within the month of realization of the impending deficiency in order to be considered for this exception, as discussed at § 414.1400(c)(2)(ii).

(2) * * *

(i) Beginning with the 2022 MIPS Payment Year, the qualified registry must have at least 25 participants by January 1 of the year prior to the applicable performance period.

(ii) Beginning with the 2023 MIPS payment year, require qualified registries to provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the qualified registries. Exceptions to this requirement may occur if the qualified registries does not receive the data from their clinician until the end of the performance period.

* * * * *

(f) * * *

(1) If CMS determines that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, has submitted a false certification under paragraph (a)(5) of this section, or has submitted data that are inaccurate, unusable, or otherwise compromised, CMS may take one or more of the following remedial actions after providing written notice to the third party intermediary:

* * * * *

(3) For purposes of paragraph (f) of this section, CMS may determine that submitted data are inaccurate, unusable, or otherwise compromised, including but not limited to, if the submitted data:

* * * * *

■ 49. Section 414.1405 is amended by—

■ a. Adding paragraphs (b)(7) and (8);

■ b. Adding paragraph, (d)(6); and

■ c. Revising paragraph (f) introductory text.

The additions and revision read as follows:

§ 414.1405 Payment.

* * * * *

(b) * * *

(7) The performance threshold for the 2022 MIPS payment year is 45 points.

(8) The performance threshold for the 2023 MIPS payment year is 60 points.

* * * * *

(d) * * *

(6) The additional performance threshold for the 2022 and 2023 MIPS payment years is 85 points.

* * * * *

(f) *Exception to application of MIPS payment adjustment factors to model-specific payments under section 1115A APMs.* Beginning with the 2019 MIPS payment year, the payment adjustment factors specified under paragraph (e) of this section are not applicable to payments that meet all of the following conditions:

* * * * *

■ 50. Section 414.1415 is amended by revising paragraph (c)(5) and (6) to read as follows:

§ 414.1415 Advanced APM criteria.

* * * * *

(c) * * *

(5) For the purposes of this section, expected expenditures means the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the APM should not exceed the Medicare Part A and Part B expenditures for a participant in the absence of the APM. If the expected expenditures under the APM exceed the Medicare Part A and Part B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for purposes of Advanced APM determinations.

(6) *Capitation.* A full capitation arrangement meets this Advanced APM criterion. For purposes of this part, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed to reconcile or share losses incurred or savings earned by the APM Entity. Arrangements between CMS and Medicare Advantage Organizations under the Medicare Advantage program (part 422 of this title) are not considered capitation arrangements for purposes of this paragraph (c)(6).

* * * * *

■ 51. Section 414.1420 is amended by revising paragraph (d)(2) introductory text, (d)(2)(ii), (d)(3)(ii)), (d)(4) introductory text and (d)(5) through (8) to read as follows:

§ 414.1420 Other payer advanced APM criteria.

* * * * *

(d) * * *

(2) *Medicaid Medical Home Model and Aligned Other Payer Medical Home Model financial risk standard.* The APM Entity participates in a Medicaid Medical Home Model or an Aligned Other Payer Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, does one or more of the following:

* * * * *

(ii) Require direct payment by the APM Entity to the payer;

* * * * *

(3) * * *

(ii) Except for risk arrangements described under paragraph (d)(2) of this section, the risk arrangement must have a marginal risk rate of at least 30 percent.

(4) *Medicaid Medical Home Model and Aligned Other Payer Medical Home Model nominal amount standard.* For a Medicaid Medical Home Model or an Aligned Other Payer Medical Home Model to meet the Medicaid Medical Home Model nominal amount standard, the total annual amount that an APM Entity potentially owes a payer or forgoes must be at least the following amounts:

* * * * *

(5) *Marginal risk rate.* For purposes of this section, the marginal risk rate is defined as the percentage of actual expenditures that exceed expected expenditures for which an APM Entity is responsible under an other payer payment arrangement.

(i) In the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the average marginal risk rate across all possible levels of actual expenditures would be used for comparison to the marginal risk rate specified in paragraph (d)(3)(ii) of this section, with exceptions for large losses as described in paragraph (d)(5)(ii) of this section and small losses

as described in paragraph (d)(5)(iii) of this section.

(ii) *Allowance for large losses.* The determination in paragraph (d)(3)(ii) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by an amount sufficient to require the APM Entity to make financial risk payments under the other payer payment arrangement greater than or equal to the total risk requirement under paragraph (d)(3)(i) of this section.

(iii) *Allowance for minimum loss rate.* The determination in paragraph (d)(3)(ii) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by less than 4 percent of expected expenditures.

(6) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as the Other Payer APM benchmark. For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Other Payer Advanced APM determinations, the expected expenditures under the payment arrangement should not exceed the expenditures for a participant in the absence of the payment arrangement. If expected expenditures under the payment arrangement exceed the expenditures that the participant would be expected to incur in the absence of the payment arrangement, such excess expenditures are not considered when assessing financial risk under the payment arrangement for Other Payer Advanced APM determinations.

(7) *Capitation.* A full capitation arrangement meets this Other Payer Advanced APM criterion. For purposes of paragraph (d)(3) of this section, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed for the purposes of reconciling or sharing losses incurred or savings earned by the participant. Arrangements made directly between CMS and Medicare Advantage Organizations under the Medicare Advantage program (part 422 of this title) are not considered capitation arrangements for purposes of this paragraph.

(8) *Aligned Other Payer Medical Home Model and Medicaid Medical Home Model 50 eligible clinician limit.* Notwithstanding paragraphs (d)(2) and (4) of this section, if an APM Entity participating in an Aligned Other Payer Medical Home Model or Medicaid Medical Home Model is owned and operated by an organization with 50 or more eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities, the requirements of paragraphs (d)(1) and (3) of this section apply.

* * * * *

■ 52. Section 414.1425 is amended by revising paragraphs (c)(5) and (6), and (d)(3) and (4) to read as follows:

§ 414.1425 Qualifying APM participant determination: In general.

* * * * *

(c) * * *

(5) Beginning in the 2020 QP Performance Period, an eligible clinician in an APM Entity is not a QP for a year if:

(i) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or

(ii) The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that QP performance period under the terms of the Advanced APM, even if such termination date occurs within such QP Performance Period.

(6) Beginning in the 2020 QP Performance Period, an eligible clinician is not a QP for a year if:

(i) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities; or

(ii) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities.

* * * * *

(d) * * *

(3) Beginning in the 2020 QP Performance Period, an eligible clinician is not a Partial QP for a year if:

(i) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or

(ii) The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that performance period under the terms of the Advanced APM.

(4) Beginning in the 2020 QP Performance Period, an eligible clinician is not a Partial QP for a year if:

(i) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities; or

(ii) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTING

■ 53. The authority citation for part 415 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 54. Section 415.172 is amended by revising the section heading and paragraph (b) to read as follows:

§ 415.172 Physician fee schedule payment for services of teaching physicians.

* * * * *

(b) *Documentation.* Except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures

and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

* * * * *

■ 55. Section 415.174 is amended by—

■ a. Revising paragraph (a)(6); and

■ b. Removing and reserving paragraph (b).

The revision reads as follows:

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

(a) * * *

(6) The medical records must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter to each beneficiary in accordance with the documentation requirements at § 415.172(b).

(b) [Reserved]

PART 416—AMBULATORY SURGICAL CENTERS

■ 56. The authority citation for part 416 is revised to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 57. Section 416.42 is amended by revising paragraph (a)(1) to read as follows:

§ 416.42 Condition for coverage—Surgical services.

* * * * *

(a) * * *

(1) Immediately before surgery—

(i) A physician must examine the patient to evaluate the risk of the procedure to be performed; and

(ii) A physician or anesthetist as defined at § 410.69(b) of this chapter must examine the patient to evaluate the risk of anesthesia.

* * * * *

PART 418—HOSPICE CARE

■ 58. The authority citation for part 418 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 59. Section 418.106 is amended by revising paragraph (b)(1) to read as follows:

§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment.

* * * * *

(b) * * *

(1) Drugs may be ordered by any of the following practitioners:

(i) A physician as defined by section 1861(r)(1) of the Act.

(ii) A nurse practitioner in accordance with state scope of practice requirements.

(iii) A physician assistant in accordance with state scope of practice requirements and hospice policy who is:

(A) The patient's attending physician; and

(B) Not an employee of or under arrangement with the hospice.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 60. The authority citation for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 61. Section 424.67 is added to subpart E to read as follows:

§ 424.67 Enrollment requirements for opioid treatment programs (OTP).

(a) *General enrollment requirement.* In order for a program or eligible professional (as that term is defined in section 1848(k)(3)(B) of the Act) to receive Medicare payment for the provision of opioid use disorder treatment services, the provider must qualify as an OTP (as that term is defined in § 8.2 of this title) and enroll in the Medicare program under the provisions of this section and of subpart P of this part.

(b) *Specific requirements and standards for enrollment.* To enroll in the Medicare program, an OTP must meet all of the following requirements and standards:

(1) Fully complete and submit the Form CMS–855B application (or its successor application) and any applicable supplement or attachment thereto to its applicable Medicare contractor. This includes, but is not limited to, the following:

(i) Maintain and submit to CMS (via the applicable supplement or attachment) a list of all physicians, other eligible professionals, and pharmacists (regardless of whether the individual is a W–2 employee of the OTP) who are legally authorized to prescribe, order, or dispense controlled substances on behalf of the OTP. The list must include the physician's, other eligible professional's, or pharmacist's:

(A) First and last name, and middle initial.

(B) Social Security Number.

(C) National Provider Identifier.

(D) License number (if applicable).

(ii) Certifying via the Form CMS–855B and/or the applicable supplement or attachment thereto that the OTP meets and will continue to meet the specific requirements and standards for enrollment described in paragraphs (b) and (d) of this section.

(2) Comply with the application fee requirements in § 424.514.

(3) Successfully complete the assigned categorical risk level screening required under, as applicable, § 424.518(b) and (c).

(4)(i) Have a current, valid certification by SAMHSA for an opioid treatment program consistent with the provisions and requirements of § 8.11 of this title.

(ii) A provisional certification under § 8.11(e) of this title does not meet the requirements of paragraph (b)(4)(i) of this section.

(5) Report on the Form CMS–855B and/or any applicable supplement all OTP staff who meet the definition of ''managing employee'' in § 424.502. Such individuals include, but are not limited to, the following:

(i) Medical director (as described in § 8.2 of this title).

(ii) Program sponsor (as described in § 8.2 of this title).

(6)(i)(A) Must not employ or contract with a prescribing or ordering physician or eligible professional or with any individual legally authorized to dispense narcotics who, within the preceding 10 years, has been convicted (as that term is defined in 42 CFR 1001.2) of a Federal or State felony that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries based on the same categories of detrimental felonies, as well as case by case detrimental determinations, found at § 424.535(a)(3).

(B) Paragraph (b)(6)(i)(A) of this section applies regardless of whether the individual in question is:

(*1*) Currently dispensing narcotics at or on behalf of the OTP; or

(*2*) A W–2 employee of the OTP.

(ii) Must not employ or contract with any personnel (regardless of whether the individual is a W–2 employee of the OTP) who is revoked from Medicare under § 424.535 or any other applicable section in Title 42, or who is on the preclusion list under § 422.222 or § 423.120(c)(6) of this chapter.

(iii) Must not employ or contract with any personnel (regardless of whether the individual is a W–2 employee of the OTP) who has a prior adverse action by a State oversight board, including, but not limited to, a reprimand, fine, or restriction, for a case or situation involving patient harm that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. CMS will consider the factors enumerated at § 424.535(a)(22) in each

case of patient harm that potentially applies to this paragraph.

(7)(i) Sign (and adhere to the term of) a provider agreement in accordance with the provisions of part 489 of this chapter.

(ii) An OTP's appeals under part 498 of a Medicare revocation (under § 424.535) and a provider agreement termination (under § 489.53 of this chapter) must be filed jointly and, as applicable, considered jointly by CMS under part 498 of this chapter.

(8) Comply with all other applicable requirements for enrollment specified in this section and in subpart P of this part.

(c) *Denial of enrollment.* CMS may deny an OTP's enrollment application on any of the following grounds:

(1)(i) The provider does not have a current, valid certification by SAMHSA as required under paragraph (b)(4)(i) of this section or fails to meet any other applicable requirement in this section.

(ii) Any of the denial reasons in § 424.530 applies.

(2) An OTP may appeal the denial of its enrollment application under part 498 of this chapter.

(d) *Continued compliance, standards, and reasons for revocation.* (1) Upon and after enrollment, an OTP—

(i) Must remain validly certified by SAMHSA as required under § 8.11 of this title.

(ii) Remains subject to, and must remain in full compliance with, the provisions of this section and of subpart P of this part. This includes, but is not limited to, the provisions of paragraph (b)(6) of this section, the revalidation provisions in § 424.515, and the deactivation and reactivation provisions in § 424.540.

(iii) Upon revalidation, successfully complete the moderate categorical risk level screening required under § 424.518(b).

(2) CMS may revoke an OTP's enrollment on any of the following grounds:

(i) The provider does not have a current, valid certification by SAMHSA as required under paragraph (b)(4)(i) or fails to meet any other applicable requirement or standard in this section, including, but not limited to, the OTP standards in paragraphs (b)(6) and (d)(1) of this section.

(ii) Any of the revocation reasons in § 424.535 applies.

(3) An OTP may appeal the revocation of its enrollment under part 498 of this title.

(e) *Claim payment.* For an OTP to receive payment for furnished drugs:

(1) The prescribing or medication ordering physician's or other eligible professional's National Provider Identifier must be listed on Field 17 of the Form CMS–1500; and

(2) All other applicable requirements of this section, this part, and part 8 of this title must be met.

(f) *Relation to part 8 of this title.* Nothing in this section shall be construed as:

(1) Supplanting any of the provisions in part 8 of this title; or

(2) Eliminating an OTP's obligation to maintain compliance with all applicable provisions in part 8 of this title.

■ 62. Section 424.502 is amended by adding the definition of ''State oversight board'' in alphabetical order to read as follows:

§ 424.502 Definitions.

* * * * *

State oversight board means, for purposes of §§ 424.530(a)(15) and 424.535(a)(22) only, any State administrative body or organization, such as (but not limited to) a medical board, licensing agency, or accreditation body, that directly or indirectly oversees or regulates the provision of health care within the State.

* * * * *

■ 63. Section 424.518 is amended by adding paragraphs (b)(1)(xii) and (xiii) and (c)(1)(iv) to read as follows:

§ 424.518 Screening levels for Medicare providers and suppliers.

* * * * *

(b) * * *

(1) * * *

(xii) Prospective (newly enrolling) opioid treatment programs that have been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.

(xiii) Revalidating opioid treatment programs.

* * * * *

(c) * * *

(1) * * *

(iv) Prospective (newly enrolling) opioid treatment programs that have not been fully and continuously certified by SAMHSA since October 23, 2018.

* * * * *

■ 64. Section 424.520 is amended by revising paragraph (d) introductory text to read as follows:

§ 424.520 Effective date of Medicare billing privileges.

* * * * *

(d) *Physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs.* The effective date for billing privileges for physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs is the later of—

* * * * *

■ 65. Section 424.521 is amended by revising the section heading and paragraph (a) introductory text to read as follows:

§ 424.521 Request for payment by physicians, non-physician practitioners, physician and non-physician organizations, ambulance suppliers, and opioid treatment programs.

(a) Physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs may retrospectively bill for services when the physician, non-physician practitioner, physician or non-physician organization, ambulance supplier, or opioid treatment program has met all program requirements, including State licensure requirements, and services were provided at the enrolled practice location for up to—

* * * * *

■ 66. Section 424.530 is amended by adding paragraph (a)(15) to read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(15) *Patient harm.* (i) The physician or other eligible professional (as that term is defined in 1848(k)(3)(B) of the Act) has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a denial is appropriate, CMS considers the following factors:

(A) The nature of the patient harm.

(B) The nature of the physician's or other eligible professional's conduct.

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by a State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(*1*) License restriction(s) pertaining to certain procedures or practices.

(2) Required compliance appearances before State oversight board members.

(*3*) License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).

(*4*) Administrative/monetary penalties.

(*5*) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.

(ii) Paragraph (a)(15)(i) of this section does not apply to actions or orders pertaining exclusively to either of the following:

(A) Required participation in rehabilitation or mental/behavioral health programs; or

(B) Required abstinence from drugs or alcohol and random drug testing.

* * * * *

■ 67. Section 424.535 is amended by—

■ a. In paragraph (a)(14) introductory text, by removing the phrase ''prescribing Part D drugs'' and adding in its place the phrase ''prescribing Part B or D drugs''; and

■ b. Adding paragraph (a)(22).

The addition reads as follows:

§ 424.535 Revocation of enrollment in the Medicare program.

(a) * * *

(22) *Patient harm.* (i) The physician or other eligible professional (as that term is defined in 1848(k)(3)(B) of the Act) has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a revocation is appropriate, CMS considers the following factors:

(A) The nature of the patient harm.

(B) The nature of the physician's or other eligible professional's conduct.

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(*1*) License restriction(s) pertaining to certain procedures or practices.

(*2*) Required compliance appearances before State medical board members.

(*3*) License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).

(*4*) Administrative or monetary penalties.

(*5*) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.

(ii) Paragraph (a)(22)(i) of this section does not apply to actions or orders pertaining exclusively to either of the following:

(A) Required participation in rehabilitation or mental/behavioral health programs; or

(B) Required abstinence from drugs or alcohol and random drug testing.

* * * * *

PART 425—MEDICARE SHARED SAVINGS PROGRAM

■ 68. The authority citation for part 425 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395hh, and 1395jjj.

§ 425.612 [Amended]

■ 69. Section 425.612 is amended in paragraph (a)(1)(v)(E) introductory text by removing the phrase ''paragraph (a)(1)(v)(B)'' and adding in its place the phrase ''paragraph (a)(1)(v)(D)''.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 70. The authority citation for part 489 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395(hh).

■ 71. Section 489.2 is amended by adding paragraphs (b)(10) and (c)(3) to read as follows:

§ 489.2 Scope of part.

* * * * *

(b) * * *

(10) Opioid treatment programs (OTPs).

(c) * * *

(3) OTPs may enter into provider agreements only to furnish opioid use disorder treatment services.

■ 72. Section 489.10 is amended by revising paragraph (a) to read as follows:

§ 489.10 Basic requirements.

(a) Any of the providers specified in § 489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter. The RNHCIs must meet the conditions for coverage, conditions for participation and the requirements set forth in this section and elsewhere in this chapter. The OTPs must meet the requirements set forth in this section and elsewhere in this chapter.

* * * * *

■ 73. Section 489.13 is amended by adding paragraph (a)(2)(iii) to read as follows:

§ 489.13 Effective date of agreement or approval.

(a) * * *

(2) * * *

(iii) For an agreement with an opioid treatment program (OTP), the effective date is the effective date of billing as established under § 424.520(d) or § 424.521(a), as applicable.

* * * * *

■ 74. Section 489.53 is amended by revising paragraph (a)(3) to read as follows:

§ 489.53 Termination by CMS.

(a) * * *

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter. In the case of an RNHCI, it no longer meets the conditions for coverage, conditions of participation and requirements set forth elsewhere in this chapter. In the case of an OTP, it no longer meets the requirements set forth in this section and elsewhere in this chapter.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/IID AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ 75. The authority citation for part 498 continues to read as follows:

Authority: 42 U.S.C. 1302, 1320a-7j, and 1395hh.

■ 76. Section 498.2 is amended in the definition of ''Provider'' by revising the introductory text and adding paragraph (3) to read as follows:

§ 498.2 Definitions.

* * * * *

Provider means any of the following:

* * * * *

(3) An entity that has in effect an agreement to participate in Medicare but only to furnish opioid use disorder treatment services.

* * * * *

Dated: October 24, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 28, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendix 1: MIPS Quality Measures

Note: Except as otherwise noted in this final rule, previously finalized measures and specialty measure sets will continue to apply for the 2022 MIPS payment year and future years. In addition, electronic Clinical Quality Measures (eCQMs) that are National Quality Forum (NQF) endorsed are shown in Table A as follows: NQF #/eCQM NQF #.

BILLING CODE 4120–01–P

TABLE Group A: New Quality Measures Finalized for the 2022 MIPS Payment Year and Future Years

A.1 International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	476
Description:	Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.
Measure Steward:	Large Urology Group Practice Association and Oregon Urology Institute
Numerator:	Patients with a documented improvement of at least 3 points in their urinary symptom score during the measurement period.
Denominator:	Equals Initial Population. Initial population is: Male patients with an initial diagnosis of benign prostatic hyperplasia, 6 months prior to, or during the measurement period, and a urinary symptom score assessment within 1 month of initial diagnosis and a follow-up urinary symptom score assessment within 6-12 months, who had a qualifying visit during the measurement period.
Exclusions:	Denominator: Patients with urinary retention that starts within 1 year of initial BPH diagnosis; Patients with an initial BPH diagnosis that starts during, or within 30 days of hospitalization; Patients with a diagnosis of morbid obesity, or with a BMI Exam >40 before the follow up urinary symptom score.
Measure Type:	Patient Reported Outcome
Measure Domain:	Person and Caregiver-Centered Experience and Outcomes (section 1848(s)(1)(B)(iv) of the Act)
High Priority Measure:	Yes (Patient Reported Outcome)
Collection Type:	eCQM Specifications
Rationale:	This measure was proposed because it represents a patient reported outcome by evaluating the patient's response regarding their symptoms associated with the diagnosis of Benign Prostatic Hyperplasia (BPH). Results can be used by clinicians in evaluating whether the patient's symptoms from BPH have improved during the 6 to 12 months after diagnosis and treatment of this disease. The measure was evaluated by the MAP and it was conditionally supported pending NQF endorsement. While we agree with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required by section 1848(q)(2)(D)(v) of the Act. Measure information provided by the measure developer indicates IPSS and AUA-SI are statistically valid and reliable symptom scores. The IPSS was adopted by the World Health Organization in 1993. The AUA-SI was developed and validated by the American Urological Association in 1992. The IPSS uses the same questions as the AUA-SI, but also adds a disease-specific quality of life question (OLeary, 2005). It is a reproducible, validated index designed to determine disease severity and response to therapy (DSilva, 2014). Based on the information provided by the measures steward, we believe the measure is evidence-based and represents an important patient reported outcome. Note: Refer to the MAP Spreadsheet of Final Recommendations to CMS and HHS at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89244.
Comment: One commenter had concerns about the proposed International Prostate Symptom Score (IPSS) or American Urological Association – Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia measure. The commenter noted that this measure was conditionally recommended by the MAP for inclusion in a federal program pending a full evaluation by NQF as there were concerns regarding the feasibility of the measure collection. Specifically, there were concerns about the measure's ability to feasibly obtain response rates electronically or in a clinical setting. While the developer indicated that the measure was tested using multiple EHR formats, MAP members indicated that additional testing with multiple EHRs should be completed. While the commenter supported patient reported outcome measures, it recommended against including this new measure in the MIPS program until there is a full evaluation and recommendation by the NQF. **Response:** We thank the commenter for their comment and agree that NQF endorsement is preferred; however, it is not required for implementation into MIPS. The measure steward completed additional testing following NQF feedback regarding their submission to NQF for the Fall 2018 review. After completing this testing, the measure steward found that it is feasible to obtain response rates electronically. The CMS document "Blueprint for the CMS Measures Management System v.15.0", explains software resources such as "Bonnie that allow eCQM developers to test and verify the behavior of their	

Category	Description
eCQM logic. The Bonnie application allows measure developers to independently load measures that they have constructed using the Measure Authoring Tool (MAT) and helps measure developers execute the measure logic against the constructed patient test deck and evaluate whether the logic aligns with the intent of the measure." After consideration of the comments, we are finalizing the *International Prostate Symptom Score (IPSS) or American Urological Association Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia* measure as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

A.2. Multimodal Pain Management

Category	Description
NQF #: / eCQM NQF #:	N/A
Quality #:	477
Description:	Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine.
Measure Steward:	American Society of Anesthesiologists (ASA)
Numerator:	Patients for whom multimodal pain management is administered in the perioperative period from 6 hours prior to anesthesia start time until discharged from the post-anesthesia care unit.
Denominator:	Patients, aged 18 years and older, who undergo selected surgical procedures
Exclusions:	Emergent Cases
Measure Type:	Process
Measure Domain:	Effective Clinical Care (section 1848(s)(1)(B)(i) of the Act)
High Priority Measure:	Yes (Opioid-related)
Collection Type:	MIPS CQMs Specifications
Rationale:	This measure was proposed because it encourages clinicians to effectively manage patients' pain using multimodal strategies, which in turn can significantly reduce unnecessary opioid use, excessive post-operative prescriptions, and length of stay. We believe there is an urgent need for measures that address the opioid epidemic affecting the nation. It is imperative to include measures in MIPS that support healthy outcomes for patients using opioids. The clinical action being evaluated within this measure supports the reduction in use of opioids for patients in the perioperative treatment of pain. The measure was updated from what was submitted to the MAP following feedback from stakeholders and NCQA's Technical Expert Panel (TEP). The original measure evaluated by the MAP was conditionally supported pending NQF endorsement. While we agree with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required by section 1848(q)(2)(D)(v) of the Act. The measure steward indicated that testing data from 503 clinicians for 24,728 cases met the denominator criteria during testing of the measure. The mean performance rate calculated from this data was 74.24 percent with a standard deviation of +/- 0.1492 with a performance range of 0.00 to 100.00. Reliability was assessed at the clinician level and based on data from a large, academic medical center and a Veterans Health Administration facility. In May 2018, the ASA conducted a systematic assessment of face validity among members of its Committee on Pain Medicine and Committee on Regional Anesthesia and Acute Pain Medicine. The 33 respondents indicated a substantial level of agreement supporting this measure's value and validity. Based on the information provided by the measures steward, we believe the measure is evidence-based and represents an important clinical process. The measure steward revised the measure by adding an age criteria and removing elective cases as an inclusion criteria. Upon stakeholder feedback, the denominator eligible cases were expanded to make the measure more applicable to ambulatory settings. Due to this denominator expansion, an age of 18 years and older was added to the denominator criteria as many of the pediatric cases captured by the expanded codes do not require multimodal pain management. Additionally, pediatric patients have a different range of appropriate multimodal pain management options. As such, the measure steward limited the patient population to the clinically relevant adult patient population. A denominator exclusion was added for emergent cases to replace the previous elective surgery requirement for denominator eligibility. The measure steward also stated, citing user feedback, when emergent cases are an exclusion criterion compared to using elective cases as an inclusion criterion, the measure produced more reliable results. We agree that these changes result in a more clinically relevant, reliable, and meaningful measure by expanding the denominator eligible code set to capture all applicable adult patients in different settings and refining the patient population to be in alignment with these changes. Note: Refer to the MAP Spreadsheet of Final Recommendations to CMS and HHS at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89244.
Comment: Several commenters supported the new Multimodal Pain Management measure. The measure aligns with the meaningful measures initiative as it seeks to manage postoperative pain through multimodal pain strategies instead of using just opioids. However, the commenter stated there is considerable room for improvement based on preliminary measure performance data. The measure would serve as a meaningful indicator of quality and limit a critical access point for opioid use, abuse, or dependence while effectively managing pain. Another commenter thanked CMS for adding this high priority measure, as multimodal pain management is an essential element of Enhanced Recovery After Surgery (ERAS). **Response:** We thank the commenters and appreciate their support of new measure Q477. We agree the measure would limit a critical access point for opioid use, abuse, or dependence while still effectively managing pain. We agree with the commenter in reference to the considerable room for improvement in performance of treating patients 6 hours prior to anesthesia start time until discharged from the post-anesthesia care unit. The Multimodal Pain Management quality measure was previously available as a Quality Clinical Data Registry (QCDR) measure under the Anesthesia Quality Institute, National Anesthesia Clinical Outcomes Registry QCDR and has produced data to support that there is room for improvement in the performance for this particular interaction between anesthesiologist and patients. The 2018 performance data also supported a clinical need to promote multimodal pain management prior to the use of opioids. We believe this measure will support eligible clinicians to use alternative pain therapies. After consideration of the comments, we are finalizing the *Multimodal Pain Management* measure as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

A.3. Adult Immunization Status

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	N/A
Description:	Percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.
Measure Steward:	National Committee for Quality Assurance
Numerator:	Numerator 1: Members in Denominator 1 (D1) who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period. Numerator 2: Members in D2 who received at least 1 Td vaccine or 1 Tdap vaccine between 9 years prior to the start of the measurement period and the end of the measurement period. Numerator 3: Members in D3 who received at least 1 dose of the herpes zoster live vaccine or 2 doses of the herpes zoster recombinant vaccine anytime on or after the members 50th birthday. Numerator 4: Members in D4 who were administered both the 13-valent pneumococcal conjugate vaccine and the 23-valent pneumococcal polysaccharide vaccine at least 12 months apart, with the first occurrence after the age of 60. Numerator 5: The actual number of required immunizations administered to members in D5.
Denominator:	Denominator 1: Members age 19 and older at the start of the measurement period. Denominator 2: Members age 19 and older at the start of the measurement period. Denominator 3: Members age 50 and older at the start of the measurement period. Denominator 4: Members age 66 and older at the start of the measurement period. Denominator 5: The total number of possible immunizations required for members age 19 and older determined by their age at the start of the measurement period.
Exclusions:	Denominator: Members with any of the following: • Prior anaphylactic reaction to the vaccine or its components any time during or before the measurement period. • History of encephalopathy within seven days after a previous dose of a Td-containing vaccine. • Active chemotherapy during the measurement period. • Bone marrow transplant during the measurement period. • History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease or cerebrospinal fluid leaks any time during the member's history prior to or during the measurement period. • In hospice or using hospice services during the measurement period.
Measure Type:	Process
Measure Domain:	Community/Population Health (section 1848(s)(1)(B)(v)of the Act)
High priority measure:	No
Collection Type:	MIPS CQMs Specifications, CMS Web Interface Measure Specifications
Rationale:	We proposed this preventive immunization measure because it is a comprehensive evaluation for compliance with recommended adult vaccinations and supports the 2019 adult immunization schedule that has been approved by the CDC, which is based on the recommendation from the Advisory Committee on Immunization Practices. NCQA and the HHS National Vaccine Program Office submitted this measure via Call for Measures to be considered for MIPS implementation. This robust composite measure assesses the quality clinical action regarding the administration of the influenza, Tdap/Td, herpes zoster, and pneumococcal vaccines. The immunizations included within this measure will reduce the prevalence of severe diseases that may be associated with hospitalization and decrease overall health care costs. This measure is consistent with Healthy People 2020 goals, developed by the Centers for Disease Control and Prevention, to promote healthy behaviors, for increasing immunization rates. The measure was evaluated by the MAP, but this entity did not support this composite measure since it had not been analytically tested at the clinician level, but clinically it is evidence-based as required by section 1848(q)(2)(D)(v) of the Act. We believe that the health plan level version of the measure can be adapted to the clinician level by revising the measure analytics to assess the proportion of patients who have been administered influenza, Tdap/Td, herpes zoster, and pneumococcal vaccines by MIPS eligible clinicians. Implementing the measure at the clinician level does not change the medical intent or evidence supporting preventive immunizations for patients. Therefore, we believe implementing the measure at the clinician level will be successful. Currently, MIPS includes three of the four composite measure's components as individual measure analytics. Individual measures: Q110: Preventive Care and Screening: Influenza Immunization; and Q111: Pneumococcal Vaccination Status for Older Adults have been implemented in the MIPS and PQRS programs for a combined total of over seven years. Another component of this composite measure, Q474: Zoster (Shingles) Vaccination, was implemented as a new individual measure in 2019 MIPS and was tested at the clinician and group level prior to submission to the Call for Measures. The administration of the vaccination diphtheria toxoids and acellular pertussis (Tdap), contained in Adult Immunization Status, is also present in the MIPS program as a component within measure Q394: Immunizations for Adolescents. We recognize this measure is specified currently for adolescents, but believe the logic this measure represents is adaptable to the adult population.

Category	Description
	We believe that the individual measures referenced above represent each component of the Adult Immunization Status composite measure. Additionally, measures Q110 and Q111 have been successfully implemented in all MIPS collection types. This accomplishment supports the face validity of these measure concepts and demonstrates the ease in which the composite health plan measure can be adapted for MIPS use. As such, we believe the health plan level version of this measure can be adapted accordingly to suit the program requirements of MIPS. Nonetheless, we will continue to work with the measure steward to obtain additional testing results regarding this composite measure's implementation for programs beyond the health plan level. The measure steward provided the following health plan evidence to support the value of proposing this composite measure as a quality measure. The information is based on commercial and Medicaid plan performance rates for members aged 19-64 and Medicare plan rates for members aged 65 and older. Across the plans, performance rates were as follows: influenza (mean=24 percent, min=3 percent, max=73 percent; Td or Tdap (mean=35 percent, min=1 percent, max=94 percent); zoster (mean=28 percent, min=0.1 percent, max=85 percent); pneumococcal (mean=17 percent, min=1 percent, max=62 percent); and composite (mean=28 percent, min=2 percent, max=79 percent). We believe this evidence represents there is a need to improve adult vaccination coverage. Based on the information provided by CDC in conjunction with the ACIP, we believe the measure is clinically evidence-based and represents an important clinical process Therefore, we maintain that this measure provides a comprehensive assessment of quality adult preventive care and would met the meaningful measure initiative. Note: Refer to the MAP Spreadsheet of Final Recommendations to CMS and HHS at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89244.

Comment: Several commenters opposed the addition of the new Adult Immunization Status measure that would result in the removal of measures Q110: Preventive Care and Screening: Influenza Immunization, Q111: Pneumococcal Vaccination Status for Older Adults, and Q474: Zoster (Shingles) Vaccination. Commenters were concerned with the complexity of this new measure and the confusion it could bring to clinicians. Benchmarks published by CMS for measures Q110 and Q111 still show a significant gap in care that can be addressed by these measures. Q474 is a newer measure, and there may be a benchmark published based on retroactive performance at a later date. Several commenters expressed concern that the new measure was not supported by the MAP, had only been tested at the health plan level, and that measure specifications had not yet been released.

One commenter opposed the new Adult Immunization Status measure in MIPS and the Web Interface because the look-back period for some of these immunizations of 10 years is not captured in the EHRs for patients that are new to a practice or where the EHR has changed. There are other barriers to Medicare beneficiaries receiving recommended immunizations, including in states with high levels of poverty, due to high cost-sharing for beneficiaries. Most vaccines are given at pharmacies or hospitals, so communication with the primary care physician is sporadic, resulting in higher burden to primary care physicians.

Another commenter did not support the new measure because it does not aid surgical teams in providing improved surgical care and it adds an unnecessary task to a surgeon's workflow that provides little value to surgical patients. Another commenter was concerned with replacing measure Q110 with an untested composite immunization measure that could prevent CMS from understanding how many patients with heart failure are receiving this potentially lifesaving immunization.

Another commenter stated they believed that the Adult Immunization Status measure should also reflect the evaluation/assessment need to update the patient's measles, mumps, and rubella (MMR) immunization status. Another commenter stated the new measure requires multiple age-appropriate preventive immunizations and provided suggestions to improve the applicable numerators and denominators for the measure.

Response: We thank the commenters for their comments. We are not finalizing the Adult Immunization Status measure for the 2020 MIPS performance period/2022 MIPS payment year due to the imminent changes in clinical guidelines for pneumococcal vaccination. We believe it is advantageous to evaluate the clinical guidelines and Adult Immunization Status measure for inclusion through future rulemaking. This assures alignment between this important clinical measure and the clinical guidelines that support it.

We appreciate the comments regarding EHRs and the eCQMs that support those systems and will continue to encourage measure stewards to develop eCQMs in the future. We agree that with the 10-year look-back period allowed for some of these immunizations, they may not have been captured in the EHR at the time of administration, or for patients that are new to a practice or where the EHR has changed. However, we believe the data from EHRs and state immunization registries should be updated and reflect the immunization status for every patient to maintain accurate and current medical record documentation. In response to the opposition of this measure citing the popularity and preference of the individual measures for individual performance rates, we believe this measure will continue to support endeavors for thorough administration of each vaccination as applicable to the eligible clinicians' patient population. We believe that submitting one vaccination measure would be less burdensome than potentially submitting several vaccination measures. The measure is specified to provide eligible clinicians' performance rates for each immunization and would be benchmarked based on the overall compliance. This would allow eligible clinicians to review and identify deficits in administration of vaccinations and make adjustments to their practice accordingly to drive and support public health initiatives.

Category	Description
	We agree this measure may not add value to the overall interaction or care a surgeon may provide to a patient especially since primary care eligible clinicians most likely represent the front-line preventive care for this clinical concept. We encourage the surgeons to collaborate and develop measures that offer quality outcomes within their specialty while decreasing burden to their workflow. We encourage the commenters to collaborate with the measure steward, NCQA, for potential measure revisions that may lead to quality outcomes for patients. In regards to the suggestions to improve the applicable numerators and denominators for the measure, we encourage the commenter to collaborate with the measure steward to revise the measure for possible implementation in MIPS in future years. After consideration of the comments, we are not finalizing the *Adult Immunization Status* measure as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years. Upon further discussion with PPRNet, the current measure steward of measure Q474, they have decided to no longer maintain the measure within MIPS and do not plan to transfer stewardship of the measure to CMS. As a result, measures Q110 and Q111, are being retained in the MIPS program and Q474 is being removed.

A.4. Functional Status Change for Patients with Neck Impairments

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	478
Description:	This is a patient-reported outcome performance measure (PRO-PM) consisting of a patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14+ with neck impairments. The change in FS is assessed using the Neck FS PROM.* The measure is risk-adjusted to patient characteristics known to be associated with FS outcomes. It is used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. *The Neck FS PROM is an item-response theory-based computer adaptive test (CAT). In addition to the CAT version, which provides for reduced patient response burden, it is available as a 10-item short form (static/paper-pencil).
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Numerator:	The proportion of a provider's (clinic's or clinician's) patient care episodes that met or exceeded the risk-adjusted predicted Residual Change Score. The Residual Change Score is defined as the difference between the Actual and Predicted Change Scores where: 1. The Actual Score is the patient's Functional Status (FS) Score; 2. The Actual Change Score is the change in the patient's FS score from Admission to Discharge; and 3. The Predicted Change Score is the risk-adjusted prediction of FS change. (Please see the Comments section of JIRA submission for details of the Risk-adjustment component.) Calculating the Residual Change Score, Example: • Actual Score at Admission = 45 • Actual Score at Discharge = 60 o Actual Change Score (Discharge minus Admission) = +15 o Predicted Change Score = +10 • Residual Change Score (Actual Change minus Predicted) = +5 Numerator Options: • Performance Met = The Residual Change Score is equal to or greater than 0 • Performance Not Met = The Residual Change Score is less than 0 Performance may be calculated on 3 levels as follows: 1. Patient Level: For the individual patient episode, the patient's Actual FS scores relative to the risk-adjusted predicted. This level should be used for optimizing care as described below.* 2. Clinician Level: The average of the Residuals for patient care episodes managed by a clinician (individual provider) over a 12 month time period. 3. Clinic Level: The average of the Residuals for patient care episodes managed by a group of clinicians within a clinic over a 12 month time period. * A provider's (clinician's or clinic's) performance must be assessed based on an average all of the provider's patient episodes. On the level of the individual patient, variation is expected. When an individual episode does not result in meeting or exceeding the performance standard, the functional data should be useful to the provider in optimizing the balance of effectiveness/efficiency for that particular care episode. For example, if patient-perceived function is not improving, or has plateaued in progress, that data may be a component of provider-patient communication and care decision-making such as the following examples: 1. Does the provider understand the patient's perception of his/her current level of function? 2. Should the treatment plan be modified? 3. Should the patient be discharged sooner than later? 4. Should the patient be referred to a different care provider?
Denominator:	Patients aged 14+ who initiated rehabilitation therapy, chiropractic, or medical episodes of care for neck impairments including but not limited to cervical (neck) pain, radiculopathy, strain, sprain, stenosis, myelopathy, spondylosis or disc disorders.
Exclusions:	None
Measure Type:	Patient Reported Outcome
Measure Domain:	Person and Caregiver-Centered Experience and Outcomes (section 1848(s)(1)(B)(iv) of the Act)
High priority measure:	Yes (Patient Reported Outcome)
Collection Type:	MIPS CQMs Specifications

Category	Description
Rationale:	We proposed this measure because neck pain is prevalent, impacts functional ability and productivity, and is costly. Measurement results can be used by clinicians in evaluating whether the patient's functional status has improved with initiation of rehabilitation therapy. The measure was evaluated by the MAP conditionally and it was supported pending NQF endorsement. While we agree with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act. The measure steward indicated that this measure offers ample room for improvement for performance based on testing data. The results from testing were that for 1378 clinics, 24.24 percent were classified as low performers, 60.01 percent as average, and 15.75 percent as high. The measure steward believed and we agree that having only 15.75 percent classified as high leaves more than adequate room for improvement in eligible clinician performance over time. Based on the information provided by the measures steward, we believe this measure is evidence-based and represents an important patient reported outcome. Note: Refer to the MAP Spreadsheet of Final Recommendations to CMS and HHS at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89244.

Comment: One commenter supported new measure Q478: Functional Status Change for Patients with Neck Impairments that will serve as a replacement to measure Q223: Functional Status Change for Patients with General Orthopedic Impairments. The new neck-specific measure was developed in response to feedback that providers and patients desired measures specific to neck impairments and had increasingly found the functional questions in the general orthopedic measures to be less meaningful. The addition of this new neck-specific measure will result in a comprehensive set of measures to support the most common orthopedic-type conditions seen by physical and occupational therapists, physicians, and chiropractors. The commenter supported CMS' recognition of patient reported outcome measures (PROMs) within the Quality Payment Program.

The commenter indicated that measure Q478, as submitted to the MUC, contained Exclusions and Exceptions that were not included in the version published in the proposed rule for measures Q217 through Q222 (84 FR 41207 through 41218). As a result, the commenter requested that the following (which is not identical to what was submitted to the MUC) be included in the measure adopted by the final rule in order to provide specific and separate clinically logical reasons for excepting or excluding patient episodes and to bring this measure into alignment with measures Q217 through Q222:

DENOMINATOR EXCLUSIONS

- Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care.
- Patient unable to complete the Neck Functional Status PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available.

DENOMINATOR EXCEPTIONS

- Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).
- Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery or hospitalized.
- Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
- Patient refused to participate.

Response: We agree with the comment that measure Q478 should be aligned as submitted to the MUC. We are finalizing the Denominator Exclusions as represented on the MUC List to read: Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care; and Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only), which matches what was indicated on the MUC. We are finalizing the Denominator Exceptions as represented on the MUC List to read: Patient refused to participate at admission and/or discharge. Patient unable to complete the Neck FS PROM at admission or discharge due to cognitive deficit, visual deficit, motor deficit, language barrier, or low reading level, and a suitable proxy/recorder is not available. Patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) - Medical reasons (e.g., scheduled for surgery or hospitalized).

After consideration of the comments, we are finalizing the *Functional Status Change for Patients with Neck Impairments* measure with modifications for the 2020 MIPS performance period/2022 MIPS payment year and future years.

TABLE Group AA: New Quality Measure Finalized for the 2023 MIPS Payment Year and Future Years

In addition to the new quality measures in Table Group A, we proposed to add one administrative claims based quality measure for the 2023 MIPS payment year and future years. Quality measures that are specified through the administrative claims collection type do not require separate data submission to CMS. Administrative claims measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare Part B claims. We proposed to add this administrative claims-based measure beginning with the 2023 MIPS payment year to allow for time to further refine the measure analytics prior to implementation within the program.

AA.1. All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions

Category	Description
NQF # / eCQM NQF #:	TBD
Quality #:	TBD
Description:	Risk-adjusted outcome measure that uses the outcome of acute, unplanned admissions (per 100 person-years at risk of admission) to assess care quality. Includes Medicare fee-for-service beneficiaries aged 65 years or older who have two or more of the following nine chronic conditions: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease or asthma, (6) depression, (7) diabetes, (8) heart failure, and (9) stroke or transient ischemic attack. The measure adjusts for: • Demographic variables, clinical comorbidities, and measures of frailty/disability. • Two social risk factors: (1) The Agency for Healthcare Research and Quality Socioeconomic Status Index (AHRQ SES Index) and (2) density of physician specialists. The AHRQ SES Index is a widely used and validated measure of area deprivation derived from the American Community Survey (ACS) census block group-level data and linked to a patient's ZIP code. It summarizes SES measures of employment, income, education, and housing.
Measure Steward:	Centers for Medicare & Medicaid Services
Numerator:	Risk-standardized acute admissions per 100 person-years at risk for admission
Denominator:	Medicare fee-for-service beneficiaries ≥ 65 years of age with ≥ 2 of 9 chronic conditions: (1) Acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia (3) Atrial fibrillation (4) Chronic kidney disease (5) Chronic obstructive pulmonary disease or asthma (6) Depression (7) Diabetes (8) Heart failure (9) Stroke or transient ischemic attack
Exclusions:	Denominator Exclusions: (1) Patients without continuous enrollment in Medicare Part A or Part B during the measurement period. (2) Patient was in hospice at any time during the year prior to the measurement year or at start of the measurement year. (3) Patient had no Evaluation and Management visit to a MIPS eligible clinician. Numerator Exclusions: (1) Planned admissions (2) Other admissions that likely do not reflect the quality of ambulatory chronic disease management and primary care provided by the included eligible clinicians: • Complications of procedures or surgeries • Accidents • Injuries • Admissions directly from a skilled nursing facility or acute rehabilitation facility • Admissions that occur within 10 days of discharge from a hospital, skilled nursing facility, or acute rehabilitation facility • Admissions that occur while patients are enrolled in Medicare's hospice benefit
Measure Type:	Outcome
Measure Domain:	Effective Clinical Care (section 1848(s)(1)(B)(i) of the Act)
High Priority Measure:	Yes (Outcome)
Collection Type:	Administrative Claims
Rationale:	We proposed this risk-adjusted administrative claims measure to assess Medicare aged > 65 patients who have two or more of the following nine chronic conditions: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease or asthma, (6) depression, (7) diabetes, (8) heart failure, and (9) stroke or transient ischemic attack. More than two-thirds of Medicare beneficiaries have been diagnosed with or treated for two or more chronic conditions. People with multiple chronic conditions (MCCs) are more likely to be admitted to the hospital than those without chronic conditions or with a single chronic condition. Additionally, they are more likely to visit the emergency department, use post-acute care (such as skilled nursing facilities), and require home health assistance based on the CMS Chronic Conditions among Medicare Beneficiaries Chartbook: 2012 Edition (cited in ACO 38 measure information form). This measure promotes improved MCC management and coordinated care by assessing the unplanned hospital admissions for this high-risk population. The measure is specified through the administrative claims collection type that does not require separate data submission to CMS. This administrative claims measure is

Category	Description
	calculated based on data available from MIPS eligible clinicians' billings on Medicare Part B claims as well as hospital inpatient, outpatient, and physician claims for clinical risk adjustment. It uses the outcome of acute, unplanned admissions (per 100 person-years at risk of admission) to assess care quality. This measure is added for the 2023 MIPS payment year to allow time to work through operational factors of implementing the measures.

Comment: One commenter urged CMS not to finalize the addition of the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions measure for the MIPS program until it has been reviewed and recommended by both the MAP Coordinating Committee and the NQF. In addition, the commenter indicated that some of the nine chronic conditions included in the measure description--(1) acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease or asthma, (6) depression, (7) diabetes, (8) heart failure, and (9) stroke or transient ischemic attack--are not actually chronic conditions. The commenter noted, for example, that acute myocardial infarction, is, by definition, acute and therefore not chronic.

Several other commenters opposed the addition of this measure and the move to adopt global and population health administrative claims measures in MIPS. As discussed in comments related to MVPs, these types of measures do not result in meaningful or actionable feedback for specialists, require a large sample to produce reliable results, and do not provide a complete picture of quality due to the limitations of claims data.

Several commenters had concerns with measure attribution at the individual level for this measure, as many unplanned readmissions are outside of the individual clinician's control. Commenters believed this measures is primary-care based, and the attribution methodology holds physicians responsible for care they did not provide. If CMS moves forward with implementation in 2021, commenters requested that CMS ensure this measure is adequately risk-adjusted, reviewed by the MAP, and reviewed for reliability. Also, commenters requested that the results of validity testing be publicly disseminated and reviewed by the NQF prior to implementation. Another commenter stated it may be more appropriate for CMS to pursue more targeted measures that focus on ambulatory-sensitive admissions, in order to hone in on variation in care that can be tied to clinician performance.

Several commenters supported the addition of this measure to MIPS.

Response: We thank the commenters for their comments. We agree that NQF endorsement of measures is preferred, however, an NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act.

Although we acknowledge that acute myocardial infarction is not a chronic condition, this diagnosis has a high correlation with coronary heart disease, which represents a chronic condition. The inclusion of this diagnosis will be reviewed, but maintain that it is appropriate to include. According to the Centers for Disease Control (CDC), coronary heart disease (CHD) is the most common type of heart disease, killing over 370,000 people annually. In addition, the CDC states that every year about 735,000 Americans have a heart attack. Of these, 525,000 are a first heart attack and 210,000 happen in people who have already had a heart attack (https://www.cdc.gov/heartdisease/facts.htm). Given the amount of resources that are allocated to patients with these conditions and the frequency at which heart attacks occur, we believe that it is important to include acute myocardial infarction in this measure in order to address its impact on unplanned hospital admission.

We believe that population measures may reduce burden on clinicians and allow for assessment of public health issues on a larger scale. We believe this measure gives valuable data for practices of 16 or more clinicians who meet the case minimum of 200. Reliability is one of the many important and scientific issues that we address and tests during our measure development process regardless of measure type (that is, whether the measures are population-based or provider-specific measures). This requirement ensures a large sample to produce reliable results and a complete picture of quality interactions between eligible clinicians and patients within Medicare Part B Claims data. As such, this perspective assesses the overall effective clinical care of patients with multiple chronic conditions (MCC) within this group of clinician's interaction with patients. The measure would work to promote improvements in MCC management and care coordination by assessing this high-risk population's rate of unplanned hospital admissions. In order to decrease clinician burden, the measure uses administrative claims data, which does not require separate data submission. The measure ensures adequate attribution to those eligible clinicians that are specifically treating multiple chronic conditions by requiring at least two of the nine chronic conditions presence on the claim form to be considered in the denominator sample.

One commenter indicated that the measure could result in unintended consequences, including increasing the risk that providers avoid admitting patients with multiple chronic conditions to the hospital for medically necessary care. We believe that eligible clinicians will treat patients ethically, ensure a patient's safety, and support positive patient outcomes. We believe this measure encourages eligible clinicians to actively seek innovation in the treatment of patient with multiple chronic conditions to avoid costly hospital admissions.

After consideration of the comments and because we value stakeholder feedback, we are not finalizing the *All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions* measure as proposed for the 2021 MIPS performance period/2023 MIPS payment year and future years. This action will allow additional time for the MAP process to occur and to obtain expert feedback prior to implementation. In addition, this will allow time to take all of the commenters' concerns into consideration in the event we propose this measure in future rulemaking.

TABLE Group B: New Specialty Measures Sets and Modifications to Previously Finalized Specialty Measure Sets Finalized for the 2022 MIPS Payment Year and Future Years

We proposed to add seven new specialty measures sets: Endocrinology, Nutrition/Dietician, Pulmonology, Chiropractic Medicine, Clinical Social Work, Audiology, and Speech Language Pathology. These sets were proposed to be added based in part on the expanded definition of the MIPS eligible clinician for physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals. In addition, we have received stakeholder feedback requesting additional specialty sets for clinician types whom did not have an existing specialty measures set. We solicited comment on applicable measures for a Clinical Social Work specialty set in the event clinical social workers were proposed for inclusion in the definition of a MIPS eligible clinician in future rulemaking. We also proposed to modify the previously finalized specialty measures sets below based upon review of updates made to existing quality measure specifications, proposed the addition of new measures for inclusion in MIPS, and considered the feedback provided by specialty societies. In the first column, existing measures with substantive changes described in Table Group D are noted with an asterisk (*), existing measures with substantive changes for the 2019 MIPS performance period described in Table Group DD are noted with a double asterisk (**), core measures that align with Core Quality Measure Collaborative (CQMC) core measure set(s) are noted with the symbol (§), and high priority measures are noted with an exclamation point (!). In addition, the Indicator column includes a "high priority type" in parentheses after each high priority indicator (!) to fully represent the regulatory definition of high priority measures. In addition, electronic Clinical Quality Measures (eCQMs) that are National Quality Forum (NQF) endorsed are shown in Table B as follows: NQF # / eCQM NQF #.

NOTE:

- In the instance a title and/or measure description had a substantive change finalized in Table Group D, the revised title and/or measure description is reflected in the specialty measure sets located in Table Group B.
- Under Table Group B, we respond to comments that are related to new measures that were proposed for addition to measure sets, and measures that were proposed for removal. Any comments received on previously finalized measures are out of scope and not included in this final rule.
- Measures that were not finalized for removal in this final rule have been added back into the applicable previously finalized specialty set(s) under Table Group B and the reason for their retention is addressed under Table Group C.

The definition of high priority at § 414.1305 includes an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.

The following specialty measure set was excluded from this group because we did not propose any changes to this specialty measure set: Interventional Radiology. Therefore, we refer readers to the CY 2018 Quality Payment Program final rule for the previously finalized Interventional Radiology specialty measure set (82 FR 54098 through 54099).

B.1. Allergy/Immunology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Allergy/Immunology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.1. Allergy/Immunology

PREVIOUSLY FINALIZED MEASURES IN THE ALLERGY/IMMUNOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.1. Allergy/Immunology

PREVIOUSLY FINALIZED MEASURES IN THE ALLERGY/IMMUNOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**
* ! (Patient Safety)	0022 / N/A	238	CMS156v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
§ ! (Outcome)	2082	338	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
§ ! (Efficiency)	2079	340	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**HIV Medical Visit Frequency:** Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between medical visits.	Health Resources and Services Administration
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.1. Allergy/Immunology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE ALLERGY/IMMUNOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	160	CMS52v8	eCQM Specifications	Process	Effective Clinical Care	**HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Health Resources and Services Administration	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale. In addition, we proposed to remove this measure from the specialty set because it is not applicable to this specialty as Allergy/Immunology specialists do not diagnose, treat or manage HIV/AIDS patients.
After consideration of the comments, we are finalizing the removal of measures from the *Allergy/Immunology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.2. Anesthesiology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Anesthesiology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.2. Anesthesiology

PREVIOUSLY FINALIZED MEASURES IN THE ANESTHESIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0236	044	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery:** Percentage of isolated Coronary Artery Bypass Graft (CABG) surgeries for patients aged 18 years and older who received a beta-blocker within 24 hours prior to surgical incision.	Centers for Medicare & Medicaid Services
* ! (Patient Safety)	2726	076	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	American Society of Anesthesiologists
! (Outcome)	N/A	404	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Anesthesiology Smoking Abstinence:** The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure.	American Society of Anesthesiologists
! (Outcome)	2681	424	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Perioperative Temperature Management:** Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.	American Society of Anesthesiologists
! (Patient Safety)	N/A	430	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy:** Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.	American Society of Anesthesiologists
! (Patient Safety)	N/A	463	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics):** Percentage of patients aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.	American Society of Anesthesiologists

B.2. Anesthesiology

MEASURES FINALIZED FOR **ADDITION** TO THE ANESTHESIOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
! (Opioid)	N/A	477	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Multimodal Pain Management**: Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine.	American Society of Anesthesiologists	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Anesthesiology specialty set as it is clinically relevant to this clinician type.
Comment: One commenter was supportive of adding the new Multimodal Pain Management measure to the Anesthesiology set. Detailed comments from this commenter were included in Table A for this measure. **Response:** We thank the commenter for supporting the addition of this new measure to the Anesthesiology set. After consideration of the comments, we are finalizing the measures for addition to the *Anesthesiology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.									

B.3a. Cardiology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Cardiology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES IN THE CARDIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0081 / 0081e	005	CMS135 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
* §	0070 / 0070e	007	CMS145 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0083 / 0083e	008	CMS144 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	National Committee for Quality Assurance

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES IN THE CARDIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§	0066	118	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	American Heart Association
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES IN THE CARDIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0018 / N/A	236	CMS165 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Inter-mediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
* ! (Patient Safety)	0022 / N/A	238	CMS156 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
* ! (Care Coordination)	0643	243	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Efficiency)	N/A	322	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients:** Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low-risk surgery patients 18 years or older for preoperative evaluation during the 12-month submission period.	American College of Cardiology Foundation

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES IN THE CARDIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Efficiency)	N/A	323	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI):** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status.	American College of Cardiology Foundation
! (Efficiency)	N/A	324	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment.	American College of Cardiology Foundation
* §	1525	326	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	American College of Cardiology
! (Outcome)	N/A	344	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2.	Society for Vascular Surgeons
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES IN THE CARDIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	438	CMS347 v3	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services
* ! (Outcome)	N/A	441	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: □ Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- And □ Most recent tobacco status is Tobacco Free -- And □ Daily Aspirin or Other Antiplatelet Unless Contraindicated -- And □ Statin Use Unless Contraindicated	Wisconsin Collaborative for Healthcare Quality (WCHQ)

B.3a. Cardiology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE CARDIOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
1543	345	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CAS who are stroke free while in the hospital or discharged alive following surgery.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0071	442	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Persistence of Beta-Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Cardiology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.3b. Electrophysiology Cardiac Specialist

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Electrophysiology Cardiac Specialist measure set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.3b. Electrophysiology Cardiac Specialist

PREVIOUSLY FINALIZED MEASURES IN THE ELECTROPHYSIOLOGY CARDIAC SPECIALIST SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	N/A	348	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Implantable Cardioverter-Defibrillator (ICD) Complications Rate:** Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD.	American College of Cardiology Foundation
* ! (Outcome)	2474	392	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation:** Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation. This measure is submitted as four rates stratified by age and gender: • Submission Age Criteria 1: Females 18-64 years of age • Submission Age Criteria 2: Males 18-64 years of age • Submission Age Criteria 3: Females 65 years of age and older • Submission Age Criteria 4: Males 65 years of age and older	American College of Cardiology Foundation
* ! (Outcome)	N/A	393	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision:** Infection rate following CIED device implantation, replacement, or revision.	American College of Cardiology Foundation

B.4. Gastroenterology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Gastroenterology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.4. Gastroenterology

PREVIOUSLY FINALIZED MEASURES IN THE GASTROENTEROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	185	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use:** Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy.	American Gastroenterological Association

B.4. Gastroenterology

PREVIOUSLY FINALIZED MEASURES IN THE GASTROENTEROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	275	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted prior to initiating anti-TNF (tumor necrosis factor) therapy.	American Gastroenterological Association
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
§ ! (Care Coordination)	0658	320	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients:** Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	American Gastroenterological Association
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.4. Gastroenterology

PREVIOUSLY FINALIZED MEASURES IN THE GASTROENTEROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Experience)	N/A	390	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment.	American Gastroenterological Association
§	N/A	401	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis**: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12-month submission period.	American Gastroenterological Association
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	N/A	425	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Photodocumentation of Cecal Intubation:** The rate of screening and surveillance colonoscopies for which photodocumentation of at least two landmarks of cecal intubation is performed to establish a complete examination.	American Society for Gastrointestinal Endoscopy
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.4. Gastroenterology

PREVIOUSLY FINALIZED MEASURES IN THE GASTROENTEROLOGY SET								
ndicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Efficiency)	N/A	439	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Age Appropriate Screening Colonoscopy:** The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.	American Gastroenterological Association

B.4. Gastroenterology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE GASTROENTEROLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	271	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment:** Percentage of patients regardless of age with an inflammatory bowel disease encounter who were prescribed prednisone equivalents greater than or equal to 10 mg/day for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills and were documented for risk of bone loss once during the reporting year or the previous calendar year. Individuals who received an assessment for bone loss during the year prior and current year are considered adequately screened to prevent overuse of X-ray assessment	American Gastroenterological Association	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	343	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Screening Colonoscopy Adenoma Detection Rate**: The percentage of patients age 50 years or older with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.	American Society for Gastrointestinal Endoscopy	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Gastroenterology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.5. Dermatology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Dermatology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.5. Dermatology

PREVIOUSLY FINALIZED MEASURES IN THE DERMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	137	N/A	MIPS CQMs Specifications	Structure	Communication and Care Coordination	**Melanoma: Continuity of Care – Recall System:** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment.	American Academy of Dermatology
! (Care Coordination)	N/A	138	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Melanoma: Coordination of Care:** Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	American Academy of Dermatology
* ** §	0028 / 0028e	226	CMS13 8v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Foundation (PCPI®)

B.5. Dermatology

PREVIOUSLY FINALIZED MEASURES IN THE DERMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	N/A	265	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient.	American Academy of Dermatology
*	N/A	317	CMS22 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
*	N/A	337	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier:** Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and/or rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.	American Academy of Dermatology
! (Care Coordination)	N/A	374	CMS50 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Outcome)	N/A	410	N/A	MIPS CQMs Specifications	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Psoriasis: Clinical Response to Systemic Medications:** Percentage of psoriasis vulgaris patients receiving systemic medication who meet minimal physician- or patient- reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control as measured by physician-and/or patient-reported outcomes will increase patient satisfaction with and adherence to treatment	American Academy of Dermatology
* ! (Care Coordination)	N/A	440	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician:** Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist	American Academy of Dermatology

B.6. Family Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Family Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0059 / N/A	001	CMS122 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
* §	0081 / 0081e	005	CMS135 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
* §	0070 / 0070e	007	CMS145 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0083 / 0083e	008	CMS144 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	009	CMS128 v8	eCQM Specifications	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	National Committee for Quality Assurance
! (Care Coordination)	N/A	024	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
	0046	039	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
! (Patient Experience)	N/A	050	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Appropriate Use)	0069 / N/A	065	CMS154v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
§ * ! (Appropriate Use)	N/A	066	CMS146v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
*	0104e	107	CMS161v8	eCQM Specifications	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
* §	2372 / N/A	112	CMS125v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	National Committee for Quality Assurance

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0034 / N/A	113	CMS130 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Colorectal Cancer Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance
§ ! (Appropriate Use)	0058	116	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription.	National Committee for Quality Assurance
* §	0055 / N/A	117	CMS131 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	National Committee for Quality Assurance
* §	0062 / N/A	119	CMS134 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
* §	0421 / 0421e	128	CMS69v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0018 / N/A	236	CMS165 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
* ! (Patient Safety)	0022 / N/A	238	CMS156 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
* ! (Care Coordination)	0643	243	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation
* ! (Opioid)	N/A	305	CMS137 v8	eCQM Specifications	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.	National Committee for Quality Assurance

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§	N/A	309	CMS124 v8	eCQM Specifications	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	National Committee for Quality Assurance
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101 / N/A	318	CMS139 v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance
§ ! (Patient Experience)	0005	321	N/A	CMS-approved Survey Vendor	Patient Engagement/Experience	Person and Caregiver-Centered Experience and Outcomes	**CAHPS for MIPS Clinician/Group Survey:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Clinician/Group Survey is comprised of 10 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice. The NQF endorsement status and endorsement id (if applicable) for each SSM utilized in this measure are as follows: • Getting Timely Care, Appointments, and Information; (Not endorsed by NQF) • How well Providers Communicate; (Not endorsed by NQF) • Patient's Rating of Provider; (NQF endorsed # 0005) • Access to Specialists; (Not endorsed by NQF) • Health Promotion and Education; (Not endorsed by NQF) • Shared Decision-Making; (Not endorsed by NQF) • Health Status and Functional Status; (Not endorsed by NQF) • Courteous and Helpful Office Staff; (NQF endorsed # 0005) • Care Coordination; (Not endorsed by NQF) • Stewardship of Patient Resources. (Not endorsed by NQF)	Agency for Healthcare Research & Quality (AHRQ) Centers for Medicare & Medicaid Services
* §	1525	326	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	American College of Cardiology

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	N/A	331	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology-Head and Neck Surgery
* ! (Appropriate Use)	N/A	332	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
! (Appropriate Use)	N/A	333	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
*	N/A	337	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier:** Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and/or rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test	American Academy of Dermatology
§ ! (Outcome)	2082	338	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
* ! (Outcome)	0209	342	N/A	MIPS CQMs Specifications	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Pain Brought Under Control Within 48 Hours:** Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization
* § ! (Outcome)	0710 / 0710e	370	CMS159 v8	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
* ! (Patient Experience)	N/A	377	CMS90v9	eCQM Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessments for Congestive Heart Failure:** Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Centers for Medicare & Medicaid Services
! (Outcome)	1879	383	N/A	MIPS CQMs Specifications	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Centers for Medicare & Medicaid Services
	N/A	387	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12-month reporting period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	1407	394	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Immunizations for Adolescents:** The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	National Committee for Quality Assurance
! (Outcome)	N/A	398	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Minnesota Community Measurement
§	N/A	400	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	401	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12-month submission period.	American Gastroenterological Association

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	2803	402	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
*	0053	418	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	438	CMS347 v3	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	Centers for Medicare & Medicaid Services
* ! (Outcome)	N/A	441	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: □ Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- AND □ Most recent tobacco status is Tobacco Free -- AND □ Daily Aspirin or Other Antiplatelet Unless Contraindicated -- AND □ Statin Use Unless Contraindicated	Wisconsin Collaborative for Healthcare Quality (WCHQ)
§ ! (Appropriate Use)	N/A	443	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.	National Committee for Quality Assurance
§ ! (Efficiency)	N/A	444	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma:** The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance
! (Appropriate Use)	0657	464	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES IN THE FAMILY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Opioid)	N/A	468	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Continuity of Pharmacotherapy for Opioid Use Disorder (OUD):** Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	University of Southern California
* ! (Appropriate Use)	N/A	472	CMS249 v2	eCQM Specifications	Process	Efficiency and Cost Reduction	**Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture:** Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.	Centers for Medicare & Medicaid Services
*	N/A	475	CMS349 v2	eCQM Specifications	Process	Community /Population Health	**HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Centers for Disease Control and Prevention

B.6. Family Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE FAMILY MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	This measure was proposed for inclusion into the Family Medicine specialty set as a replacement for measure Q109: Osteoarthritis (OA): Function and Pain Assessment, which was proposed for removal. Measure Q182 includes the patient population in measure Q109, but is more robust in that it requires more frequent assessment and a plan of care.

Comment: One commenter opposed the addition of the new Adult Immunization Status measure to the Family Medicine set. Detailed comments were included in the comments under this measure in Table A. Generally, the commenter stated that the new measure carries too high of a burden to primary care physicians, and the measure has not yet been tested at the clinician level.

Response: We thank the commenter for their comment. We have decided not to finalize the addition of the new Adult Immunization Status measure. We disagree that this measure carries a higher burden as it combines components of previously implemented measures within the Family Medicine set. Please see Table A.3 for the complete rationale.

Comment: One commenter opposed the addition of measure Q182: Functional Outcome Assessment to the Family Medicine set because of the frequency requirement of every visit or every 30 days for all patients over age 18. Doing a functional assessment at this frequency for all patients seen by family physicians, particularly healthy patients, is burdensome, wasteful, and detracts from meaningful care needed by patients during a visit. The measure requires a more targeted denominator that will benefit from functional assessment. At the most recent meeting of the CQMC, stakeholders opposed measure Q182 for these reasons.

Response: We thank the commenter for their comment, however, the Family Medicine set contains 68 quality measures and eligible clinicians may choose not to submit measure Q182.

After consideration of the comments, we are finalizing the measures for addition to the *Family Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.6. Family Medicine

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE FAMILY MEDICINE SET Note: In this this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	109	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0712e	371	CMS160v 8	eCQM Specifications	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.	Minnesota Community Measurement	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0071	442	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Persistence of Beta-Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Family Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.7. Internal Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Internal Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0059 / N/A	001	CMS122v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
* §	0081 / 0081e	005	CMS135v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	0067	006	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
* §	0070 / 0070e	007	CMS145v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0083 / 0083e	008	CMS144v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	009	CMS12 8v8	eCQM Specifications	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	National Committee for Quality Assurance
! (Care Coordination)	N/A	024	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
	0046	039	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
! (Patient Experience)	N/A	050	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology -Head and Neck Surgery
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Pneumococcal Vaccination Status for Older Adults**: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
§ ! (Appropriate Use)	0058	116	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription	National Committee for Quality Assurance
* §	0055 / N/A	117	CMS131v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Eye Exam**: Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	National Committee for Quality Assurance
* §	0062 / N/A	119	CMS134v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0421 / 0421e	128	CMS69 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v 9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS13 8v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* § ! (Outcome)	0018 / N/A	236	CMS16 5v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
* ! (Patient Safety)	0022 / N/A	238	CMS15 6v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
* ! (Care Coordination)	0643	243	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	American College of Cardiology Foundation

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	N/A	277	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.	American Academy of Sleep Medicine
	N/A	279	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured.	American Academy of Sleep Medicine
* ! (Opioid)	N/A	305	CMS13 7v8	eCQM Specifications	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. □ Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. □ Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.	National Committee for Quality Assurance
§	N/A	309	CMS12 4v8	eCQM Specifications	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	National Committee for Quality Assurance
*	N/A	317	CMS22 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101 / N/A	318	CMS13 9v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Patient Experience)	0005	321	N/A	CMS-approved Survey Vendor	Patient Engagement/ Experience	Person and Caregiver-Centered Experience and Outcomes	**CAHPS for MIPS Clinician/Group Survey:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Clinician/Group Survey is comprised of 10 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice. The NQF endorsement status and endorsement id (if applicable) for each SSM utilized in this measure are as follows: • Getting Timely Care, Appointments, and Information; (Not endorsed by NQF) • How well Providers Communicate; (Not endorsed by NQF) • Patient's Rating of Provider; (NQF endorsed # 0005) • Access to Specialists; (Not endorsed by NQF) • Health Promotion and Education; (Not endorsed by NQF) • Shared Decision-Making; (Not endorsed by NQF) • Health Status and Functional Status; (Not endorsed by NQF) • Courteous and Helpful Office Staff; (NQF endorsed # 0005) • Care Coordination; (Not endorsed by NQF) • Stewardship of Patient Resources. (Not endorsed by NQF)	Agency for Healthcare Research & Quality (AHRQ)
* §	1525	326	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	American College of Cardiology
! (Appropria te Use)	N/A	331	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology -Head and Neck Surgery
* ! (Appropria te Use)	N/A	332	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without Clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery
! (Appropria te Use)	N/A	333	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology -Head and Neck Surgery

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	337	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier:** Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and/or rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test	American Academy of Dermatology
§ ! (Outcome)	2082	338	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
* ! (Outcome)	0209	342	N/A	MIPS CQMs Specifications	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Pain Brought Under Control Within 48 Hours:** Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization
* § ! (Outcome)	0710 / 0710e	370	CMS159v8	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
* ! (Patient Experience)	N/A	377	CMS90v9	eCQM Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessments for Congestive Heart Failure:** Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Centers for Medicare & Medicaid Services
! (Outcome)	1879	383	N/A	MIPS CQMs Specifications	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Centers for Medicare & Medicaid Services

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	N/A	387	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12-month reporting period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	N/A	398	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Minnesota Community Measurement
§	N/A	400	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§	N/A	401	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12-month submission period.	American Gastro-enterological Association
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	0053	418	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	438	CMS347v3	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services
* ! (Outcome)	N/A	441	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: □ Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- AND □ Most recent tobacco status is Tobacco Free -- AND □ Daily Aspirin or Other Antiplatelet Unless Contraindicated -- AND □ Statin Use Unless Contraindicated.	Wisconsin Collaborative for Healthcare Quality

B.7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES IN THE INTERNAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Appropriate Use)	N/A	443	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.	National Committee for Quality Assurance
§ ! (Efficiency)	N/A	444	NA	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma:** The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance
! (Opioid)	N/A	468	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Continuity of Pharmacotherapy for Opioid Use Disorder (OUD):** Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	University of Southern California
* ! (Appropriate Use)	N/A	472	CMS249v2	eCQM Specifications	Process	Efficiency and Cost Reduction	**Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture:** Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.	Centers for Medicare & Medicaid Services
u*	N/A	475	CMS349v2	eCQM Specifications	Process	Community/Population Health	**HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Centers for Disease Control and Prevention

B7. Internal Medicine

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE INTERNAL MEDICINE SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0712e	371	CMS160v8	eCQM Specifications	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.	Minnesota Community Measurement	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0071	442	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Persistence of Beta-Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Internal Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.8. Emergency Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Emergency Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.8. Emergency Medicine

PREVIOUSLY FINALIZED MEASURES IN THE EMERGENCY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Appropriate Use)	N/A	066	CMS146 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis**: Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode	National Committee for Quality Assurance
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
*	0104e	107	CMS161 v8	eCQM Specifications	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
§ ! (Appropriate Use)	0058	116	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription.	National Committee for Quality Assurance
	N/A	187	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Thrombolytic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV alteplase was initiated within three hours of time last known well.	American Heart Association
	N/A	254	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain:** Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location.	American College of Emergency Physicians
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services

B.8. Emergency Medicine

PREVIOUSLY FINALIZED MEASURES IN THE EMERGENCY MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	N/A	331	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology -Head and Neck Surgery
* ! (Appropriate Use)	N/A	332	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
! (Appropriate Use)	N/A	333	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
* ! (Efficiency)	N/A	415	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older:** Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.	American College of Emergency Physicians
* ! (Efficiency)	N/A	416	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years:** Percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury.	American College of Emergency Physicians

B.8. Emergency Medicine

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE EMERGENCY MEDICINE SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	255	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure:** Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED).	American College of Emergency Physicians	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

Comment: One commenter opposed the removal of measure Q091 from the Emergency Medicine set. The commenter understood CMS' rationale for removing the measure because it is clinical equivalent to measure Q093: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use. However, the commenter believed that for emergency physicians, measure Q091 remains the more meaningful measure for emergency medicine physicians.

Response: We thank the commenters for their comment. In the circumstance an eligible clinician does not prescribe and antibiotic, most likely a topical therapy would be prescribed. However, the eligible clinician is able to prescribe both an antibiotic and topical therapy and remain numerator compliant for this measure. Despite their limited utility, about 20-40 percent of patients with AOE receive oral antibiotics, often in addition to topical therapy (Rosenfeld, et al., 2014). We encourage the commenter to collaborate with the measure steward to develop a measure that promotes the use of antibiotic alternatives while decreasing inappropriate antibiotic usage, and submit to the Call for Measures once tested at the clinician level.

After consideration of the comments, we are finalizing the removal of measures from the *Emergency Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.9. Obstetrics/Gynecology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Obstetrics/Gynecology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES IN THE OBSTETRICS/GYNECOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
! (Patient Experience)	N/A	050	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement
*	N/A	111	CMS127 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES IN THE OBSTETRICS/GYNECOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	2372 / N/A	112	CMS125 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	National Committee for Quality Assurance
* §	0421 / 0421e	128	CMS69v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v 9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES IN THE OBSTETRICS/GYNECOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0018 / N/A	236	CMS165 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
! (Care Coordination)	N/A	265	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient.	American Academy of Dermatology
§	N/A	309	CMS124 v8	eCQM Specifications	Process	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	National Committee for Quality Assurance
§	N/A	310	CMS153 v8	eCQM Specifications	Process	Community/ Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	National Committee for Quality Assurance
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v 8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES IN THE OBSTETRICS/GYNECOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	0053	418	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture	National Committee for Quality Assurance
! (Patient Safety)	2063	422	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury:** Percentage of patients who undergo cystoscopy to evaluate for lower urinary tract injury at the time of hysterectomy for pelvic organ prolapse.	American Urogynecologic Society
! (Patient Safety)	N/A	429	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy:** Percentage of patients who are screened for uterine malignancy prior to vaginal closure or obliterative surgery for pelvic organ prolapse.	American Urogynecologic Society
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	N/A	432	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the bladder recognized either during or within 30 days after surgery.	American Urogynecologic Society
! (Outcome)	N/A	433	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing surgical repair of pelvic organ prolapse that is complicated by a bowel injury at the time of index surgery that is recognized intraoperatively or within 30 days after surgery.	American Urogynecologic Society
! (Outcome)	N/A	434	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the ureter recognized either during or within 30 days after surgery.	American Urogynecologic Society
§ ! (Appropriate Use)	N/A	443	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Non-Recommended Cervical Cancer Screening in Adolescent Females:** The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.	National Committee for Quality Assurance

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES IN THE OBSTETRICS/GYNECOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Care Coordination)	N/A	448	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Appropriate Workup Prior to Endometrial Ablation:** Percentage of patients, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results are documented before undergoing an endometrial ablation.	Centers for Medicare & Medicaid Services
* ! (Appropriate Use)	N/A	472	CMS249 v2	eCQM Specifications	Process	Efficiency and Cost Reduction	**Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture:** Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.	Centers for Medicare & Medicaid Services
*	N/A	475	CMS349 v2	eCQM Specifications	Process	Community/ Population Health	**HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Centers for Disease Control and Prevention

B.9. Obstetrics/Gynecology

MEASURES FINALIZED FOR **ADDITION** TO THE OBSTETRICS/GYNECOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	N/A	335	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse):** Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Obstetrics/Gynecology specialty set as it is clinically relevant to this clinician type and drives quality of care by assessing the rate of elective deliveries before 39 weeks gestation in the absence of medical indication, following The American College of Obstetrics and Gynecology clinical guidance.
* ! (Care Coordination)	N/A	336	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Maternity Care: Postpartum Follow-up and Care Coordination**: Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth and who received a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Obstetrics/Gynecology specialty set as it is clinically relevant to this clinician type.

Comment: One commenter noted the inclusion of the proposed Adult Immunization Status measure under the Obstetrics/Gynecology set. The commenter encouraged CMS to also consider adopting the Prenatal Immunization Status measure, which was created specifically for maternal populations and better reflects the Advisory Committee on Immunization Practices (ACIP) recommendations for pregnant women, specifically Tdap and influenza. Like the Adult Immunization Status measure, the Prenatal Immunization Status measure will help to address substantial disparities in prenatal immunization rates. Getting a flu shot reduces a pregnant woman's risk of hospitalization by 40 percent and helps protect the newborn before he/she is old enough to be vaccinated.

Response: The Adult Immunization Status measure is not being finalized at this time. We encourage the commenter to collaborate with the measure steward of the Prenatal Immunization Status measure to submit to the Call for Measures for consideration for inclusion in MIPS.

After consideration of the comments, we are finalizing the measures for addition to the *Obstetrics/Gynecology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.9. Obstetrics/Gynecology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE OBSTETRICS/GYNECOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	428	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence:** Percentage of patients undergoing appropriate preoperative evaluation of stress urinary incontinence prior to pelvic organ prolapse surgery per American College of Obstetrics and Gynecology (ACOG), American Urogynecologic Society, and American Urological Association guidelines.	American Urogynecologic Society	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
We received no comments on measures proposed for removal impacting this specialty measure set; therefore, we are finalizing the removal of measures from the *Obstetrics/Gynecology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.								

B.10. Ophthalmology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Ophthalmology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.10. Ophthalmology

PREVIOUSLY FINALIZED MEASURES IN THE OPHTHALMOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0086 / 0086e	012	CMS143v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	0087	014	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Age-Related Macular Degeneration (AMD): Dilated Macular Examination:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity during one or more office visits within the 12 month performance period.	American Academy of Ophthalmology
* ! (Care Coordination)	0089 / 0089e	019	CMS142v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0055 / N/A	117	CMS131v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	National Committee for Quality Assurance

B.10. Ophthalmology

PREVIOUSLY FINALIZED MEASURES IN THE OPHTHALMOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Outcome)	0563	141	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Outcome	Communication and Care Coordination	**Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within the 12 month performance period.	American Academy of Ophthalmology
* ! (Outcome)	0565 / 0565e	191	CMS133v8	eCQM Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery:** Percentage of cataract surgeries for patients aged 18 years and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.10. Ophthalmology

PREVIOUSLY FINALIZED MEASURES IN THE OPHTHALMOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Outcome)	N/A	303	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.	American Academy of Ophthalmology
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
! (Outcome)	N/A	384	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery:** Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment who did not require a return to the operating room within 90 days of surgery.	American Academy of Ophthalmology
! (Outcome) *	N/A	385	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery:** Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.	American Academy of Ophthalmology
! (Outcome)	N/A	389	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Cataract Surgery: Difference Between Planned and Final Refraction:** Percentage of patients aged 18 years and older who had cataract surgery performed and who achieved a final refraction within +/- 1.0 diopters of their planned (target) refraction.	American Academy of Ophthalmology

B.10. Ophthalmology

MEASURES FINALIZED FOR ADDITION TO THE OPHTHALMOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
! (Patient Experience)	N/A	304	N/A	MIPS CQMs Specifications	Patient Engagement/Experience	Person and Caregiver-Centered Experience and Outcomes	**Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.	American Academy of Ophthalmology	We proposed to include this measure in the Ophthalmology specialty set as it is applicable to this clinician type and drives quality of care by assessing patient satisfaction following cataract surgery.
Comment: One commenter supported the addition of measure Q304: Cataracts: Patient Satisfaction within 90 days Following Cataract Surgery to the Ophthalmology set. The new measure quantifies the percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey. The commenter stated measure Q304 was fairly developed based on stakeholder input and appreciated CMS prioritizing beneficiary satisfaction measures. **Response:** We thank the comment for supporting the addition of measure Q304 to the Ophthalmology set. After consideration of the comments, we are finalizing the measures for addition to the *Ophthalmology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.								

B.10. Ophthalmology

PREVIOSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE OPHTHALMOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0564 / 0564e	192	CMS132 v8	eCQM Specifications, MIPS CQMs Specifications	Outcome	Patient Safety	**Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures**: Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Physician Consortium for Performance Improvement Foundation (PCPI®)	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	388	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy):** Percentage of patients aged 18 years and older who had cataract surgery performed and had an unplanned rupture of the posterior capsule requiring vitrectomy.	American Academy of Ophthalmology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Ophthalmology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.11. Orthopedic Surgery

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Orthopedic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	N/A	024	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0421 / 0421e	128	CMS69 v8	Medicare Part B Claims Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v 9	Medicare Part B Claims Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
*	N/A	178	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.	American College of Rheumatology

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	180	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Glucocorticoid Management:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.	American College of Rheumatology
* ** §	0028 / 0028e	226	CMS13 8v8	Medicare Part B Claims Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	317	CMS22 v8	Medicare Part B Claims Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101 / N/A	318	CMS13 9v8	eCQM Specifications, CMS Web Interface Measure Specifications,	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period	National Committee for Quality Assurance
! (Care Coordination)	N/A	350	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** Percentage of patients regardless of age undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g., non-steroidal anti-inflammatory drug (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure.	American Association of Hip and Knee Surgeons

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	N/A	351	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation:** Percentage of patients regardless of age undergoing a total knee replacement who are evaluated for the presence or absence of venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g., History of Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), Myocardial Infarction (MI), Arrhythmia and Stroke).	American Association of Hip and Knee Surgeons
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
! (Patient Experience)	N/A	375	CMS66 v8	eCQM Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Knee Replacement:** Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
! (Patient Experience)	N/A	376	CMS56 v8	eCQM Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Hip Replacement:** Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
*	0053	418	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance
* ! (Outcome)	N/A	459	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Back Pain After Lumbar Discectomy/Laminectomy:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	460	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Back Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain	Minnesota Community Measurement
* ! (Outcome)	N/A	461	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Leg Pain After Lumbar Discectomy/Laminectomy:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE ORTHOPEDIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	N/A	469	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status After Lumbar Fusion:** For patients 18 years of age and older who had a lumbar fusion procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a)* at one year (9 to 15 months) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	470	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status After Primary Total Knee Replacement:** For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) at one year (9 to 15 months) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	471	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status After Lumbar Discectomy/Laminectomy:** For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) * at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	473	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Leg Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain	Minnesota Community Measurement

B.11. Orthopedic Surgery

MEASURES FINALIZED FOR **ADDITION** TO THE ORTHOPEDIC SURGERY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	This measure is being proposed for inclusion into the Orthopedic Surgery specialty set as a replacement for measure Q109: Osteoarthritis (OA): Function and Pain Assessment, which is being proposed for removal. Measure Q182 includes the patient population in measure Q109, but is more robust in that it requires more frequent assessment and a plan of care.
* ! (Outcome)	0422	217	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Knee Impairments**: A patient-reported outcome measure of risk-adjusted change in functional status for patients aged 14 years+ with knee impairments. The change in functional status (FS) is assessed using the Knee FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.

B.11. Orthopedic Surgery

MEASURES FINALIZED FOR **ADDITION** TO THE ORTHOPEDIC SURGERY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0423	218	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Hip Impairments**: A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with hip impairments. The change in functional status (FS) is assessed using the Hip FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.
* ! (Outcome)	0424	219	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with foot, ankle and lower leg impairments. The change in functional status (FS) assessed using the Foot/Ankle FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.

B.11. Orthopedic Surgery

MEASURES FINALIZED FOR **ADDITION** TO THE ORTHOPEDIC SURGERY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0425	220	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Low Back Impairments**: A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with low back impairments. The change in functional status (FS) is assessed using the Low Back FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.
* ! (Outcome)	0426	221	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Shoulder Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.

B.11. Orthopedic Surgery

MEASURES FINALIZED FOR **ADDITION** TO THE ORTHOPEDIC SURGERY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0427	222	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Elbow, Wrist or Hand Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS is assessed using the Elbow/Wrist/Hand FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.) The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure)	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for inclusion into the Orthopedic Surgery specialty set as it is clinically relevant and the denominator was expanded to allow for this clinician type.
! (Outcome)	N/A	478	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Change for Patients with Neck Impairments:** This is a patient-reported outcome performance measure (PRO-PM) consisting of a patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14+ with neck impairments. The change in FS is assessed using the Neck FS PROM.* The measure is risk-adjusted to patient characteristics known to be associated with FS outcomes. It is used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. *The Neck FS PROM is an item-response theory-based computer adaptive test (CAT). In addition to the CAT version, which provides for reduced patient response burden, it is available as a 10-item short form (static/paper-pencil).	Focus on Therapeutic Outcomes, Inc.	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Orthopedic Surgery specialty set as it is clinically relevant to this clinician type.

Comment: Three commenters requested that CMS add measure Q357: Surgical Site Infection (SSI) to Orthopedic Surgery set. This measure currently is assigned as a quality measure in Plastic Surgery, General Surgery, and Otolaryngology sets. In light of the many surgical procedures performed by orthopedic surgeons, it would be appropriate to add this measure to the Orthopedic Surgery set.

Response: We thank the commenters for their comments and would point them to the current posted measure specification as the orthopedic surgeon would not be eligible to submit this measure. The coding contained within the measure's denominator is isolated to general surgery. The measure steward explains that the "risk adjustment is performed with a parsimonious dataset and aims to allow efficient data collection resources and data reporting. Measures have been harmonized when possible." Adding orthopedic surgery procedures to this measure may challenge the inherent risk adjustment. We encourage the commenter to work with the measure steward to include coding within the denominator of measure Q357 that is applicable to the Orthopedic Surgery MIPS eligible clinician, yet maintain the risk adjustment. If measure Q357's denominator is found to support to Orthopedic Surgery, we encourage the commenters to submit their recommendation to the Call for Specialty Measure Set.

After consideration of the comments, we are finalizing the measures for addition to the *Orthopedic Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE ORTHOPEDIC SURGERY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0097	046	N/A	Medicare Part B Claim Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age. • Submission Criteria 2: 65 years and older. • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	109	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	179	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.	American College of Rheumatology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

B.11. Orthopedic Surgery

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE ORTHOPEDIC SURGERY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	352	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet**: Percentage of patients regardless of age undergoing a total knee replacement who had the prophylactic antibiotic completely infused prior to the inflation of the proximal tourniquet	American Association of Hip and Knee Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	353	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report:** Percentage of patients regardless of age undergoing a total knee replacement whose operative report identifies the prosthetic implant specifications including the prosthetic implant manufacturer, the brand name of the prosthetic implant and the size of each prosthetic implant.	American Association of Hip and Knee Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Orthopedic Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.12. Otolaryngology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Otolaryngology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.12. Otolaryngology

PREVIOUSLY FINALIZED MEASURES IN THE OTOLARYNGOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
§ ! (Appropriate Use)	0069 / N/A	065	CMS154v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.12. Otolaryngology

PREVIOUSLY FINALIZED MEASURES IN THE OTOLARYNGOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
* §	0421 / 0421e	128	CMS69 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.12. Otolaryngology

PREVIOUSLY FINALIZED MEASURES IN THE OTOLARYNGOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	N/A	265	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient.	American Academy of Dermatology
	N/A	277	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.	American Academy of Sleep Medicine
	N/A	279	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured.	American Academy of Sleep Medicine
*	N/A	317	CMS22 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101 / N/A	318	CMS13 9v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance
! (Appropriate Use)	N/A	331	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology-Head and Neck Surgery
* ! (Appropriate Use)	N/A	332	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without Clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
! (Appropriate Use)	N/A	333	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology-Head and Neck Surgery
! (Outcome)	N/A	357	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI).	American College of Surgeons

B.12. Otolaryngology

PREVIOUSLY FINALIZED MEASURES IN THE OTOLARYNGOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
! (Outcome)	N/A	398	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Minnesota Community Measurement
	2803	402	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Appropriate Use)	0657	464	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.12. Otolaryngology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE OTOLARYNGOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Otolaryngology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.13. Pathology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Pathology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.13. Pathology

PREVIOUSLY FNALIZED MEASURES IN THE PATHOLOGY SET								
Indicator	**NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	1854	249	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Barrett's Esophagus:** Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia.	College of American Pathologists
	1853	250	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Radical Prostatectomy Pathology Reporting:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.	College of American Pathologists
! (Care Coordination)	N/A	395	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Lung Cancer Reporting (Biopsy/Cytology Specimens):** Pathology reports based on biopsy and/or cytology specimens with a diagnosis of primary non-small cell lung cancer classified into specific histologic type or classified as non-small cell lung cancer not otherwise specified (NSCLC-NOS) with an explanation included in the pathology report.	College of American Pathologists
! (Care Coordination)	N/A	396	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Lung Cancer Reporting (Resection Specimens):** Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer (NSCLC), histologic type.	College of American Pathologists
! (Care Coordination)	N/A	397	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Melanoma Reporting:** Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness, ulceration and mitotic rate.	College of American Pathologists

B.13. Pathology

MEASURES FINALIZED FOR **ADDITION** TO THE PATHOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	N/A	440	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician:** Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist	American Academy of Dermatology	This measure was proposed for inclusion into the Pathology specialty set as it is applicable to a subset of pathologists and drives care coordination and communication.
We received no comments on the measures proposed for addition to this specialty set. Therefore, we are finalizing the measures for addition to the *Pathology Specialty Measure Set* as indicated for the 2020 MIS performance period/2022 MIPS payment year and future years.									

B.14. Pediatrics

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Pediatrics specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.14. Pediatrics

PREVIOUSLY FNALIZED MEASURES IN THE PEDIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Appropriate Use)	0069 / N/A	065	CMS154v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
* § ! (Appropriate Use)	N/A	066	CMS146v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology-Head and Neck Surgery
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
§	0409	205	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea, and syphilis screenings were performed at least once since the diagnosis of HIV infection.	Health Resources and Services Administration

B.14. Pediatrics

PREVIOUSLY FNALIZED MEASURES IN THE PEDIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§	N/A	239	CMS155v8	eCQM Specifications	Process	Community / Population Health	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. □ Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. □ Percentage of patients with counseling for nutrition. □ Percentage of patients with counseling for physical activity.	National Committee for Quality Assurance
* §	N/A	240	CMS117v8	eCQM Specifications	Process	Community / Population Health	**Childhood Immunization Status:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	National Committee for Quality Assurance
* ! (Opioid)	N/A	305	CMS137v8	eCQM Specifications	Process	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. □ Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. □ Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.	National Committee for Quality Assurance
§	N/A	310	CMS153v8	eCQM Specifications	Process	Community / Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	National Committee for Quality Assurance

B.14. Pediatrics

PREVIOUSLY FNALIZED MEASURES IN THE PEDIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	N/A	366	CMS136v9	eCQM Specifications	Process	Effective Clinical Care	**Follow-Up Care for Children Prescribed ADHD Medication (ADD):** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b) Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	National Committee for Quality Assurance
*	N/A	379	CMS74v9	eCQM Specifications	Process	Effective Clinical Care	**Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Centers for Medicare & Medicaid Services
* ! (Patient Safety)	1365e	382	CMS177v8	eCQM Specifications	Process	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* ! (Care Coordination)	0576	391	N/A	MIPS CQMs Specifications	Process	Communication/Care Coordination	**Follow-up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted: • The percentage of discharges for which the patient received follow-up within 30 days after discharge. • The percentage of discharges for which the patient received follow-up within 7 days after discharge.	National Committee for Quality Assurance
* §	1407	394	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Immunizations for Adolescents:** The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	National Committee for Quality Assurance
! (Outcome)	N/A	398	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Minnesota Community Measurement

B.14. Pediatrics

PREVIOUSLY FNALIZED MEASURES IN THE PEDIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	2803	402	NA	MIPS CQMs Specifications	Process	Community /Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
§ ! (Efficiency)	N/A	444	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma:** The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance
! (Appropriate Use)	0657	464	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)

B.14. Pediatrics

MEASURES FINALIZED FOR **ADDITION** TO THE PEDIATRICS SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* § ! (Outcome)	0710 / 0710e	370	CMS159 v8	eCQM Specifications, CMS Web Interface Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement	We proposed to include this measure in the Pediatrics specialty set as the denominator was expanded to include pediatric patients and it drives quality by measuring depression remission.
We received no comments on the measures proposed for addition to this specialty set. Therefore, we are finalizing the measures for addition to the *Pediatrics Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.									

B.14. Pediatrics

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE PEDIATRICS SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	160	CMS52v8	eCQM Specifications	Process	Effective Clinical Care	**HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Health Resources and Services Administration	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	467	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Developmental Screening in the First Three Years of Life:** The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.	Oregon Health & Science University	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Pediatrics Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposal for removal from the MIPS program.

Please note, that the proposed rule title for this table should had read "Previously Finalized Measures Proposed for Removal from the Pediatrics Set."

B.15. Physical Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Physical Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.15. Physical Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421 / 0421 e	128	CMS69 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419 e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance

B.15. Physical Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028 e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology

B.15. Physical Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Opioid)	N/A	468	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Continuity of Pharmacotherapy for Opioid Use Disorder (OUD):** Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	University of Southern California

B.15. Physical Medicine

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE PHYSICAL MEDICINE SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	109	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Physical Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.16. Plastic Surgery

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Plastic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.16. Plastic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE PLASTIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.16. Plastic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE PLASTIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	317	CMS22v8	Medicare Part B Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Outcome)	N/A	355	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period.	American College of Surgeons
! (Outcome)	N/A	356	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.	American College of Surgeons
! (Outcome)	N/A	357	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI).	American College of Surgeons
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons

B.17. Preventive Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Preventive Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PREVENTIVE MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0059 / N/A	001	CMS122 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
! (Care Coordination)	N/A	024	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
	0046	039	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PREVENTIVE MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127 v8	Medicare Part B Claims Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
* §	2372 / N/A	112	CMS125 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.	National Committee for Quality Assurance
* §	0034 / N/A	113	CMS130 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Colorectal Cancer Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	National Committee for Quality Assurance
§ ! (Appropriate Use)	0058	116	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis:** The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription.	National Committee for Quality Assurance
* §	0062 / N/A	119	CMS134 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PREVENTIVE MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PREVENTIVE MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v 8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	NA	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	NA	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES IN THE PREVENTIVE MEDICINE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	438	CMS347 v3	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services
*	N/A	475	CMS349 v2	eCQM Specifications	Process	Community/ Population Health	**HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Centers for Disease Control and Prevention

B.17. Preventive Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE PREVENTIVE MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	This measure was proposed for inclusion into the Preventive Medicine specialty set as a replacement for measure Q109: Osteoarthritis (OA): Function and Pain Assessment, which was proposed for removal. Measure Q182 includes the patient population in measure Q109, but is more robust in that it requires more frequent assessment and a plan of care.
We received no comments on the measures proposed for addition to this specialty set. Therefore, we are finalizing the measures for addition to the *Preventive Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.									

B.17. Preventive Medicine

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE PREVENTIVE MEDICINE SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	109	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Preventive Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

Please note that the proposed rule title for this table should have read "Previously Finalized Measures Proposed for Removal from the Preventive Medicine Set."

B.18. Neurology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Neurology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.18. Neurology

PREVIOUSLY FINALIZED MEASURES IN THE NEUROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
* ! (Patient Safety)	NA	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services

B.18. Neurology

PREVIOUSLY FINALIZED MEASURES IN THE NEUROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	268	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy:** Percentage of all patients of childbearing potential (12 years and older) diagnosed with epilepsy who were counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy.	American Academy of Neurology
	2872e	281	CMS149 v8	eCQM Specifications	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	282	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.	American Psychiatric Association/ American Academy of Neurology
*	N/A	283	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Psychiatric Association/ American Academy of Neurology

B.18. Neurology

PREVIOUSLY FINALIZED MEASURES IN THE NEUROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Patient Safety)	N/A	286	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: 1) dangerousness to self or others and 2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Psychiatric Association/ American Academy of Neurology
* ! (Care Coordination)	N/A	288	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Dementia: Education and Support of Caregivers for Patients with Dementia:** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months	American Psychiatric Association/ American Academy of Neurology
*	N/A	290	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease:** Percentage of all patients with a diagnosis of Parkinson's Disease [PD] who were assessed for psychiatric symptoms in the past 12 months.	American Academy of Neurology
	N/A	291	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease:** Percentage of all patients with a diagnosis of Parkinson's Disease [PD] who were assessed for cognitive impairment or dysfunction in the past 12 months.	American Academy of Neurology
! (Care Coordination)	N/A	293	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Parkinson's Disease: Rehabilitative Therapy Options:** Percentage of all patients with a diagnosis of Parkinson's Disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (i.e., physical, occupational, and speech therapy) discussed in the past 12 months	American Academy of Neurology
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.18. Neurology

PREVIOUSLY FINALIZED MEASURES IN THE NEUROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Experience)	N/A	386	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences:** Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (e.g., advance directives, invasive ventilation, hospice) at least once annually.	American Academy of Neurology
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
! (Efficiency)	N/A	419	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Overuse of Imaging for the Evaluation of Primary Headache:** Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present.	American Academy of Neurology
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	N/A	435	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Patient Reported Outcome	Effective Clinical Care	**Quality Of Life Assessment For Patients With Primary Headache Disorders:** Percentage of patients with a diagnosis of primary headache disorder whose health related quality of life (HRQoL) was assessed with a tool(s) during at least two visits during the 12 month measurement period AND whose health related quality of life score stayed the same or improved.	American Academy of Neurology

B.19. Mental/Behavioral Health

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Mental/Behavioral Health specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.19. Mental/Behavioral Health

PREVIOUSLY FINALIZED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	009	CMS128 v8	eCQM Specifications	Process	Effective Clinical Care	**Anti-Depressant Medication Management:** Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	National Committee for Quality Assurance
*	0104e	107	CMS161 v8	eCQM Specifications	Process	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0421 / 0421e	128	CMS69v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/P opulation Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v 9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services

B.19. Mental/Behavioral Health

PREVIOUSLY FINALIZED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	2872e	281	CMS149 v8	eCQM Specifications	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	282	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.	American Psychiatric Association/ American Academy of Neurology
*	N/A	283	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Psychiatric Association/ American Academy of Neurology
* ! (Patient Safety)	N/A	286	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: 1) dangerousness to self or others and 2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Psychiatric Association/ American Academy of Neurology
* ! (Care Coordination)	N/A	288	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Dementia: Education and Support of Caregivers for Patients with Dementia:** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months	American Psychiatric Association/ American Academy of Neurology

B.19. Mental/Behavioral Health

PREVIOUSLY FINALIZED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
	N/A	366	CMS136v9	eCQM Specifications	Process	Effective Clinical Care	**Follow-Up Care for Children Prescribed ADHD Medication (ADD):** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	National Committee for Quality Assurance
* § ! (Outcome)	0710 / 0710e	370	CMS159v8	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
* ! (Patient Safety)	1365e	382	CMS177v8	eCQM Specifications	Process	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	1879	383	N/A	MIPS CQMs Specifications	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Centers for Medicare & Medicaid Services

B.19. Mental/Behavioral Health

PREVIOUSLY FINALIZED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Care Coordination)	0576	391	N/A	MIPS CQMs Specifications	Process	Communication/ Care Coordination	**Follow-up After Hospitalization for Mental Illness (FUH):** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted: ● The percentage of discharges for which the patient received follow-up within 30 days after discharge. ● The percentage of discharges for which the patient received follow-up within 7 days after discharge.	National Committee for Quality Assurance
	2803	402	NA	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Opioid)	N/A	468	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Continuity of Pharmacotherapy for Opioid Use Disorder (OUD):** Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	University of Southern California

B.19. Mental/Behavioral Health

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE MENTAL/BEHAVIORAL HEALTH SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	325	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions:** Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition.	American Psychiatric Association	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0712e	371	CMS160v8	eCQM Specifications	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.	Minnesota Community Measurement	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table for rationale.
0711	411	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Six Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission six months (+/- 60 days) after an index event date.	Minnesota Community Measurement	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the measures for removal from the *Mental/Behavioral Health Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.20. Diagnostic Radiology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Diagnostic Radiology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.20. Diagnostic Radiology

PREVIOUSLY FINALIZED MEASURES IN THE DIAGNOSTIC RADIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	N/A	145	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy:** Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available).	American College of Radiology
! (Efficiency)	0508	146	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms:** Percentage of final reports for screening mammograms that are classified as "probably benign".	American College of Radiology
! (Care Coordination)	N/A	147	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy:** Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), etc.) that were performed.	Society of Nuclear Medicine and Molecular Imaging
	0507	195	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Radiology: Stenosis Measurement in Carotid Imaging Reports:** Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement.	American College of Radiology
! (Care Coordination)	0509	225	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Structure	Communication and Care Coordination	**Radiology: Reminder System for Screening Mammograms:** Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram.	American College of Radiology
! (Appropriate Use)	N/A	360	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies:** Percentage of computed tomography (CT) and cardiac nuclear medicine (myocardial perfusion studies) imaging reports for all patients, regardless of age, that document a count of known previous CT (any type of CT) and cardiac nuclear medicine (myocardial perfusion) studies that the patient has received in the 12-month period prior to the current study.	American College of Radiology

B.20. Diagnostic Radiology

PREVIOUSLY FINALIZED MEASURES IN THE DIAGNOSTIC RADIOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	N/A	364	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines:** Percentage of final reports for CT imaging studies with a finding of an incidental pulmonary nodule for patients aged 35 years and older that contain an impression or conclusion that includes a recommended interval and modality for follow-up (e.g., type of imaging or biopsy) or for no follow-up, and source of recommendations (e.g., guidelines such as Fleischner Society, American Lung Association, American College of Chest Physicians).	American College of Radiology
* ! (Appropriate Use)	N/A	405	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Appropriate Follow-up Imaging for Incidental Abdominal Lesions:** Percentage of final reports for imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow-up imaging recommended based on radiological findings: • Cystic renal lesion that is simple appearing* *(Bosniak I or II)*. • Adrenal lesion less than or equal to 1.0 cm. • Adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols.	American College of Radiology
! (Appropriate Use)	N/A	406	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Appropriate Follow-Up Imaging for Incidental Thyroid Nodules in Patients:** Percentage of final reports for computed tomography (CT), CT angiography (CTA) or magnetic resonance imaging (MRI) or magnetic resonance angiogram (MRA) studies of the chest or neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally with follow-up imaging recommended.	American College of Radiology
	N/A	436	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques:** Percentage of final reports for patients aged 18 years and older undergoing computed tomography (CT) with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control. • Adjustment of the mA and/or kV according to patient size. • Use of iterative reconstruction technique.	American College of Radiology/ American Medical Association-Physician Consortium for Performance Improvement/ National Committee for Quality Assurance

B.20. Diagnostic Radiology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE DIAGNOSTIC RADIOLOGY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	361	N/A	MIPS CQMs Specifications	Structure	Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry:** Percentage of total computed tomography (CT) studies performed for all patients, regardless of age, that are submitted to a radiation dose index registry that is capable of collecting at a minimum selected data elements.	American College of Radiology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	362	N/A	MIPS CQMs Specifications	Structure	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes:** Percentage of final reports for computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12 month period after the study.	American College of Radiology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

Comment: One commenter opposed the removal of four radiology measures from the Diagnostic Radiology set: measures Q146, Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms, Q225, Radiology: Reminder System for Screening Mammograms, Q361, Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry, and Q362, Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes.

Response: Please see our detailed response under Table C for the decision to retain measures Q146 and 225 and finalize removal of measures Q361 and Q362.

After consideration of the comments, we are finalizing the removal of measures from the *Diagnostic Radiology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.21. Nephrology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Nephrology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.21. Nephrology

PREVIOUSLY FINALIZED MEASURES IN THE NEPHROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Outcome)	0059 / N/A	001	CMS122 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement
*	N/A	111	CMS127 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance
* §	0062 / N/A	119	CMS134 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance

B.21. Nephrology

PREVIOUSLY FINALIZED MEASURES IN THE NEPHROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101 / N/A	318	CMS139v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance
§	N/A	400	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk:** Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.21. Nephrology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE NEPHROLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0097	046	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age. • Submission Criteria 2: 65 years and older. • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance	This measure was proposed for removal beginning with 2022 MIPS Payment Year. See Table C for rationale.
1667	328	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL.	Renal Physicians Association	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	330	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter.	Renal Physicians Association	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	403	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Adult Kidney Disease: Referral to Hospice:** Percentage of patients aged 18 years and older with a diagnosis of end -stage renal disease (ESRD) who withdraw from hemodialysis or peritoneal dialysis who are referred to hospice care.	Renal Physicians Association	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Zoster (Shingles) Vaccination:**	PPRNet	This measure was proposed for removal beginning with the 2022

B.21. Nephrology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE NEPHROLOGY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
						The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.		MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Nephrology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.22. General Surgery

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the General Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.22. General Surgery

PREVIOUSLY FINALIZED MEASURES IN THE GENERAL SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421 / 0421 e	128	CMS69 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419 e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.22. General Surgery

PREVIOUSLY FINALIZED MEASURES IN THE GENERAL SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI)
	N/A	264	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sentinel Lymph Node Biopsy for Invasive Breast Cancer**: The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients before or after neoadjuvant systemic therapy, who undergo a sentinel lymph node (SLN) procedure.	American Society of Breast Surgeons
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Outcome)	N/A	355	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period.	American College of Surgeons
! (Outcome)	N/A	356	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.	American College of Surgeons
! (Outcome)	N/A	357	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI).	American College of Surgeons
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.22. General Surgery

PREVIOUSLY FINALIZED MEASURES IN THE GENERAL SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.22. General Surgery

MEASURES FINALIZED FOR **ADDITION** TO THE GENERAL SURGERY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
! (Outcome)	N/A	354	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Anastomotic Leak Intervention**: Percentage of patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery.	American College of Surgeons	We proposed to include this measure in the General Surgery specialty set as it is clinically relevant to this clinician type.

Comment: One commenter generally supported the addition of measure Q354: Anastomotic Leak Intervention to the General Surgery set, as it a foundational conformance measure that identifies adverse events for the specified procedures and provides relevant and actionable data for surgical practice. However, in order to reliably and validly measure anastomotic leak intervention, the commenter said a single source to collect, analyze, and aggregate data is needed.

The commenter has found that measuring the same quality measure, with the same measure specification across registries, does not ensure accurate benchmarking due to inconsistencies in program implementation and data interpretation, including the lack of standardized data definitions, lack of standardized risk adjustment/data analytics, inconsistency of data ascertainment methods, and lack of common normalization methods.

Response: We thank the commenter for supporting the addition of measure Q354 to the General Surgery set. We require measures to be submitted as specified for MIPS and clinicians should not use specifications from other programs to ensure that performance can be assessed across MIPS eligible clinicians. In addition, Qualified Registries and QCDRs are required to perform data validation execution reports to ensure accurate benchmarking. We believe that the measure specification, which contains specific coding to define the sample population and the measure flow that outlines the systemic approach to align patients into the appropriate numerator options, supports standardized implementation of the measure concept regardless of the data source.

After consideration of the comments, we are finalizing the measures for addition to the *General Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.22. General Surgery

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE GENERAL SURGERY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0097	046	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age. • Submission Criteria 2: 65 years and older. • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *General Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.23. Vascular Surgery

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Vascular Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.23. Vascular Surgery

PREVIOUSLY FINALIZED MEASURES IN THE VASCULAR SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.23. Vascular Surgery

PREVIOUSLY FINALIZED MEASURES IN THE VASCULAR SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* § ! (Outcome)	0018 / N/A	236	CMS165 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
! (Outcome)	N/A	258	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7):** Percent of patients undergoing open repair of small or moderate sized non-ruptured infrarenal abdominal aortic aneurysms (AAA) who do not experience a major complication (discharge to home no later than post-operative day #7).	Society for Vascular Surgeons
! (Outcome)	N/A	259	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of patients undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2).	Society for Vascular Surgeons

B.23. Vascular Surgery

PREVIOUSLY FINALIZED MEASURES IN THE VASCULAR SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Outcome)	N/A	260	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing Carotid Endarterectomy (CEA) who are discharged to home no later than post-operative day #2.	Society for Vascular Surgeons
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Outcome)	N/A	344	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2.	Society for Vascular Surgeons
! (Outcome)	N/A	357	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI).	American College of Surgeons
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
! (Outcome)	N/A	420	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Effective Clinical Care	**Varicose Vein Treatment with Saphenous Ablation: Outcome Survey:** Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.	Society of Interventional Radiology

B.23. Vascular Surgery

PREVIOUSLY FINALIZED MEASURES IN THE VASCULAR SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	N/A	441	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control):** The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: □ Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- AND □ Most recent tobacco status is Tobacco Free -- AND □ Daily Aspirin or Other Antiplatelet Unless Contraindicated -- AND □ Statin Use Unless Contraindicated.	Wisconsin Collaborative for Healthcare Quality (WCHQ)

B.23. Vascular Surgery

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE VASCULAR SURGERY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
1543	345	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive**: Percent of asymptomatic patients undergoing CAS who are stroke free while in the hospital or discharged alive following surgery.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
1540	346	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CEA who are stroke free or discharged alive following surgery.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
1534	347	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Are Discharged Alive**: Percent of patients undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) who are discharged alive.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale
1523	417	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive**: Percentage of patients undergoing open repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) who are discharged alive.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Vascular Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.24. Thoracic Surgery

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Thoracic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.24. Thoracic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE THORACIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
! (Outcome)	0129	164	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Prolonged Intubation:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours.	Society of Thoracic Surgeons

B.24. Thoracic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE THORACIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Outcome)	0114	167	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis.	Society of Thoracic Surgeons
! (Outcome)	0115	168	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason.	Society of Thoracic Surgeons
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services

B.24. Thoracic Surgery

PREVIOUSLY FINALIZED MEASURES IN THE THORACIC SURGERY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
§! (Outcome)	0119	445	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG):** Percent of patients aged 18 years and older undergoing isolated CABG who die, including both all deaths occurring during the hospitalization in which the CABG was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure.	Society of Thoracic Surgeons

B.24. Thoracic Surgery

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE THORACIC SURGERY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0130	165	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention.	Society of Thoracic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0131	166	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Stroke:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours.	Society of Thoracic Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Thoracic Surgery Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.25. Urology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Urology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.25. Urology

PREVIOUSLY FINALIZED MEASURES IN THE UROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance
! (Patient Experience)	N/A	050	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance
* § ! (Appropriate Use)	0389 / 0389e	102	CMS129 v9	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.25. Urology

PREVIOUSLY FINALIZED MEASURES IN THE UROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0390	104	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer**: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate.	American Urological Association Education and Research
* §	0062 / N/A	119	CMS134 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.25. Urology

PREVIOUSLY FINALIZED MEASURES IN THE UROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	N/A	265	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient.	American Academy of Dermatology
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Patient Experience)	N/A	358	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American College of Surgeons
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
! (Patient Safety)	N/A	429	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy:** Percentage of patients who are screened for uterine malignancy prior to vaginal closure or obliterative surgery for pelvic organ prolapse.	American Urogynecologic Society
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	N/A	432	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the bladder recognized either during or within 30 days after surgery.	American Urogynecologic Society

B.25. Urology

PREVIOUSLY FINALIZED MEASURES IN THE UROLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Outcome)	N/A	433	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair:** Percentage of patients undergoing surgical repair of pelvic organ prolapse that is complicated by a bowel injury at the time of index surgery that is recognized intraoperatively or within 30 days after surgery.	American Urogynecologic Society
! (Outcome)	N/A	434	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair:** Percentage of patients undergoing pelvic organ prolapse repairs who sustain an injury to the ureter recognized either during or within 30 days after surgery.	American Urogynecologic Society
*	N/A	462	CMS645 v3	eCQM Specifications	Process	Effective Clinical Care	**Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Oregon Urology Institute

B.25. Urology

MEASURES FINALIZED FOR **ADDITION** TO THE UROLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
! (Outcome)	N/A	476	CMS771 v1	eCQM Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia:** Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association Symptom Index (AUA-SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.	Large Urology Group Practice Association and Oregon Urology Institute	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Urology specialty set as it is clinically relevant to this clinician type.
We received no comments on the measures proposed for addition to this specialty set. Therefore, we are finalizing the measures for addition to the *Urology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.									

B.25. Urology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE UROLOGY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0420	131	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	428	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence**: Percentage of patients undergoing appropriate preoperative evaluation of stress urinary incontinence prior to pelvic organ prolapse surgery per American College of Obstetrics and Gynecology (ACOG), American Urogynecologic Society, and American Urological Association guidelines	American Urogynecologic Society	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the removal of measures from the *Urology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.26a. Oncology/Hematology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Oncology/Hematology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The Oncology specialty set has been updated to include Hematology and has been renamed as Oncology/Hematology. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.26a. Oncology/Hematology

PREVIOUSLY FINALIZED MEASURES IN THE ONCOLOGY/HEMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* § ! (Appropriate Use)	0389 / 0389e	102	CMS129v9	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance

B.26a. Oncology/Hematology

PREVIOUSLY FINALIZED MEASURES IN THE ONCOLOGY/HEMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* § ! (Patient Experience)	0384 / 0384e	143	CMS157v8	eCQM Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* ! (Patient Experience)	0383	144	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain:** Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician.	American Society of Clinical Oncology
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	1853	250	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Radical Prostatectomy Pathology Reporting:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.	College of American Pathologists

B.26a. Oncology/Hematology

PREVIOUSLY FINALIZED MEASURES IN THE ONCOLOGY/HEMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* § ! (Appropriate Use)	1858	450	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy:** Percentage of female patients (aged 18 years and older) with AJCC stage I (T1c) – III, human epidermal growth factor receptor 2 (HER2) positive breast cancer receiving adjuvant chemotherapy who are also receiving trastuzumab.	American Society of Clinical Oncology
§	1859	451	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who Receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy:** Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom RAS (KRAS and NRAS) gene mutation testing was performed	American Society of Clinical Oncology

B.26a. Oncology/Hematology

PREVIOUSLY FINALIZED MEASURES IN THE ONCOLOGY/HEMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Appropriate Use)	1860	452	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies:** Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and RAS (KRAS or NRAS) gene mutation spared treatment with anti-EGFR monoclonal antibodies.	American Society of Clinical Oncology
§ ! (Appropriate Use)	0210	453	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score – better):** Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life.	American Society of Clinical Oncology
§ ! (Outcome)	0213	455	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better):** Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.	American Society of Clinical Oncology
§ ! (Outcome)	0216	457	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days (lower score – better):** Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.	American Society of Clinical Oncology
*	N/A	462	CMS645v3	eCQM Specifications	Process	Effective Clinical Care	**Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Oregon Urology Institute

B.26a. Oncology/Hematology

MEASURES FINALIZED FOR **ADDITION** TO THE ONCOLOGY/HEMATOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
	N/A	067	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow:** Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia who had baseline cytogenetic testing performed on bone marrow.	American Society of Hematology	We proposed to include this measure in the Oncology/Hematology specialty set as this set was updated to include Hematology for the 2020 performance period and this measure is clinically relevant.
	N/A	069	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hematology: Multiple Myeloma: Treatment with Bisphosphonates:** Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period.	American Society of Hematology	We proposed to include this measure in the Oncology/Hematology specialty set as this set was updated to include Hematology for the 2020 performance period and this measure is clinically relevant.
	N/A	070	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry**: Percentage of patients aged 18 years and older, seen within a 12-month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Oncology/Hematology specialty set as this set was updated to include Hematology for the 2020 performance period and this measure is clinically relevant.

Comment: One commenter did not support the addition of measure Q069: Hematology: Multiple Myeloma: Treatment with Bisphosphonates to the Oncology/Hematology set until further review by the measure steward. The commenter stated that the two bisphosphonate drugs listed in the specifications are pamidronate and zoledronate. However, patients are being treated with the drug denosumab and should not be counted as non-concordant for this measure. Not only is denosumab FDA-approved for this indication, it is also considered an alternative to pamidronate and zoledronic acid in the NCCN and ASCO guidelines. Therefore, the commenter recommended that before inclusion of measure Q069 in the Oncology/Hematology measure set, the measure steward should review current guidelines and consider editing the numerator criteria so that a patient receiving pamidronate, zoledronic acid, or denosumab be considered concordant with the measure.

One commenter thanked CMS for the proposed additions to the Oncology/Hematology set and encouraged finalization of this measure set.

Response: We thank the commenter for their comment and agree that it is important to allow eligible clinicians and patients to utilize shared decision making when determining what treatment to administer as denosumab has been clinically indicated in the treatment of bone problems in patients with multiple myeloma that is not in remission. We have collaborated with the measure steward and agree that in the clinical situation in which denosumab is indicated and administered to the patient that eligible clinicians may submit a medical reason or patient reason exception when clinically applicable and documented in the patient's medical chart.

After consideration of the comments, we are finalizing the measures for addition to the *Oncology/Hematology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.26a. Oncology/Hematology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE ONCOLOLGY/HEMATOLOGY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
1857	449	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies:** Percentage of female patients (aged 18 years and older) with breast cancer who are human epidermal growth factor receptor 2 (HER2)/neu negative who are not administered HER2-targeted therapies.	American Society of Clinical Oncology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	454	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Percentage of Patients who Died from Cancer with More than One Emergency Department Visit in the Last 30 Days of Life (lower score – better):** Percentage of patients who died from cancer with more than one emergency department visit in the last 30 days of life.	American Society of Clinical Oncology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0215	456	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Percentage of Patients who Died from Cancer Not Admitted to Hospice (lower score – better):** Percentage of patients who died from cancer not admitted to hospice.	American Society of Clinical Oncology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Zoster (Shingles) Vaccination**: The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination**.**	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the measures for removal from the *Oncology/Hematology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.26b. Radiation Oncology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Radiation Oncology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.26b. Radiation Oncology

PREVIOUSLY FINALIZED MEASURES IN THE RADIATION ONCOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* § ! (Appropriate Use)	0389 / 0389e	102	CMS129 v9	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* § ! (Patient Experience)	0384 / 0384e	143	CMS157 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcome	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* ! (Patient Experience)	0383	144	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcome	**Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain:** Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician.	American Society of Clinical Oncology

B.27. Infectious Disease

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Infectious Disease specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.27. Infectious Disease

PREVIOUSLY FINALIZED MEASURES IN THE INFECTIOUS DISEASE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	National Committee for Quality Assurance
! (Patient Safety)	0419 / 0419e	130	CMS68v 9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
§	0409	205	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea, and syphilis screenings were performed at least once since the diagnosis of HIV infection.	Health Resources and Services Administration
§ ! (Outcome)	2082	338	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Health Resources and Services Administration
§ ! (Efficiency)	2079	340	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**HIV Medical Visit Frequency:** Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period, with a	Health Resources and Services Administration

B.27. Infectious Disease

PREVIOUSLY FINALIZED MEASURES IN THE INFECTIOUS DISEASE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
							minimum of 60 days between medical visits.	
*	N/A	475	CMS349 v2	eCQM Specifications	Process	Community/ Population Health	**HIV Screening:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Centers for Disease Control and Prevention

B.27. Infectious Disease

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE INFECTIOUS DISEASE SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	407	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Appropriate Treatment of Methicillin-Susceptible Staphylococcus Aureus (MSSA) Bacteremia:** Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. Nafcillin, Oxacillin or Cefazolin) as definitive therapy.	Infectious Diseases Society of America	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0657	464	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use**: Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAOHNSF)	We agree with specialty society feedback to remove this measure from this specialty set. Most infectious disease physicians consult on patients in the inpatient setting. This measure applies to the outpatient setting and is reported by primary care, pediatricians, or other physicians to assess appropriate testing for children with otitis media with effusion, hence this measure does not support the inpatient setting where the majority of eligible clinicians within this specialty practice. We agree with specialty society feedback that this measure is neither an applicable nor a clinically relevant quality measure to assess the clinical performance of Infectious Disease physicians only working within outpatient settings.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Zoster (Shingles) Vaccination**: The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Infectious Disease Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.28. Neurosurgical

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Neurosurgical specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.28. Neurosurgical

PREVIOUSLY FINALIZED MEASURES IN THE NEUROSURGICAL SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Appropriate Use)	0268	021	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications fo a first OR second-generation cephalosporin prophylactic antibiotic who had an order for a first OR second-generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
! (Patient Safety)	N/A	023	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated i all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low- Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis t be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests t documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
	N/A	187	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Stroke and Stroke Rehabilitation: Thrombolytic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV alteplase was initiated within three hours of time last known well.	American Heart Association

B.28. Neurosurgical

PREVIOUSLY FINALIZED MEASURES IN THE NEUROSURGICAL SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Outcome)	N/A	409	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Clinical Outcome Post Endovascular Stroke Treatment:** Percentage of patients with a mRs score of 0 to 2 at 90 days following endovascular stroke intervention.	Society of Interventional Radiology
! (Outcome)	N/A	413	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Door to Puncture Time for Endovascular Stroke Treatment:** Percentage of patients undergoing endovascular stroke treatment who have a door to puncture time of less than two hours.	Society of Interventional Radiology
* ! (Outcome)	N/A	459	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Back Pain After Lumbar Discectomy/Laminectomy:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	460	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Back Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain	Minnesota Community Measurement
* ! (Outcome)	N/A	461	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Leg Pain After Lumbar Discectomy/Laminectomy:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement

B.28. Neurosurgical

PREVIOUSLY FINALIZED MEASURES IN THE NEUROSURGICAL SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	N/A	469	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status After Lumbar Fusion:** For patients 18 years of age and older who had a lumbar fusion procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a)* at one year (9 to 15 months) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	471	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status After Lumbar Discectomy/Laminectomy:** For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) * at three months (6 to 20 weeks) postoperatively.	Minnesota Community Measurement
* ! (Outcome)	N/A	473	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Leg Pain After Lumbar Fusion:** For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain	Minnesota Community Measurement

B.28. Neurosurgical

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE NEUROSURGICAL SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
1543	345	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CAS who are stroke free while in the hospital or discharged alive following surgery.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
1540	346	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CEA who are stroke free or discharged alive following surgery.	Society for Vascular Surgeons	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures form the Neurosurgical Specialty Measure Set as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.29. Podiatry

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Podiatry specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.29. Podiatry

PREVIOUSLY FINALIZED MEASURES IN THE PODIATRY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association
	0416	127	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.	American Podiatric Medical Association
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance

B.29. Podiatry

PREVIOUSLY FINALIZED MEASURES IN THE PODIATRY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Patient Safety)	0101 / N/A	318	CMS139 v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance

B.30. Hospitalists

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Hospitalists specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.30. Hospitalists

PREVIOUSLY FINALIZED MEASURES IN THE HOSPITALISTS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0081 / 0081e	005	CMS135 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0083 / 0083e	008	CMS144 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
* ! (Patient Safety)	2726	076	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	American Society of Anesthesiologists

B.30. Hospitalists

PREVIOUSLY FINALIZED MEASURES IN THE HOSPITALISTS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services

B.30. Hospitalists

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE HOSPITALISTS SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	407	N/A	Medicare Part B Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Appropriate Treatment of Methicillin-Susceptible Staphylococcus Aureus (MSSA) Bacteremia:** Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. Nafcillin, Oxacillin or Cefazolin) as definitive therapy.	Infectious Diseases Society of America	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Hospitalists Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.31. Rheumatology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Rheumatology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.31. Rheumatology

PREVIOUSLY FINALIZED MEASURES IN THE RHEUMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Care Coordination)	N/A	024	N/A	Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance
	0046	039	N/A	Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement
*	N/A	111	CMS127 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance

B.31. Rheumatology

PREVIOUSLY FINALIZED MEASURES IN THE RHEUMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
*	N/A	176	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Tuberculosis Screening:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).	American College of Rheumatology
*	2523	177	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment of disease activity using an ACR-preferred RA disease activity assessment tool at ≥50% of encounters for RA for each patient during the measurement year.	American College of Rheumatology
*	N/A	178	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.	American College of Rheumatology
*	N/A	180	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Glucocorticoid Management:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.	American College of Rheumatology

B.31. Rheumatology

PREVIOUSLY FINALIZED MEASURES IN THE RHEUMATOLOGY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ** §	0028 / 0028e	226	CMS138 v8	Part B Claims Measure Specifications, eCQM Specifications, Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* § ! (Outcome)	0018 / N/A	236	CMS165 v8	Part B Claims Measure Specifications, eCQM Specifications, Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance
* ! (Patient Safety)	0022 / N/A	238	CMS156 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
*	N/A	317	CMS22v 8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Care Coordination)	N/A	374	CMS50v 8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services
	2803	402	N/A	MIPS CQMs Specifications	Process	Community/ Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance

B.31. Rheumatology

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE RHEUMATOLOGY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	179	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.	American College of Rheumatology	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the removal of measures from the *Rheumatology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.32. Dentistry

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Dentistry specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.32. Dentistry

PREVIOUSLY FINALIZED MEASURES IN THE DENTISTRY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	N/A	378	CMS75v8	eCQM Specifications	Outcome	Community/ Population Health	**Children Who Have Dental Decay or Cavities:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.	Centers for Medicare & Medicaid Services
*	N/A	379	CMS74v9	eCQM Specifications	Process	Effective Clinical Care	**Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Centers for Medicare & Medicaid Services

B.33. Physical Therapy/Occupational Therapy

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Physical Therapy/Occupational Therapy specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.33. Physical Therapy/Occupational Therapy

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure**	**Indicator**	**Measure Title and Description**	**Measure Steward**
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services
* ! (Outcome)	0422	217	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Knee Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients aged 14 years+ with knee impairments. The change in functional status (FS) is assessed using the Knee FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.

B.33. Physical Therapy/Occupational Therapy

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure**	**Indicator**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	0423	218	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Hip Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with hip impairments. The change in functional status (FS) is assessed using the Hip FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.
* ! (Outcome)	0424	219	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with foot, ankle and lower leg impairments. The change in functional status (FS) assessed using the Foot/Ankle FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.
* ! (Outcome)	0425	220	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Low Back Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with low back impairments. The change in functional status (FS) is assessed using the Low Back FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.

B.33. Physical Therapy/Occupational Therapy

PREVIOUSLY FINALIZED MEASURES IN THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure**	**Indicator**	**Measure Title and Description**	**Measure Steward**
* ! (Outcome)	0426	221	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Shoulder Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.
* ! (Outcome)	0427	222	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Elbow, Wrist or Hand Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS is assessed using the Elbow/Wrist/Hand FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.) The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.

B.33. Physical Therapy/Occupational Therapy

MEASURES FINALIZED FOR ADDITION TO THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
	0416	127	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.	American Podiatric Medical Association	We proposed to include this measure in the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.33. Physical Therapy/Occupational Therapy

MEASURES FINALIZED FOR **ADDITION** TO THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
	2872e	281	CMS149 v8	eCQM Specifications	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.
*	N/A	282	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.	American Psychiatric Association/ American Academy of Neurology	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.

B.33. Physical Therapy/Occupational Therapy

MEASURES FINALIZED FOR **ADDITION** TO THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	N/A	288	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Dementia: Education and Support of Caregivers for Patients with Dementia:** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months	American Psychiatric Association/ American Academy of Neurology	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.
! (Patient Safety)	0101 / N/A	318	CMS139 v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure into the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.
! (Outcome)	N/A	478	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Change for Patients with Neck Impairments:** This is a patient-reported outcome performance measure (PRO-PM) consisting of a patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14+ with neck impairments. The change in FS is assessed using the Neck FS PROM.* The measure is risk-adjusted to patient characteristics known to be associated with FS outcomes. It is used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. *The Neck FS PROM is an item-response theory-based computer adaptive test (CAT). In addition to the CAT version, which provides for reduced patient response burden, it is available as a 10-item short form (static/paper-pencil).	Focus on Therapeutic Outcomes, Inc.	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Physical Therapy/Occupational Therapy specialty set as it is clinically relevant to this clinician type.

Comment: One commenter was pleased to see the expansion of the Physical Therapy/Occupational Therapy set they had advocated for during the specialty measure set comment process. This updated measure set will allow these types of providers to more easily navigate and choose measures that are appropriate to their practice.

Response: We thank the commenter for their support on the expansion of this set.

After consideration of the comments, we are finalizing the measures for addition to the *Physical Therapy/Occupational Therapy Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.33. Physical Therapy/Occupational Therapy

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR **REMOVAL** FROM THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0428	223	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with General Orthopedic Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients aged 14 years+ with general orthopedic impairments (neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment). The change in FS is assessed using the General Orthopedic FS PROM (patient reported outcome measure) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey).	Focus on Therapeutic Outcomes, Inc.	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the measures for removal from the *Physical Therapy/Occupational Therapy Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures were proposed for removal from the MIPS program.								

B.34. Geriatrics

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Geriatrics specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.34. Geriatrics

PREVIOUSLY FINALIZED MEASURES IN THE GERIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
	0046	039	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
! (Patient Experience)	N/A	050	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.	National Committee for Quality Assurance
*	0041 / 0041e	110	CMS147v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Influenza Immunization**: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	111	CMS127v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	National Committee for Quality Assurance

B.34. Geriatrics

PREVIOUSLY FINALIZED MEASURES IN THE GERIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services
* ! (Patient Safety)	0022 / N/A	238	CMS15 6v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance
	2872e	281	CMS14 9v8	eCQM Specifications	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Physician Consortium for Performance Improvement Foundation (PCPI®)
*	N/A	282	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.	American Psychiatric Association/ American Academy of Neurology
*	N/A	283	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Psychiatric Association/ American Academy of Neurology

B.34. Geriatrics

PREVIOUSLY FINALIZED MEASURES IN THE GERIATRICS SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
* ! (Patient Safety)	N/A	286	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: 1) dangerousness to self or others and 2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Psychiatric Association/ American Academy of Neurology
* ! (Care Coordination)	N/A	288	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Dementia: Education and Support of Caregivers for Patients with Dementia:** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months	American Psychiatric Association/ American Academy of Neurology
* § ! (Outcome)	0710 / 0710e	370	CMS159v8	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement
! (Opioid)	N/A	408	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	412	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology
! (Opioid)	N/A	414	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview documented at least once during Opioid Therapy in the medical record.	American Academy of Neurology
§ ! (Outcome)	0213	455	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better):** Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.	American Society of Clinical Oncology

B. 34. Geriatrics

MEASURES FINALIZED FOR **ADDITION** TO THE GERIATRICS SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
	N/A	048	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older**: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	National Committee for Quality Assurance	We proposed to include this measure into the Geriatrics specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance	We proposed to include this measure into the Geriatrics specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance	We proposed to include this measure into the Geriatrics specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B. 34. Geriatrics

MEASURES FINALIZED FOR **ADDITION** TO THE GERIATRICS SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title And Description**	**Measure Steward**	**Rationale for Inclusion**
! (Outcome)	N/A	476	CMS771v1	eCQM Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia:** Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association Symptom Index (AUA-SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.	Large Urology Group Practice Association and Oregon Urology Institute	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Geriatrics specialty set as it is clinically relevant to this clinician type.

Comment: One commenter appreciated the finalization of the Geriatrics set for use in the Quality performance category last year. The commenter encouraged CMS to continue to facilitate and sponsor measure development for the multi-morbid patient with functional impairment who is not institutionalized population. The commenter recommended that CMS prioritize measures that specifically address care of the geriatric population.

The commenter supported the four measures proposed for addition to the Geriatrics set: Q048: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older, Q154: Falls: Risk Assessment, Q155: Falls: Plan of Care, and Q476: International Prostate Symptom Score (IPPS) or American Urological Association Symptom Index (AUA-SI) change 6 – 12 months after diagnosis of Benign Prostatic Hyperplasia.

Response: We appreciate the comment received supporting the additional measures to the Geriatrics set.

After consideration of the comments, we are finalizing the measures for addition to the *Geriatrics Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years

B.34. Geriatrics

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE GERIATRICS SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	Quality #	CMS eCQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0097	046	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age. • Submission Criteria 2: 65 years and older. • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

Comment: One commenter agreed with the removal of Q046 from the Geriatrics set and MIPS altogether. The commenter noted the large caregiver burden associated with this measure may lead to slow or little adoption and the cumbersome specifications will lead to inaccurate data.

Response: We thank the commenter for supporting the removal of measure Q046.

After consideration of the comments, we are finalizing the measures for removal from the *Geriatrics Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures were proposed for removal from the MIPS program.

B.35. Urgent Care

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Urgent Care specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.35. Urgent Care

PREVIOUSLY FINALIZED MEASURES IN THE URGENT CARE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§ ! (Appropriate Use)	0069 / N/A	065	CMS154 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	National Committee for Quality Assurance
§ * ! (Appropriate Use)	N/A	066	CMS146 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	National Committee for Quality Assurance
! (Appropriate Use)	0654	093	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy.	American Academy of Otolaryngology – Head and Neck Surgery Foundation
§ ! (Appropriate Use)	0058	116	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis:** The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription.	National Committee for Quality Assurance
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.35. Urgent Care

PREVIOUSLY FINALIZED MEASURES IN THE URGENT CARE SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
! (Appropriate Use)	N/A	331	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse):** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	American Academy of Otolaryngology – Head and Neck Surgery Foundation
* ! (Appropriate Use)	N/A	332	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology – Head and Neck Surgery Foundation
! (Appropriate Use)	N/A	333	N/A	MIPS CQMs Specifications	Efficiency	Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.	American Academy of Otolaryngology – Head and Neck Surgery Foundation
	2803	402	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance
	2152	431	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)
! (Appropriate Use)	0657	464	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.35. Urgent Care

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE URGENT CARE SET Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.								
NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology - Head and Neck Surgery	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
0420	131	N/A	Medicare Part B Claims Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.
After consideration of the comments, we are finalizing the measures for removal from the *Urgent Care Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.								

B.36. Skilled Nursing Facility

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Skilled Nursing Facility specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that we are maintaining within the set, measures that were proposed to be added, and measures that were proposed for removal, as applicable.

B.36. Skilled Nursing Facility

PREVIOUSLY FINALIZED MEASURES IN THE SKILLED NURSING FACILITY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§	0067	006	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association
* §	0070 / 0070e	007	CMS145 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Physician Consortium for Performance Improvement Foundation (PCPI®)
* §	0083 / 0083e	008	CMS144 v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Physician Consortium For Performance Improvement Foundation (PCPI®)
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance
*	0041 / 0041e	110	CMS147 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Physician Consortium for Performance Improvement Foundation (PCPI®)

B.36. Skilled Nursing Facility

PREVIOUSLY FINALIZED MEASURES IN THE SKILLED NURSING FACILITY SET								
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**
§	0066	118	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	American Heart Association
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services
*	N/A	317	CMS22v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
* §	1525	326	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	American College of Cardiology

B.36 Skilled Nursing Facility

PREVIOUSLY FINALIZED MEASURES FINALIZED FOR REMOVAL FROM THE SKILLED NURSING FACILITY SET

Note: In this final rule, we are removing the following measure(s) below from this specific specialty measure set based upon review of updates made to existing quality measure specifications, the addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.

NQF # / eCQM NQF #	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Removal**
N/A	474	N/A	MIPS CQMs Specifications	Process	Community /Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	This measure was proposed for removal beginning with the 2022 MIPS Payment Year. See Table C for rationale.

After consideration of the comments, we are finalizing the measures for removal from the *Skilled Nursing Facility Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years. Note: Where applicable, see Table C for any comments and responses pertaining to measures that were proposed for removal from the MIPS program.

B.37. Endocrinology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Endocrinology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.37. Endocrinology

MEASURES FINALIZED FOR **ADDITION** TO THE ENDOCRINOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* § ! (Outcome)	0059 / N/A	001	CMS122v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set as it is clinically relevant to this clinician type.
	0046	039	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Screening for Osteoporosis for Women Aged 65-85 Years of Age:** Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* §	0055 / N/A	117	CMS131v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
§	0066	118	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	American Heart Association	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.37. Endocrinology

MEASURES FINALIZED FOR **ADDITION** TO THE ENDOCRINOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* §	0062 / N/A	119	CMS134v8	eCQM Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes: Medical Attention for Nephropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
	0417	126	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	American Podiatric Medical Association	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and $<$ 25 kg/m^2.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.37. Endocrinology

MEASURES FINALIZED FOR **ADDITION** TO THE ENDOCRINOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* § ! (Outcome)	0018 / N/A	236	CMS165v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.37. Endocrinology

MEASURES FINALIZED FOR **ADDITION** TO THE ENDOCRINOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
*	0053	418	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	National Committee for Quality Assurance	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
*	N/A	438	CMS347v3	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.
*	N/A	462	CMS645v3	eCQM Specifications	Process	Effective Clinical Care	**Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Oregon Urology Institute	We proposed to include this measure in the Endocrinology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type.

Comment: One commenter appreciated a proposed specialty measure set for endocrinology and that its recommended measures were included. A second commenter supported the addition of this set and encouraged CMS to continue exploring new measures focused on diabetes and obesity care.
Response: We thank the commenters for supporting the new Endocrinology set. We encourage the second commenter to collaborate with measure developers to construct new measures focusing on these areas or find existing quality measures outside of MIPS and submit to the Call for Measures for possible inclusion in future years.
After consideration of the comments, we are finalizing the new *Endocrinology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.38. Nutrition/Dietician

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Nutrition/Dietician specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.38. Nutrition/Dietician

MEASURES FINALIZED FOR **ADDITION** TO THE NUTRITION/DIETICIAN SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* § ! (Outcome)	0059 / N/A	001	CMS122 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.

B.38. Nutrition/Dietician

MEASURES FINALIZED FOR **ADDITION** TO THE NUTRITION/DIETICIAN SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.
§	N/A	239	CMS155 v8	eCQM Specifications	Process	Community / Population Health	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. □ Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. □ Percentage of patients with counseling for nutrition. □ Percentage of patients with counseling for physical activity.	National Committee for Quality Assurance	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.
	2152	431	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Nutrition/Dietician specialty set as it is clinically relevant to this clinician type.

Comment: Several commenters recommended that CMS adopt four eCQMs as quality measures in MIPS and adopt a specialty measure set for nutrition professionals. These include: NQF #3087/MUC16-294: Completion of a Malnutrition Screening within 24 hours of Admission, NQF #3088/MUC16-296: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening, NQF #3089/MUC16-372: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment, and NQF #3090/MUC16-344: Appropriate Documentation of a Malnutrition Diagnosis. These four measures have been thoroughly evaluated and tested in the hospital setting for inpatients. In addition, one of the commenters has re-specified these four eCQMs for use in the outpatient setting and submitted them for potential use in the MIPS through a qualified clinical data registry for reporting by eligible clinicians in 2020. The commenters recommended CMS include these malnutrition measures in the outpatient setting and to continue exploring new measures focused on diabetes and obesity care.

Response: We thank the commenters for their comment and have finalized the Nutrition/Dietician set. The measures recommended for inclusion within this specialty set are not current or proposed quality measures. Specialty sets are comprised of MIPS quality measures only, and we encourage the commenters to work with the measure stewards of the aforementioned eCQMs for submission to the yearly Call for Measures for consideration of inclusion into MIPS. We encourage the final commenter to collaborate with measure developers to construct new measures focusing on these areas or find existing quality measures outside of MIPS and submit to the Call for Measures for possible inclusion in future years.

After consideration of the comments, we are finalizing the new *Nutrition/Dietician Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.39. Pulmonology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Pulmonology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.39. Pulmonology

MEASURES FINALIZED FOR **ADDITION** TO THE PULMONOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Care Coordination)	0326	047	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
	0102	052	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy**: Percentage of patients aged 18 years and older with a diagnosis of COPD (FEV1/FVC < 70%) and who have an FEV1 less than 60% predicted and have symptoms who were prescribed a long-acting inhaled bronchodilator.	American Thoracic Society	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
* §	0421 / 0421e	128	CMS69v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.

B.39. Pulmonology

MEASURES FINALIZED FOR **ADDITION** TO THE PULMONOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
* § ! (Outcome)	0018 / N/A	236	CMS165v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.

B.39. Pulmonology

MEASURES FINALIZED FOR ADDITION TO THE PULMONOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Patient Safety)	0022 / N/A	238	CMS156v8	eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.	National Committee for Quality Assurance	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
	N/A	277	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.	American Academy of Sleep Medicine	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
	N/A	279	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured.	American Academy of Sleep Medicine	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
! (Care Coordination)	N/A	374	CMS50v8	eCQM Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Closing the Referral Loop: Receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
! (Outcome)	N/A	398	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Optimal Asthma Control:** Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Minnesota Community Measurement	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.
	2152	431	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.

B.39. Pulmonology

MEASURES FINALIZED FOR **ADDITION** TO THE PULMONOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
§ ! (Efficiency)	N/A	444	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**Medication Management for People with Asthma:** The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	National Committee for Quality Assurance	We proposed to include this measure in the Pulmonology specialty set as it is clinically relevant to this clinician type.

Comment: One commenter stated that the Pulmonary set includes measures that address the pharmacologic management of COPD, tobacco screening and cessation intervention, severity assessment of sleep apnea and adherence to positive airway pressure therapy, optimal asthma control and medication management for people with asthma. The commenter concurred with the inclusion of the measures in the Pulmonary set and recommended that CMS add measures to address improvements in quality of life scores and functional capacity for those COPD patients who are enrolled in pulmonary rehabilitation programs.

The commenter requested that two outcomes measures developed by the American Association for Cardiovascular and Pulmonary Rehabilitation (AACVPR) be included in the Pulmonary set: NQF measure #0770: Percentage of patients with COPD enrolled in pulmonary rehabilitation (PR) who are found to increase their health-related quality of life score (HRQQL) and NQF measure #0701: Percentage of patients with COPD who are enrolled in pulmonary rehabilitation (PR) who are found to increase their functional capacity by at least 25 meters (82 feet), as measured by a standardized 6-minute walk test (6MWT).

The commenter also supported the inclusion of measure Q052: Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy in the Pulmonology set and requested that measure Q051: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation be added if not finalized for removal.

Response: We thank the commenter for supporting the addition of measure Q052 to the Pulmonology set. As discussed under Table C, we are finalizing removal of measure Q051 from MIPS. We note that there is no NQF #0770 currently available. There is an NQF #0700: Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation if that is the measure the commenter was referring to. We encourage the commenter to collaborate with the measure steward(s) of the AACVPR COPD measures to submit them to the Call for Measures, if fully tested at the clinician level.

Comment: One commenter supported the addition of measures Q277: Sleep Apnea: Severity Assessment at Initial Diagnosis and Q279: Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy to the Pulmonology set.

Response: We thank the commenter supporting the addition of measures Q277 and Q279 to the Pulmonology set.

After consideration of the comments, we are finalizing the new *Pulmonology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.40. Chiropractic Medicine

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Chiropractic Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.40. Chiropractic Medicine

MEASURES FINALIZED FOR ADDITION TO THE CHIROPRACTIC MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.
* ! (Outcome)	0422	217	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Knee Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients aged 14 years+ with knee impairments. The change in functional status (FS) is assessed using the Knee FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.

B.40. Chiropractic Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE CHIROPRACTIC MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0423	218	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Hip Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with hip impairments. The change in functional status (FS) is assessed using the Hip FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.
* ! (Outcome)	0424	219	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with foot, ankle and lower leg impairments. The change in functional status (FS) assessed using the Foot/Ankle FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.

B.40. Chiropractic Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE CHIROPRACTIC MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0425	220	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Low Back Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with low back impairments. The change in functional status (FS) is assessed using the Low Back FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.
* ! (Outcome)	0426	221	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Shoulder Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.

B.40. Chiropractic Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE CHIROPRACTIC MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Outcome)	0427	222	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with Elbow, Wrist or Hand Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS is assessed using the Elbow/Wrist/Hand FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.) The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).	Focus on Therapeutic Outcomes, Inc.	We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.
! (Outcome)	N/A	478	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Change for Patients with Neck Impairments:** This is a patient-reported outcome performance measure (PRO-PM) consisting of a patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14+ with neck impairments. The change in FS is assessed using the Neck FS PROM.* The measure is risk-adjusted to patient characteristics known to be associated with FS outcomes. It is used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. *The Neck FS PROM is an item-response theory-based computer adaptive test (CAT). In addition to the CAT version, which provides for reduced patient response burden, it is available as a 10-item short form (static/paper-pencil).	Focus on Therapeutic Outcomes, Inc.	This measure was proposed as a new measure for the 2020 performance period. We proposed to include this measure in the Chiropractic Medicine specialty set as it is clinically relevant to this clinician type.

B.40. Chiropractic Medicine

MEASURES FINALIZED FOR **ADDITION** TO THE CHIROPRACTIC MEDICINE SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
Comment: One commenter appreciated the addition of measures Q217: Functional Status Change for Patients with Knee Impairments, Q218: Functional Status Change for Patients with Hip Impairments, Q219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments, Q220: Functional Status Change for Patients with Low Back Impairments, and Q221 to the Functional Status Change for Patients with Shoulder Impairments to the Chiropractic Medicine set. The commenter pointed out, however, that many solo practitioners will struggle to make the 20 case minimums for these measures. In addition, the majority of these CQMs require the use of an extraspinal CPT code 98943 which currently is not covered by Medicare. The commenter also stated that FOTO measures have no denominator exclusions. **Response:** We thank the commenter for supporting the addition of measures Q217 through Q221 to the Chiropractic Medicine set. Measures Q217 through Q221 are MIPS CQMs, meaning that all-payer data can be utilized for determining performance. Therefore, extraspinal CPT code 98943 may be denominator eligible within all-payer data. Additionally, the measures' denominator is not limited to the single extraspinal CPT code 98943 and allows the denominator eligibility to be established by additional CPT codes covered by Medicare. Moreover, we remind the commenter that the current posted FOTO measures do contain denominator exclusions. We also refer the commenter to Tables D.25 through D.29 of this final rule as there are multiple changes being finalized for measures Q217 through Q221 regarding denominator exclusions and denominator exceptions. After consideration of the comments, we are finalizing the new *Chiropractic Medicine Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.									

B.41. Clinical Social Work

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, we solicited comment on applicable measures for a Clinical Social Work specialty set, which takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that may be proposed for this new measure set in the event clinical social workers were proposed for inclusion in the definition of a MIPS eligible clinician in future rulemaking.

B.41. Clinical Social Work

MEASURES FINALIZED FOR **ADDITION** TO THE CLINICAL SOCIAL WORK SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
* ! (Patient Safety)	NA	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.

B.41. Clinical Social Work

MEASURES FINALIZED FOR **ADDITION** TO THE CLINICAL SOCIAL WORK SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community /Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
	2872e	281	CMS149v8	eCQM Specifications	Process	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
*	N/A	282	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.	American Psychiatric Association /American Academy of Neurology	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
*	N/A	283	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management:** Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.	American Psychiatric Association /American Academy of Neurology	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.

B.41. Clinical Social Work

MEASURES FINALIZED FOR **ADDITION** TO THE CLINICAL SOCIAL WORK SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Patient Safety)	N/A	286	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia:** Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: 1) dangerousness to self or others and 2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.	American Psychiatric Association/ American Academy of Neurology	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
* ! (Care Coordination)	N/A	288	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Dementia: Education and Support of Caregivers for Patients with Dementia:** Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months	American Psychiatric Association/American Academy of Neurology	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
* § ! (Outcome)	0710 / 0710e	370	CMS159v8	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Twelve Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.	Minnesota Community Measurement	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
* ! (Patient Safety)	1365e	382	CMS177v8	eCQM Specifications	Process	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
! (Outcome)	1879	383	N/A	MIPS CQMs Specifications	Intermediate Outcome	Patient Safety	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.

B.41. Clinical Social Work

MEASURES FINALIZED FOR **ADDITION** TO THE CLINICAL SOCIAL WORK SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
	2803	402	NA	MIPS CQMs Specifications	Process	Community / Population Health	**Tobacco Use and Help with Quitting Among Adolescents:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.	National Committee for Quality Assurance	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.
	2152	431	N/A	MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Clinical Social Work specialty set as it is clinically relevant to this clinician type.

Comment: One commenter supported all measures proposed for the Clinical Social Work set. The commenter requested the addition of several other measures for this set: Assessment of Unhealthy Alcohol Use for adolescents 12-20 every year if cessation not achieved, Assessment of Unhealthy Drug Use for adults every two years with follow up plan for cessation if not achieved, and Assessment of Unhealthy Drug Use for adolescents every two years with follow up plan for cessation if not achieved.

Another commenter supported the addition of this set and appreciated CMS revisiting the inclusion of clinical social workers (CSWs) as MIPS-eligible clinicians. CSWs are a functional member of the multidisciplinary oncology care team, and oncology CSWs (OCSWs) continue to be frequent contributors of care interventions highlighted in multiple MIPS quality metrics. The commenter suggested that measure Q047: Advance Care Plan be added to this measure set, as counseling patients in this area is not limited to oncology patients.

Response: We did not identify the three additional measures recommended for this set as MIPS quality measures and we encourage the commenter to submit them to the next Call for Measures, along with the recommendation to add Q047 to this set. We thank the commenters for supporting the new Clinical Social Work set and encourage them to submit their feedback with rationale during this solicitation process for future consideration in rulemaking. Note: Because measure Q282: Dementia: Functional Status Assessment was not finalized for removal from MIPS, it has been added to the Clinical Social Work. As a result, measures Q182: Functional Outcome Assessment was not finalized for addition to this set as it is duplicative to measure Q282 as outlined in the PFS proposed rule (84 FR 41171).

After consideration of the comments, we are finalizing the new *Clinical Social Work Measure Set* as indicated. Due to the availability of these measures as a new MIPS specialty measure set, we will take this into consideration for future rulemaking regarding whether to add clinical social workers as a MIPS eligible clinician type.

B.42. Audiology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Audiology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.42. Audiology

MEASURES FINALIZED FOR **ADDITION** TO THE AUDIOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Patient Safety)	0419 / 0419e	130	CMS68 v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
*	0418 / 0418e	134	CMS2v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Patient Safety)	0101	154	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Care Coordination)	0101	155	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.42. Audiology

MEASURES FINALIZED FOR **ADDITION** TO THE AUDIOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ! (Patient Safety)	NA	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Audiology specialty set as it is clinically relevant.
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Audiology specialty set as it is clinically relevant and the measure owner is proposing to expand the denominator to include this clinician type.
* ** §	0028 / 0028e	226	CMS138v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community / Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.

B.42. Audiology

MEASURES FINALIZED FOR **ADDITION** TO THE AUDIOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Care Coordination)	N/A	261	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness:** Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness	Audiology Quality Consortium	We proposed to include this measure in the Audiology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
! (Patient Safety)	0101 / N/A	318	CMS139v8	eCQM Specifications, CMS Web Interface Measure Specifications	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance	We proposed to include this measure in the Audiology specialty set as it is clinically relevant.

Comment: One commenter supported the inclusion of the new Audiology set and appreciated the multiple options for participation in MIPS that take into consideration the unique care provided by audiologists to Medicare beneficiaries. The new measures under the Audiology set would be available in addition to other MIPS measures already reported by audiologists.

Commenters requested that additional CPT codes be added to measures under this set: measure Q181: Elder Maltreatment Screen and Follow-Up Plan, measure Q182: Functional Outcome Assessment, and measure Q318: Falls: Screening for Future Fall Risk.

Response: We thank the commenters for supporting the new Audiology set and encourage them to reach out and collaborate with the measure stewards to refine the denominator eligible CPT coding.

After consideration of the comments, we are finalizing the new *Audiology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.

B.43. Speech Language Pathology

In addition to the considerations discussed in the introductory language of Table B of the appendix of this final rule, the Speech Language Pathology specialty set takes additional criteria into consideration, which includes, but is not limited to: whether the measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. Measure tables in this set include previously finalized measures that were proposed for this new measure set.

B.43. Speech Language Pathology

MEASURES FINALIZED FOR **ADDITION** TO THE SPEECH LANGUAGE PATHOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
! (Patient Safety)	0419 / 0419e	130	CMS68v9	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Speech Language Pathology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
* ! (Patient Safety)	N/A	181	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Speech Language Pathology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type. The measure owner is also proposing to add coding for this clinician type for the 2020 performance period.
* ! (Care Coordination)	2624	182	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Centers for Medicare & Medicaid Services	We proposed to include this measure in the Speech Language Pathology specialty set based upon stakeholder feedback requesting inclusion in a specialty set for this clinician type. The measure owner is also proposing to add coding for this clinician type for the 2020 performance period.

B.43. Speech Language Pathology

MEASURES FINALIZED FOR **ADDITION** TO THE SPEECH LANGUAGE PATHOLOGY SET									
Indicator	**NQF # / eCQM NQF #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**National Quality Strategy Domain**	**Measure Title and Description**	**Measure Steward**	**Rationale for Inclusion**
* ** §	0028 / 0028e	226	CMS138 v8	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed to include this measure in the Speech Language Pathology specialty set based upon past stakeholder feedback requesting inclusion in a specialty set for this clinician type.
Comment: One commenter supported the addition of two new measures for speech language pathologists: measures Q181: Elder Maltreatment Screen and Follow-Up Plan and Q182: Functional Outcome Assessment. The addition of these measures provides SLPs the opportunity to move closer to meeting the reporting threshold. The commenter requested that additional CPT codes be added to measures Q181 and Q182. **Response:** We thank the commenter for supporting the addition of measures Q181 and Q182 to the Speech Language Pathology set and encourage them to reach out and collaborate with the measure stewards to refine the denominator eligible CPT coding. After consideration of the comments, we are finalizing the new *Speech Language Pathology Specialty Measure Set* as indicated for the 2020 MIPS performance period/2022 MIPS payment year and future years.								

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

In this final rule, we are removing 42 previously finalized quality measures from the MIPS Program for the 2022 MIPS payment year and future years. These measures are discussed in detail below. Our measure removal criteria was discussed in the CY 2019 final rule (83 FR 59763 through 59765).

Further considerations are given in the evaluation of the measure's performance data, to determine whether there is or no longer is variation in performance. As discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763), additional criteria that we use for the removal of measures also includes extremely topped out measures, which means measures that are topped-out with an average (mean) performance rate between 98-100 percent. Beginning with the 2020 MIPS performance period/2022 MIPS payment year, we refer readers also to section III.K.3.c.(1)(d)(iv) of this final rule for additional removal criteria finalized for CY 2020.

NOTE: Since publication of the measures in Table C in CY2020 PFS proposed rule, we have determined the following measures will be retained in the 2020 MIPS performance period/2022 MIPS payment year: Q110, Q111, Q146, Q178, Q185, Q225, Q249, Q250, Q264, Q282, Q288, Q395, and Q396. As such, these measures have been removed from Table C and integrated back into the relevant previously finalized measure sets under Table B in this final rule. Our decisions not to finalize these measures for removal in this final rule are detailed in our responses to the public comments for these measures in Table Group C.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0097	046	N/A	Medicare Part B Claim Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age. • Submission Criteria 2: 65 years and older. • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure is duplicative of previously finalized measure Q130: Documentation of Current Medications in the Medical Record that also addresses assessment of current medications at the time of a patient and eligible clinician encounter. This measure is not only duplicative but includes measure logic that has demonstrated to be historically challenging for implementation by eligible clinicians. This measure is a legacy measure from the Physician Quality Reporting Initiative that was implemented initially as a Medicare Part B claims only measure. With the expansion of collection methods being used in the program, unforeseen implementation challenges have arisen. We believe measure Q130 is the best measure to support the quality outcome of current medications being documented in the medical record. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty sets as it is clinically relevant to these clinician types: Pulmonology and Clinical Social Work.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0091	051	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented.	American Thoracic Society	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program to ensure measures are not duplicative and present an opportunity to provide a meaningful impact to quality. We prefer the more robust, previously finalized measure Q52: Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy that assesses appropriate management of COPD by prescribing a long-acting inhaled bronchodilator for symptomatic patients based on spirometry test results that demonstrate FEV1/FVC < 70 percent, FEV1 < 60 percent, and patient's assessed COPD symptoms. Measure Q51 represents the process having the spirometry results reviewed and documented which is essentially a component of measure Q52. Therefore, we prefer to have eligible clinicians report the more robust measure Q52 which address spirometry results to provide the best option in pharmacological treatment. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty set as it is clinically relevant to this clinician type: Pulmonology.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	068	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy:** Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy.	American Society of Hematology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because we believe that documentation of iron stores would be considered a standard of care during administration of erythropoietin therapy. We believe this measure does not align with the meaningful measure initiative. There is limited adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty set as it is clinically relevant to this clinician type: Oncology/ Hematology.
0653	091	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations.	American Academy of Otolaryngology-Head and Neck Surgery	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it represents the clinical equivalency of previously finalized measure Q93: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use. In the circumstance an eligible clinician does not prescribe an antibiotic, most likely a topical therapy would be prescribed. However, the eligible clinician is able to prescribe both an antibiotic and topical and remain numerator compliant for this measure which does not address the overuse of systemic antimicrobial use. Therefore, we believe this measure is not providing a meaningful impact to quality improvement.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	109	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure is duplicative of previously finalized measure Q182: Functional Outcome Assessment that also addresses functional assessment and possibly pain depending on which standardized tool utilized. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: add coding for physical therapists and occupational therapists to the list of denominator eligible encounters as well as add this measure to the Physical Therapy/ Occupational Therapy specialty set. The measure steward states and we agree that for individuals with osteoarthritis (OA), physical therapists and occupational therapists provide various interventions with the goals of improving muscle performance, activity and participation, and promoting physical activity. Despite these revisions offered by the measure steward, we believe that it is important to reduce duplicity within the program and prefer the more robust measure Q182 which also supports physical and occupation therapist, more frequent functional assessment, and care plan for identified functional deficiencies.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0420	131	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program due to the controversy surrounding the potential correlation between assessment of pain and increase in prescriptions for opioid medications. After consideration of previous stakeholder feedback, we believe this measure may have the unintended consequence of encouraging excessive prescribing of pharmacologic therapies to assist with pain management. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: expand the denominator to include coding for audiology and speech language pathology MIPS eligible clinicians and remove the denominator exception allowing for patients with severe mental and/or physical incapacities to be excluded from the numerator. The measure steward submitted this substantive change based on a literature search the supports the need for improved pain assessment and follow up in patients with dementia. In addition, we proposed to add this measure to the following specialty measure sets in the event the measure is retained in the MIPS program based on stakeholder comments as it is clinically relevant to these clinician types: Chiropractic Medicine, Clinical Social Work, Audiology and Speech Language Pathology. Despite these revisions offered by the measure steward, we believe that it is important to ensure that the MIPS quality measures support the safety of patients and have a meaningful impact on quality management of pain by all eligible clinicians.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	160	CMS52v8	eCQM Specifications	Process	Effective Clinical Care	**HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Health Resources and Services Administration	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it does not align with the meaningful measure initiative. There is limited adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: update the numerator with addition of Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis and parenteral pentamidine and oral clindamycin with primaquine to Population one. For Population two and three, we would add intravenous pentamidine to the "Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis" value set. In alignment with these updates, the measure steward has is updating and creating definitions related to CD4 Count Tests to include oral clindamycin and primaquine for population 1 and update logic in all three numerators to allow for 'Medication Active' documentation in addition to 'Medication, Order' documentation for appropriate capture of either an active or ordered medication. Additionally, we would adopt the measure steward's substantive change to remove Leucovoin as a medication option and add oral Clindamycin to align with guideline updates. Additionally, we would update logic for denominator exceptions in population 1 to reflect "3 months or less after". Additionally, if the measure is not finalized for removal from the MIPS program, we proposed to remove the measure from the Allergy/ Immunology specialty set since this measure is not applicable to this specialty as Allergy/Immunology specialists do not diagnose, treat or manage HIV/AIDS patients. In addition, if the measure is retained in the MIPS program based on stakeholder comments we proposed to add this measure to the following specialty set as it is clinically relevant to this clinician type: Pulmonology. Despite these revisions, we believe this measure is not providing a meaningful impact to quality improvement due to lack of adoption by eligible clinicians.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0130	165	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention.	Society of Thoracic Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this inverse measure is 0.5 percent for the MIPS CQMs specifications collection type For an inverse measure, a lower calculated performance rate indicates better clinical care or control. As such, the MIPS CQMs specifications collection type is considered extremely topped out. The average performance rate is based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.
0131	166	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Stroke:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours.	Society of Thoracic Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in (83 FR 59761 through 59763). The average performance for this inverse measure is 1.3 percent for the MIPS CQMs specifications collection type. For an inverse measure, a lower calculated performance rate indicates better clinical care or control. As such, the MIPS CQMs specifications collection type is considered extremely topped out. The average performance rate is based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.
N/A	179	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.	American College of Rheumatology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because previously finalized measure Q177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity assesses the same patient population, but requires more frequent assessment in order to be numerator compliant making it a more robust measure.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0564 / 0564e	192	CMS132 v8	eCQM Specifications, MIPS CQMs Specifications	Outcome	Patient Safety	**Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Physician Consortium for Performance Improvement Foundation (PCPI®)	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The measure steward proposed to update the language to better clarify how the measure is currently implemented. They also requested to update the denominator exclusion data elements/value sets; removing 'Aphakia and Other Disorders of Lens,' 'Cysts of Iris, Ciliary Body and Anterior Chamber,' 'Enophthalmos,' and 'Prior Pars Plana Vitrectomy' and adding 'Glaucoma Associated with Congenital Anomalies, Dystrophies and Systemic Syndromes,' 'Other Endophthalmitis,' and 'Purulent Endophthalmitis'. We do not believe these changes will have an impact on performance rates because the measure is extremely topped out. In addition, the measure steward is updating the measure to specify the complication should be assessed of the operative eye. This is an inverse measure with extremely high performance rate of 0.9 percent for eCQM specifications collection type and 0.2 percent for MIPS CQMs collection type. For an inverse measure, a lower calculated performance rate indicates better clinical care or control. As such, the eCQM and MIPS CQMs specifications collection types are considered extremely topped out. Average performance rates are based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0428	223	N/A	MIPS CQMs Specifications	Patient Reported Outcome	Communication and Care Coordination	**Functional Status Change for Patients with General Orthopedic Impairments:** A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients aged 14 years+ with general orthopedic impairments (neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment). The change in FS is assessed using the General Orthopedic FS PROM (patient reported outcome measure) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey).	Focus on Therapeutic Outcomes, Inc.	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program as the measure steward, Focus on Therapeutic Outcomes, Inc. (FOTO) no longer supports the inclusion of the measure. The patient population within this measure is captured in the FOTO measure A.4: Functional Status Change for Patients with Neck Impairments. In the event we do not finalize A.4: Functional Status Change for Patients with Neck Impairments, we would maintain this measure with the following substantive changes: update the numerator to require meeting or exceeding the risk adjusted prediction of the functional status change to be a Performance Met, move the current denominator exclusions to denominator exceptions, add denominator exclusion for patients with diagnosis of a degenerative neurological condition at any time before or during the episode of care, and add denominator exceptions for ongoing care not indicated: patient self-discharged early, patient discharged after only 1-2 visits due medical events, patient seen only 1-2 visits. In the event the proposed substantive change(s) are finalized, the substantive changes would not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes.
N/A	255	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure:** Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED).	American College of Emergency Physicians	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure narrows the eligible patient population to the Rh-Negative pregnant women which has not been able to create a benchmark. This is a result of the limited patient population and measure adoption which does not provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. This does not align with the meaningful measure initiative. We encourage measure stewards to develop a measure that expands the patient population to those that had their Rh Status evaluated in the Emergency Department (ED) and received Rh-immunoglobulin (Rhogam) if Rh-negative.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	262	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Image Confirmation of Successful Excision of Image-Localized Breast Lesion:** Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy.	American Society of Breast Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this measure is 100 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	271	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment:** Percentage of patients regardless of age with an inflammatory bowel disease encounter who were prescribed prednisone equivalents greater than or equal to 10 mg/day for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills and were documented for risk of bone loss once during the reporting year or the previous calendar year. Individuals who received an assessment for bone loss during the year prior and current year are considered adequately screened to prevent overuse of X-ray assessment.	American Gastro-enterological Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because the substantive changes submitted by the measure steward would require a less meaningful quality action and extend the prednisone usage from 60 to 90 or greater consecutive days. The revised measure's quality action would be simplified to prescribing supplements such as calcium and/or vitamin D optimization. Additionally, the measure steward proposed to replace the term "Loss Assessment" with "Health Optimization" throughout the measure, define the patient population as 18 and over, as well as updating the numerator definition to "Documentation that calcium and/or Vitamin D optimization has been ordered or performed. This includes, but is not limited to, checking serum levels, documenting use of supplements or prescribing supplements" to better align with the measure's intent. The current measure requires a Central Dual-energy X-Ray Absorptiometry (DXA) and documented review of systems and medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed within the past two years. We agree that patients without risk factors would not be appropriate for frequent DXA scans as the current quality measure requires. The measure steward's substantive changes for the measure do not account for patients with high risk factors, which may warrant additional screening and pharmacologic treatment. The measure would be more robust if it was revised to assess based on multiple clinical criteria such as age, risk factors, etc. We encourage the measure steward to submit a new measure that takes into account risk factors and require the appropriate clinical action.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	325	N/A	MIPS CQMs Specifications	Process	Communication and Care Coordination	**Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions:** Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition.	American Psychiatric Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program as we have reexamined public comments received during last year's rulemaking cycle. Stakeholders commented that it is burdensome for clinicians to retrieve specialists' reports for all patient visits. This insinuates the communication may be happening, but the co-morbid treating physician is not looking for and/or considering the MDD status. Additionally, this measure is duplicative to previously finalized measure Q374: Closing the Referral Loop: Receipt of Specialist Report which specifies numerator compliance as receipt of report from the referring eligible clinician. In the event that the measure is maintained, we proposed to add this measure to the following specialty sets: Clinical Social Work.
1667	328	N/A	MIPS CQMs Specifications	Intermediate Outcome	Effective Clinical Care	**Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL.	Renal Physicians Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure does not align with the meaningful measure initiative. There is limited patient population and adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. There were zero submissions for the 2017 performance period.
N/A	329	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated.	Renal Physicians Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure does not align with the meaningful measure initiative. There is limited adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty set based on stakeholder feedback: Nephrology.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	330	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter.	Renal Physicians Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure does not align with the meaningful measure initiative. There is limited adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians.
N/A	343	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Screening Colonoscopy Adenoma Detection Rate:** The percentage of patients age 50 years or older with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.	American Society for Gastrointestinal Endoscopy	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program after review of previous stakeholder feedback, scoring implications, and attribution to the MIPS eligible clinician. The measure does not account for variables which may influence the adenoma detection rate such as geographic location, socioeconomic status of patient population, community compliance of screening, etc. Due to the measure construct, benchmarks calculated from this measure are misrepresented and do not align with the MIPS scoring methodology where 100 percent indicates better clinical care or control. Guidelines and supplemental literature support a performance target for adenoma detection rate of 25 percent for a mixed gender population (20 percent in women and 30 percent in men). In addition, the measure does not account for MIPS eligible clinicians that fail to detect adenomas, but may score higher based on the patient population.
1543	345	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CAS who are stroke free while in the hospital or discharged alive following surgery.	Society for Vascular Surgeons	We proposed the removal of this measure (finalized in (81 FR 77558 through 77675) as a quality measure from the MIPS program because it is duplicative in concept and patient population as the previously finalized measure Q344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients without Major Complications (Discharged to Home by Post-Operative Day #2). Measure Q344 is a more comprehensive measure accounting for the patient population found within measure Q345 as well as assessing for complications and appropriate length of stay. Based on input from the measure steward, we proposed the substantive change of replacing the "or" with "and" in the title and the numerator statement in the circumstance that this measure is not finalized for removal. Despite these revisions, this measure is still duplicative in nature and less comprehensive as compared to measure Q344.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
1540	346	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) Who Are Stroke Free or Discharged Alive:** Percent of asymptomatic patients undergoing CEA who are stroke free or discharged alive following surgery.	Society for Vascular Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is duplicative in concept and patient population as the previously finalized measure Q260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2). Measure Q260 is a more comprehensive measure accounting for the patient population found within measure Q346 as well as assessing for complications and appropriate length of stay. Based on input from the measure steward, we proposed the substantive change of replacing the "or" with "and" in the title and the numerator statement in the circumstance that this measure is not finalized for removal. Despite these revisions, this measure is still duplicative in nature and less comprehensive as compared to measure Q260.
1534	347	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Are Discharged Alive:** Percent of patients undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) who are discharged alive.	Society for Vascular Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is duplicative in concept and patient population as the previously finalized measure Q259: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2). Measure Q259 is a more comprehensive measure accounting for the patient population found within measure Q347 as well as assessing for complications and appropriate length of stay.
N/A	352	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet:** Percentage of patients regardless of age undergoing a total knee replacement who had the prophylactic antibiotic completely infused prior to the inflation of the proximal tourniquet.	American Association of Hip and Knee Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this measure is 98.8 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
NA	353	N/A	MIPS CQMs Specifications	Process	Patient Safety	**Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report:** Percentage of patients regardless of age undergoing a total knee replacement whose operative report identifies the prosthetic implant specifications including the prosthetic implant manufacturer, the brand name of the prosthetic implant and the size of each prosthetic implant.	American Association of Hip and Knee Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this measure is 98.6 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.
N/A	361	N/A	MIPS CQMs Specifications	Structure	Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry:** Percentage of total computed tomography (CT) studies performed for all patients, regardless of age, that are submitted to a radiation dose index registry that is capable of collecting at a minimum selected data elements.	American College of Radiology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this is not furthering quality care, but simply submitting to a radiation dose index and does not deter excessive radiation. Despite this structure measure supporting patient care, it does not measure quality care that directly impacts patients. We believe this measure is not providing a meaningful impact to quality improvement to require radiation reduction.
N/A	362	N/A	MIPS CQMs Specifications	Structure	Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes:** Percentage of final reports for computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12 month period after the study.	American College of Radiology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this is not furthering quality care, but simply setting up a database. Despite this structure supporting patient care, it does not measure quality care that directly impacts patients. We believe this measure is not providing a meaningful impact to quality improvement.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0712e	371	CMS160 v8	eCQM Specifications	Process	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.	Minnesota Community Measurement	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure only captures the process of depression screening and is duplicative of previously finalized measure Q370: Depression Remission at Twelve Months. Measure Q370 is a more robust outcome measure, requiring depression remission for numerator compliance. The screening element found within this process measure is a part of logic for measure Q370. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty set as it is clinically relevant to the clinician type: Pediatrics.
N/A	372	CMS82v7	eCQM Specifications	Process	Community/Population Health	**Maternal Depression Screening:** The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	National Committee for Quality Assurance	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because denominator eligibility is determined by the visits to the child's MIPS eligible clinician. The quality action would not be attributed to the child's MIPS eligible clinician, but rather to the obstetrician or primary care provider of the mother. The measure does not account for instances where the mother is not present for the child's visits.
N/A	388	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy):** Percentage of patients aged 18 years and older who had cataract surgery performed and had an unplanned rupture of the posterior capsule requiring vitrectomy.	American Academy of Ophthalmology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying, making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this inverse measure is 0.4 percent for the MIPS CQMs specifications collection type. For an inverse measure, a lower calculated performance rate indicates better clinical care or control. As such, the MIPS CQMs specifications collection type is considered extremely topped out. The average performance rate is based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	403	N/A	MIPS CQMs Specifications	Process	Person and Caregiver-Centered Experience and Outcomes	**Adult Kidney Disease: Referral to Hospice:** Percentage of patients aged 18 years and older with a diagnosis of end -stage renal disease (ESRD) who withdraw from hemodialysis or peritoneal dialysis who are referred to hospice care.	Renal Physicians Association	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this measure does not align with the meaningful measure initiative. There is limited adoption of the quality measure and does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. This concept would be more inclusive and better represented if the denominator was expanded to include patients with multiple chronic conditions.
N/A	407	N/A	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications	Process	Effective Clinical Care	**Appropriate Treatment of Methicillin-Susceptible Staphylococcus Aureus (MSSA) Bacteremia:** Percentage of patients with sepsis due to MSSA bacteremia who received beta-lactam antibiotic (e.g. Nafcillin, Oxacillin or Cefazolin) as definitive therapy.	Infectious Diseases Society of America	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying, making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this measure is 98.7 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: add criteria for denominator eligibility to include Diagnosis for Bacteremia (ICD-10-CM): R78.81 AND Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere (ICD-10-CM): B95.61. Despite these revisions offered by the measures steward, we do not believe this will affect the average performance for this measure.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0711	411	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Depression Remission at Six Months:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission six months (+/- 60 days) after an index event date.	Minnesota Community Measurement	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this patient population and quality action are duplicative of previously finalized measure Q370: Depression Remission at Twelve Months but vary in timeframe in which depression remission is required. The extended timeframe allows assessment of patient to ensure management and prevention of depression relapse. American Psychiatric Association (2010) states "Continuation therapy is the four-to-nine month period beyond the acute treatment phase during which the patient is treated with antidepressants, psychotherapy, ECT or other somatic therapies to prevent relapse. Relapse is common within the first 6 months following remission from an acute depressive episode; as many as 20-85 percent of patients may relapse." In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: update the denominator allowing PHQ-9/PHQ9M to be administered during the index encounter or up to 7 days prior to encounter. In addition, we proposed to add this measure to the following specialty measure sets in the event the measure is retained in the MIPS program based on stakeholder comments within the program as it is clinically relevant to these clinician types: Pediatrics and Clinical Social Work. Despite these revisions offered by the measures steward, we prefer measure Q370 which supports the quality outcome depression remission at 12 months.
1523	417	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive:** Percentage of patients undergoing open repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA) who are discharged alive.	Society for Vascular Surgeons	We proposed the removal of this measure (finalized in (81 FR 77558 through 77675) as a quality measure from the MIPS program because it is duplicative in concept and patient population as the previously finalized measure Q258: Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7). Measure Q258 is a more comprehensive measure accounting for the patient population found within measure Q417 as well as assessing for complications and appropriate length of stay.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
N/A	428	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence:** Percentage of patients undergoing appropriate preoperative evaluation of stress urinary incontinence prior to pelvic organ prolapse surgery per American College of Obstetrics and Gynecology (ACOG), American Urogynecologic Society, and American Urological Association guidelines.	American Urogynecologic Society	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because it is considered a standard of care that has limited opportunity to improve clinical outcomes. Performance on this measure is extremely high and unvarying making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance for this measure is 98 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip.
0071	442	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Persistence of Beta-Blocker Treatment After a Heart Attack:** The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who were prescribed persistent beta-blocker treatment for six months after discharge.	National Committee for Quality Assurance	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because the patient population is captured within previously finalized measure Q007: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%). While the quality action requires persistent beta-blocker treatment, the performance period is narrowed to only include the patients hospitalized and discharged for the first 6 months of the performance period. This does not include patient hospitalized and discharged after July 1, thus missing a substantial portion of the patient population. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: update the denominator exclusion adding advance illness and frailty. Despite these revisions offered by the measure steward, we maintain that measure Q007 will capture the patient population sampled within this measure and allows for a 12 month performance period.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0733	446	N/A	MIPS CQMs Specifications	Outcome	Patient Safety	**Operative Mortality Stratified by the Five STS-EACTS Mortality Categories:** Percent of patients undergoing index pediatric and/or congenital heart surgery who die, including both 1) all deaths occurring during the hospitalization in which the procedure was performed, even if after 30 days (including patients transferred to other acute care facilities), and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure, stratified by the five STAT Mortality Levels, a multi-institutional validated complexity stratification tool.	Society of Thoracic Surgeons	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because the denominator has a very limited patient population. We believe this measure does not align with the meaningful measure initiative. The limited patient population and adoption of the quality measure does not allow for the creation of benchmarks to provide a meaningful impact to quality improvement. The limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. In the event that the measure is retained in the MIPS program based on stakeholder comments, we proposed to add this measure to the following specialty set as it is clinically relevant to this clinician type: Thoracic Surgery.
1857	449	N/A	MIPS CQMs Specifications	Process	Efficiency and Cost Reduction	**HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies:** Percentage of female patients (aged 18 years and older) with breast cancer who are human epidermal growth factor receptor 2 (HER2)/neu negative who are not administered HER2-targeted therapies.	American Society of Clinical Oncology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because clinically we believe this to be standard of care. The performance data does not support a meaningful gap. The average performance for this measure is 97.4 percent for the MIPS CQMs specifications collection type based on the current MIPS benchmarking data located at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/342/2019%20MIPS%20Quality%20Benchmarks.zip. In the circumstance we do not finalize removal of this measure, we would maintain this measure with the following substantive change(s) based on the measure steward's input: update the denominator definition to align with current guidelines as referenced in Table D. 68: Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy of this document.
N/A	454	N/A	MIPS CQMs Specifications	Outcome	Effective Clinical Care	**Percentage of Patients who Died from Cancer with More than One Emergency Department Visit in the Last 30 Days of Life (lower score – better):** Percentage of patients who died from cancer with more than one emergency department visit in the last 30 days of life.	American Society of Clinical Oncology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because this may be outside of the eligible clinician's control. We believe previously finalized measure Q455: Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better) is a related concept that can be a better indicator of compassionate outcomes to the end of life care for oncology patients.

TABLE C: Previously Finalized Quality Measures Finalized for Removal in the 2022 MIPS Payment Year and Future Years

NQF # / eCQM NQF #	Quality #	CMS e-CQM ID	Collection Type	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Rationale for Removal
0215	456	N/A	MIPS CQMs Specifications	Process	Effective Clinical Care	**Percentage of Patients who Died From Cancer Not Admitted to Hospice (lower score – better):** Percentage of patients who died from cancer not admitted to hospice.	American Society of Clinical Oncology	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program because the concept would be captured in measure Q457: Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days (lower score – better) and is the more robust measure as it requires at least 3 days of hospice prior to death.
N/A	467	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Developmental Screening in the First Three Years of Life:** The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.	Oregon Health & Science University	We proposed the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program after review of denominator of this process measure is not able to specifically target a pediatric patients primary clinician for performance of developmental screening. The measure owner submitted a substantive change to revise the denominator eligible coding to include well-child visits. The well-child visit encounters would likely include the attestation of the numerator's quality action and therefore inflate performance of the measure. While we agree that screening pediatric patients for development milestones is indicative of quality interactions with patients, we believe that the complexity of implementing the change creates a less meaningful assessment of MIPS eligible clinicians.
N/A	474	N/A	MIPS CQMs Specifications	Process	Community/Population Health	**Zoster (Shingles) Vaccination:** The percentage of patients aged 50 years and older who have had the Shingrix zoster (shingles) vaccination.	PPRNet	We propose the removal of this measure (finalized in 83 FR 60108) as a quality measure from the MIPS program because it is duplicative of measure A.3: Adult Immunization Status proposed in this proposed rule. This new measure, if finalized, is a more robust immunization measure which requires multiple age appropriate preventive immunizations. We are proposing to remove this measure to be consistent with ensuring measures are not duplicative and present an opportunity to provide a meaningful impact to quality.

TABLE C: Summary of Comments and Responses

Comment: One commenter opposed the removal of measure Q046: Medication Reconciliation Post Discharge, stating that the proposed replacement of this measure with measure Q130: Documentation of Current Medications in the Medical Record is not appropriate for patients who are at high risk post discharge.

One commenter opposed the removal of measure Q046 as it is in the current CQMC core set for ACO/Primary Care. At the most recent meeting of the CQMC, the CQMC preferred measure Q046 over measure Q130, stating that both measures are check box and may not show evidence of improved patient outcome. Another commenter requested that measure Q046 not be removed from the MIPS program until the CQMC has completed its maintenance cycle review of this measure expected by the end of 2019.

Several commenters opposed the removal of Q046, stating that measure Q130 does not reference use of the measure by a clinical pharmacist. Removing the measure may preclude pharmacists due to the measure Q130's use of the term "eligible clinician." The commenters urged CMS to explore a new measure that focuses on ensuring that the best reconciled medication list is available in all of the patient's health care locations, including post-discharge.

One commenter preferred NQF #2988's approach to measure attribution, date of reconciliation, medication assessment process, and inclusion of allergy and adverse drug event documentation requirements.

Response: We appreciate the commenters' feedback. CMS believes that measures Q046 and Q130 are duplicative in measurement as both measures review current medications, which may represent the reconciliation of medication post discharge, and would represent the same patient population. Due to the overlap, measure Q130

TABLE C: Summary of Comments and Responses

represents a broader population of patients since it is not just focused on patients that have a 30-day inpatient discharge. We agree that it is advantageous for patients to have their medications reviewed post discharge, although we believe the quality action represented in measure Q130 would support the same quality action. In reference to the concern about the preclusion of pharmacists and team-based approach, the quality action of measures Q046 or Q130 does not require the consultation of a pharmacist, although may be appropriate in some instances. We strive to maintain robust measures that meet the meaningful measures initiative and we encourage the commenter to work with measures' developers to submit new, more robust measures through the Call for Measures process that evaluates documentation of medication in the medical record. We attempt to align with CQMC, but believe this measure is duplicative of a more broadly applicable measure. As MIPS moves forward, we will continue to explore ways to align measurement across programs. We reviewed NQF #2988: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities and believe this measure would not be an adequate replacement for measure Q130. This measure is focused on all patients receiving dialysis services whereas measure Q130 is broadly applicable to all patient types in a variety of clinical settings. We believe that this population of patients would be captured within office visits currently found within the denominator of measure Q130. We will take this into consideration for future substantive change proposals to include this additional care setting of dialysis services. Alternatively, we encourage the commenter to submit NQF #2988 or other measures they believe may represent beneficial quality measures within to the Call for Measures once fully tested at the clinician level.

Comment: One commenter supported the removal of measure Q051: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation, citing CMS' rationale that the measure is duplicative of measure Q052, Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy. Although the commenter preferred both quality measures be retained, the commenter supported CMS' proposal to use measure Q052 to support the use of spirometry to diagnose COPD. Another commenter agreed with the removal of measure Q051 because if a patient has COPD but is asymptomatic at the time, the patient would not be captured in the denominator due to the wording of the specification. The commenter asked if there should there be a similar measure that captures patients who are well maintained and asymptomatic, and if EHRs able to this capture this data.

Response: We thank the commenters for supporting the removal of measure Q051 and agreeing that measure Q052 is a more robust measure. We thank the commenter for their concern with certain patient populations not being captured within measure Q052, however, measure Q051 does not require continual spirometry evaluation, but rather documentation of a single spirometry result. Most likely, this would be captured at the time of diagnosis as discussed in the clinical recommendation statement within measure Q051, and the above patient population of concern is not required to have continual evaluation for this measure. We encourage the other commenter to collaborate with the measure steward to revise current MIPS measures for proposed implementation in future years or to develop new robust, meaningful measures to submit to the Call for Measures once fully tested at the clinician level.

Comment: One commenter opposed the removal of measure Q091: Acute Otitis Externa (AOE): Topical Therapy as it is an important measure for otolaryngology, is evidence-based, and is applicable to the practice of many otolaryngologists and other specialties who treat these patients.

Response: We thank the commenter for their comment. We agree that measure Q091 is evidence-based, but it does not address the inappropriate use of antibiotics. In the circumstance an eligible clinician does not prescribe and antibiotic, most likely a topical therapy would be prescribed. However, the eligible clinician is able to prescribe both an antibiotic and topical and remain numerator compliant for this measure. Despite their limited utility, about 20-40 percent of patients with AOE receive oral antibiotics, often in addition to topical therapy (Rosenfeld, et al., 2014).

Comment: Several commenters opposed the removal of rheumatology measures Q109: Osteoarthritis (OA): Function and Pain Assessment and Q178: Rheumatoid Arthritis (RA): Functional Status Assessment. These measures are clinically relevant for rheumatology and the removal of these rheumatology-specific measures dramatically reduces the number of quality measures that are applicable to this specialty. Removing these measures will add unnecessary burden to the commenter's practice and negatively impact its scoring and payment incentive. The rationale for removal of measures Q109 and Q178 is that they are duplicative to measure Q182: Functional Outcome Assessment. The commenter stated that both of these measures should be kept, as they are clinically relevant and important for these rheumatoid arthritis and osteoarthritis as two diseases that affect a large patient population at their practice.

Another commenter opposed the removal of these measures, stating that measure Q182 is a measure used by physical therapists. Another commenter opposed the removal of measure Q109 and preferred this existing measure over measure Q182 because it is more targeted to a population that will benefit from functional assessment.

Response: We thank the commenters for their comments. We believe that duplicative measures are counterintuitive to the meaningful measures initiative that promotes more focused quality measure development towards outcomes that are meaningful to patients, families and their providers. Measures Q109 is a measure that has a focus on functional outcomes for patient populations that are disease specific. Measure Q182 is a disease non-specific, broadly applicable measure and allows eligible clinicians to use an assessment that is validated and meets their individual patient's clinical needs. The measure supports tools that address functional as well as pain aspects for these clinical assessments. The clinical rationale of the measure indicates "The tool should be selected based on purpose of the assessment and type of injury sustained (Lesher, et al, 2017; and Wales, et al., 2016). Utilization of validated pain and function scales help to differentiate treatment approaches in order to improve the patient's ability to function (ICSI, 2012).

We value stakeholder feedback and agree that measure Q178 is clinically relevant for rheumatology and we believe the proposed measure changes ensure that clinicians are utilizing the preferred assessment tools for standardization of performance. According to the American College of Rheumatology's RA treatment guidelines, functional status assessment using a standardized, validated measure should be performed routinely for RA patients, at least once per year, but more frequently if disease is active. As a result, we are not finalizing the removal of measure Q178 from MIPS and will finalize the substantive change for this measure outlined in the 2020 PFS proposed rule (84 FR 41164) shown under Table D.83 of this final rule.

Comment. One commenter urged CMS to defer removal of measures Q110 and Q111 for an additional year until the new Adult Immunization Status measure is proven and determined to be reportable by surgeons and because removal of measure Q110 would impact the surgeon's workflow. Another commenter opposed removal of measure Q110 because there are an estimated 1,100 dialysis patients that die each year of influenza, and most of these deaths can be prevented by influenza immunization. Several commenters stated that CMS should not remove EHR reportable eCQM measures Q110 and Q111 when alternative eCQM measures are not available to be reported.

One commenter agreed with the removal of measures Q110 and Q111.

TABLE C: Summary of Comments and Responses

Response: We thank the commenters for their comments. Per our discussion on the Adult Immunization Status measure under Table A.3, we are retaining measures Q110 and Q111 because the new measure Adult Immunization Status measure is not being finalized for the 2020 MIPS performance period/2022 MIPS payment year due to the imminent changes in clinical guidelines for pneumococcal vaccination and because we believe it is advantageous to evaluate the clinical guidelines and Adult Immunization Status measure for inclusion through future rulemaking. We would encourage the commenter to work with the measure steward to revise the measure to better fit the surgeon's workflow for possible implementation in future years. We agree that the administration of the influenza vaccine is critical for certain patient populations and would note that the Adult Immunization Status measure has an influenza vaccine component. We are finalizing substantive changes for measures Q110 and Q111 as outlined in the 2020 PFS proposed rule (84 FR 41158 and 41159) shown under Tables D.81 and D.82 of this final rule.

Comment: Several commenters opposed the removal of measure Q131: Pain Assessment because physical and occupational therapists cannot prescribe opioids. Therefore, while it might make sense to eliminate this measure for physicians, it makes no sense to eliminate this measure for physical and occupational therapists. Another commenter did not support the removal of Q131, stating that there is no requirement within this measure that opioids must be used to improve a patient's pain level. Another commenter opposed the removal of measure Q131 because it targets two of CMS' highest priority areas— measures based on outcomes and measures targeting opioid use, management, and treatment.

Two additional commenters opposed the removal of measure Q131 as chiropractors are only being reimbursed for manipulation codes for two claims-based quality measures: Q131 and Q182: Functional Outcome Assessment. These current limitations have diminished the number of chiropractors willing to opt-in to MIPS. Chiropractors are not allowed to prescribe opioid medications and chiropractic care is an excellent tool in the fight against opioid abuse.

Another commenter opposed the removal of measure Q131 given that approximately 100 million Americans live with chronic pain. The measure focuses on appropriate follow-up, which is not limited to medication use. A separate measure maintained by the American Academy of Neurology and the American Psychiatric Association specifically addressing pain for patients with dementia could be retired given this measure's proposed expansion to include those who are non-verbal. Another commenter opposed the removal of Q131 as it would negatively impact rheumatology practices and reduce the number of high priority measures available to them. Another commenter stated that speech language pathologists are not authorized under any state law to prescribe medications; therefore, there is no increased risk when they complete the pain assessment.

Response: We thank the commenters for their feedback and concerns cited on removing measure Q131. However, measure Q131 is not limited to clinicians (that is, speech language pathologists) unable to prescribe medications, but is available for a broad range of eligible clinician types. As measure Q131 is unable to be revised at this time, retaining it within MIPS would still allow the measure to be utilized by clinicians who are able to prescribe opioids. We believe that it is important to consider the negative impact our measures may inadvertently have on current health crises, such as the opioid epidemic, and support efforts that ensure positive outcomes in patient care and deter the possibility of overtreatment of pain. We encourage the submission of measures that are structured in a way that manages pain, yet deters opioid use. Regarding the comment addressing the changes to an American Academy of Neurology and American Psychiatric Association maintained measure, we currently do not have a measure that addresses pain in patients with dementia that is being expanded to include non-verbal patients and encourage the commenter to collaborate with the measure stewards to refine the measure for implementation in future years. In an abundance of caution, as the risks outweigh the quality of care assessed from this measure, we are finalizing the removal of measure Q131.

Comment: One commenter opposed the removal of four radiology measures from MIPS: measures Q146, Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms, Q225, Radiology: Reminder System for Screening Mammograms, Q361, Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry, and Q362, Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes. Ninety-five percent of radiology measures are topped out and four are proposed for removal in 2020, with two other measures removed in 2019. The commenter also stated that many high-performing measures are still showing a low adoption rate among radiologists, thus a reason for the high performance score may be a result of a small pool of high-performing individuals choosing to report certain measures. This would skew the average score and mask the actual performance gap than if the measure was reported across a larger number of practices, including those with worse performance on the measures in question.

The rationale for removing measures Q361 and Q362 is that the measures are process/structural or not directly related to patient outcome. The commenter stated that is especially problematic for radiology in that the imaging services are typically provided at an early state of the care process, and process measures support care improvement across the care continuum. Additionally, both of those measures were part of the Optimizing Patient Exposure to Ionizing Radiation Physician Quality Reporting System (PQRS) specialty measures group until MIPS began in 2017. The performance data on which these have been assessed is largely based on the limited number of cases (20) to be reported when using a measures group. This skews the actual performance gap toward higher scores from higher performing groups.

The other two measures, Q146 and Q225, proposed for removal are specific to radiologists performing screening mammography. Removal of the two breast imaging measures would leave many groups/eligible clinicians who only have a case mix relative to these mammography measures (typical in community and rural settings) without any practice-relevant measures to report. Additionally, breast cancer screening may be ideal as an initial concept for a radiology MVP.

Response: We thank the commenters for their feedback on measures Q146, Q225, Q361, and Q362. After consideration of the feedback, we are retaining measures Q146 and Q225 to ensure that MIPS eligible clinicians/groups who only have a case mix relative to screening mammography would have applicable measures within the Diagnostic Radiology set. Although we acknowledge that a small sample size of high performing clinicians may lead to an overall high performance rate, CMS believes that retaining the measures Q361 and Q361 in MIPS will not lead to increased adoption given the fact that the measures have been available for multiple years. Therefore, we conclude that eligible clinicians do not believe this measure supports quality outcomes or is meaningful for their scope of practice. CMS encourages the commenter to collaborate with measure stewards to develop an outcome-based measure that assesses the safe practices of radiation exposure by setting an appropriate threshold to determine performance.

We acknowledge that these measures support processes related to outcomes, and we are motivated to implement outcome based measures that support direct patient care. While we recognize that measure stewards may have difficulties in developing outcome based measures, we believe it is important to include measures that support the meaningful measure initiative. The lack of a quality measures does not preclude the creation of clinical processes that drive positive outcomes for patients. Therefore, we are finalizing removal of measures Q361, and Q362 for the 2020 MIPS performance period/2022 MIPS payment year and future years.

Comment: One commenter supported the removal of measure Q160: HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis from the eCQM measure type.

TABLE C: Summary of Comments and Responses

Response: We thank the commenter for supporting the removal of measure Q160.

Comment: One commenter disagreed with the removal of measure Q165: Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate and measure Q166: Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG) from the Thoracic Surgery set. The commenter indicated that a high performance rate on a specific measure does not necessarily mean that a measure is not meaningful. Removing these measures may create serious unintended consequences including negative effects on patient care, and could also make it difficult to track performance on these measures over time.

Response: We thank the commenter for their consideration and encourage them to collaborate with measure stewards to develop a quality measure that assess a more comprehensive list of complications for CABG surgery, including, but not limited to, infection, mortality, and re-exploration. A comprehensive composite measure would likely identify a performance gap that allows eligible clinicians to maximize their potential quality performance category score. Additionally, by removing these extremely topped out measures, we are attempting to reduce reporting burden where there is little room for improvement.

Comment: One commenter opposed the removal of measure Q178: Rheumatoid Arthritis (RA): Functional Status Assessment by replacing it with the non-rheumatology-specific measure Q182: Functional Outcome Assessment, as this would remove a specialty-specific measure from the MIPS program. Measure Q178 could also be used in a rheumatology-specific MVP. The commenter indicated that measure Q178 is an important steppingstone for the commenter's work toward developing and implementing rheumatology outcome measures and its work with the NQF to develop a patient-reported functional status outcome measure. Replacing measure Q178 with measure Q182, in effect, removes restrictions around requiring specific tools to meet the measure, thereby lowering performance thresholds for rheumatology providers. Additionally, measure Q182 is more focused on functional status assessments and care plans within physical and occupational therapy.

Another commenter disagreed with CMS' rationale for removing measures Q178 and Q179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis, including that other measures are more appropriate and that the rheumatoid arthritis measures are duplicative. If practices begin reporting on other functional assessment measures, the feedback will not be directly relevant to rheumatology practices and patients as the data will include that of other specialties and for other diseases. If CMS is unwilling to retain these measures, the Agency should at least parse out data based on the specialty reporting the measure and associated diagnoses.

Another commenter opposed removal of five measures from MIPS that would be removed from the Rheumatology set given the impact of rheumatoid arthritis has on the Medicare population. The more specialty measures are removed, the less relevant CMS' quality programs are to specialists.

Response: We thank the commenters for their comments opposing the removal of measures Q178 and Q179. Measures Q179 and Q177: Rheumatoid Arthritis (RA) Periodic Assessment of Disease Activity assess the same patient population for disease activity, however, measure Q177 requires this assessment to be completed during at least 50 percent of the eligible encounters for each patient as opposed to only once per performance period, ensuring the assessment is being given on a more consistent basis. Measure Q182 only includes settings without any diagnosis coding within the denominator criteria as this is a broadly applicable measure, relevant to MIPS clinician types beyond physical and occupational therapy.

We value stakeholder feedback and agree that measure Q178 is clinically relevant for rheumatology and we believe the proposed measure changes ensure that clinicians are utilizing the preferred assessment tools for standardization of performance. According to the American College of Rheumatology's RA treatment guidelines, functional status assessment using a standardized, validated measure should be performed routinely for RA patients, at least once per year, but more frequently if disease is active. As a result, we are not finalizing the removal of measure Q178 from MIPS and will finalize the substantive changes for this measure outlined in the 2020 PFS proposed rule (84 FR 41164) shown under Table D.83 of this final rule. We encourage collaboration with the measure steward to refine the measure for MIPS for future program years. We agree that this measure may be applicable to a Rheumatology-specific MVP and encourage the commenter to look for future rulemaking and solicitation for recommendations regarding MVPs.

Comment: One commenter agreed that measure Q179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis should be removed from MIPS as it anticipates it will soon be a topped-out measure.

Response: We thank the commenter for supporting the removal of measure Q179.

Comment: One multi-society commenter requested that measure Q185: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use remain in MIPS until meaningful alternatives can be developed. The commenter stated that for colonoscopy to be cost-effective, the intervals between examinations must be optimal. The commenter disagreed with benchmarks established by CMS suggesting this measure is topping out, because that does align with the evidence from surveys of practice. The commenter also requested that measure Q185 remain in the MIPS program so that it may be included in MVP for colorectal cancer screening through which it believes more accurate benchmarks for the measure will be developed. The commenter responded that the measure is being proposed for removal from MIPS because the measure was not updated by the measure steward to align with new guidelines and stated that measure Q185 should remain in MIPS until updated guidelines are released and the impact on this measure can be evaluated.

One commenter supported removal of measure Q185. While the measure is currently included in the CQMC Gastroenterology Core Set, the commenter supported removing the measure from this program until the measure steward has updated the specifications to align with recently updated clinical guidelines.
Response: We appreciate the concern cited for measure Q185. We originally proposed this measure to be removed for the 2019 performance period to allow the measure to be updated with new guidelines. After further discussion with the measure steward, they now support continued inclusion of measure Q185 in MIPS, given it is a well-established, valid measure with variability still seen in practice. It is anticipated that new guidelines will be released that may necessitate a future substantive change of the measure.

Comment: One commenter opposed the substantive change to measure Q191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery (eCQM: CMS133v8). Within the context of this comment, the commenter opposed the removal of measure Q192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures (eCQM: CMS132v8), including to the changes to 2020 eCQM specifications for measures Q191 and Q192 (see response under Table C for further details on measure Q192). The commenter stated that the proposed change should not be finalized for the registry versions of the measures and should be reversed for the eCQM versions of measures Q191 and Q192, which have already been published. Another commenter opposed the removal of measure Q192 and Q388: Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy) as these are two important patient safety measures. The commenter encouraged CMS to retain measures Q192 and Q388 and consider the application of the flat percentages scoring methodology for these measures.

TABLE C: Summary of Comments and Responses

One multi-organization commenter also opposed the elimination of two cataract surgery outcome measures Q192 and Q388 due to topped out status without accounting for the clinical relevance of these measures. Maintenance of these measures, either through the EHR or registry, allow cataract surgeons real-time awareness of complication rates and provide real opportunities for quality improvement where necessary. The commenter urged CMS to conduct more thorough analyses of factors potentially influencing topped out performance. Another commenter cited concerns with CMS' proposal to eliminate measure Q192 because cataract surgeons frequently state it is the most meaningful measure they report on because it is a true indicator to patients whether the physician provides good quality care.

One commenter supported the removal of measure Q192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures from the eCQM measure type.

Response: We thank the commenter for supporting the removal of measure Q192. As the performance on measures Q192 and Q388 is extremely high and unvarying they do not allow meaningful benchmarks to be established. By removing measures that are extremely topped out, we are attempting to reduce reporting burden where there is little room for improvement. Removal allows eligible clinicians to maximize their potential quality performance score as these measures' topped out status would limit the score awarded per the 2019 Benchmark File.

Comment: One commenter opposed the removal of four extremely topped out pathology measures from the MIPS program that would impact the number of measures available to report for pathologists: measures Q249: Barrett's Esophagus, Q250: Radical Prostatectomy Pathology Reporting, Q395: Lung Cancer Reporting (Biopsy/Cytology Specimens), and Q396: Lung Cancer Reporting (Resection Specimens). Removal would limit the pathology specialty set to two measures, both of which are skin cancer measures and thus would not be applicable to more than 50 percent of pathologists.

The commenter opposed the removal of the four measures based on its scoring analysis. Extrapolating from the commenter's QCDR, half of the practices who reported as a group did not meet the 20 case minimum for measure Q397 and 92 percent of individuals who reported did not meet the 20 case minimum. Therefore, most pathology practices who are single specialty would not be able to report the two measures left in the Pathology set and have no measures available to report, thus ending up with a negative MIPS payment adjustment. The commenter also requested that CMS apply the Eligible Measure Applicability (EMA) process automatically to practices who are unable to report on a minimum of six measures. In summary, the commenter requested that CMS maintain the current pathology specialty measure set and add the proposed measure Q440, even if CMS finalizes its proposal to increase data completeness to 70 percent.

A second commenter also opposed the removal of the four pathology measures, stating that only about 50 percent of practicing pathologists will be able to be scored on quality. Given that most pathologists are exempted from promoting interoperability and unable to be scored on cost, the rest will receive a neutral payment adjustment since they can only be scored in the improvement activities category.

Response: In the CY 2020 PFS proposed rule (84 FR 40749), we indicated that changes were not made to the Pathology set. In this final rule, we clarified that we in fact did propose changes to the Pathology set, as described in the CY 2020 PFS Proposed Rule (84 FR 41020 through 41022). We thank the commenters for their concerns on the proposed removal of the pathology measures and agree that many eligible clinicians would not meet the case minimum and would therefore be unable to utilize measures Q397 and Q440 leaving them with no applicable quality measures for submission. As a result, we are not finalizing the removal of measures Q249, Q250, Q395, and Q396 for the 2020 MIPS performance period/2022 MIPS payment year and are adding measure Q440 as requested.

Comment: One commenter opposed the proposed removal of measure Q264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer that measures the percentage of clinically node negative breast cancer patients before or after neoadjuvant systemic therapy, who undergo sentinel lymph node (SLN) procedure. The commenter opposed the removal of measures based solely on extremely topped out or topped out status. Assessing value of care for a patient differs from placement of a measure into a payment program. The commenter stated that when CMS removes a valued measure such as Q265 because it is "topped out" the Agency is sending the wrong message to the field. The commenter would rather build on topped out measures so that patients are subjected to all the proper aspects of a care model in support of quality.

Response: We thank the commenter for their comment and upon further consideration have decided to retain measure Q264. This decision was made in order to have a breast specific measure within the General Surgery set for clinicians with this focus. Measure Q264 also shows some variation within the performance data submitted across MIPS eligible clinicians potentially allowing for movement within the performance rate. However, when reviewing the performance data for Q265, there was little to no variance and remained extremely topped out. We believe this measure represents a valuable measure concept and the removal of measure Q265 should not preclude clinicians from completing the quality action, however measures with topped out performance do not allow for the creation on meaningful benchmarks to discern quality among eligible clinicians. We do agree with the commenter that this measure could be built upon to create a measure with a broader focus of a care model. We would encourage the commenter to collaborate with measures stewards to develop a measure and submit to the Call for Measures when tested at the clinician level.

Comment: One commenter recommended that CMS delay removing measure Q271: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment from the MIPS program until the CQMC has completed its maintenance cycle review of these measures expected by the end of 2019.

Another commenter recommended that measure Q271 be retained in MIPS as it intends to modify the measure specification rationale, as recommended by CMS, to address the concern that the measure does not account for patients with risk factors. Due to this feedback, the commenter has expanded the rationale section of the measure specification as requested to include guidance on appropriate use of DXA scans for high-risk IBD patients and will submit these changes during the next measure maintenance cycle. As a result, the commenter requested that the measure remain in MIPS until the measure can be updated.

Response: We thank the commenter for their comment and disagree with delaying removal of measure Q271. We have reviewed the revisions proposed by the measure steward for MIPS 2020 implementation. Based on our interpretation, the revised measure's quality action would be simplified to prescribing supplements such as calcium and/or vitamin D optimization. Additionally, the measure steward proposed to replace the term "Loss Assessment" with "Health Optimization" throughout the measure, define the patient population as 18 and over, as well as updating the numerator definition to "Documentation that calcium and/or Vitamin D optimization has been ordered or performed. This includes, but is not limited to, checking serum levels, documenting use of supplements or prescribing supplements" to better align with the measure's intent. The current measure requires a Central Dual-energy X-Ray Absorptiometry (DXA) and documented review of systems and medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed within the past two years. We agree that patients without risk factors would

TABLE C: Summary of Comments and Responses

not be appropriate for frequent DXA scans as the current quality measure requires. The measure steward's substantive changes for the measure do not account for patients with high risk factors, which may warrant additional screening and pharmacologic treatment. The measure would be more robust if it was revised to assess based on multiple clinical criteria such as age, risk factors, etc. as recommended by CMS. We encourage the commenter to collaborate with the measure steward to submit a new measure during the Call for Measures process that is more robust and takes into account risk factors and require the appropriate clinical action. We thank the second commenter for their comment regarding future revisions, however, we would remind them that for the 2020 performance period the measure would not account for all clinical criteria and may not require the most appropriate clinical action. We encourage the commenter to work with measure steward to update all aspects of the measure to reflect applicable clinical quality actions for each patient population and submit to the Call for Measures once it is fully tested at the clinician level.

Comment: One commenter did not support removal of measure Q282: Dementia Functional Status Assessment, stating that the proposed duplicative measure: Q182: Functional Outcome Assessment focuses on use of physical therapy tools and as such is not applicable to this patient population. The commenter evaluated integration of measure Q182 into its QCDR in 2020 and felt given the restrictive slate of available tools, that it could not be broadly used by neurology clinicians. The commenter remains committed to measure harmonization and expanded the denominator to include physical therapy and occupational therapy as a result.

Another commenter opposed removal of measure Q282 because the measure is specific to patients with dementia and captures the percentage of patients for whom an assessment of functional status was performed at least once in the last 12 months. Measure Q182 includes patients aged 18 years and older and requires more frequent assessment and a plan of care. Also, the commenter did not believe that measure Q182 was duplicative to Q282.

Another commenter did support the removal of measure Q282, stating that the proposed duplicative measure Q182 focuses on the use of physical therapy tools and as such is not applicable to this patient population.

Response: We thank the commenter for their concern and would refer them to the measure specification which provides examples of tools for functional outcome assessment, but are not exhaustive and allow eligible clinicians to select any functional normed and validated tool. However, the proposed addition of mental/behavioral health coding to measure Q182 is not being finalized because the testing has not been completed. As a result, we are not finalizing the removal of measure Q282 from MIPS and will finalize the substantive change for this measure outlined in the 2020 PFS proposed rule (84 FR 41171) shown under Table D.79 of this final rule. Additionally, as we are not finalizing measure Q282 for removal, we will no longer be adding measure Q182: Functional Outcome Assessment to the Neurology, Geriatrics, and Mental/Behavioral Health sets as this was only proposed as a replacement measure.

Comment: One commenter did not support the removal of measure Q288: Dementia Education and Support of Caregivers for Patients with Dementia. CMS indicated there is overlap with measure Q286: Dementia: Safety Concern Screening and Follow-up for Patients with Dementia; however, the commenter stated that the measure numerators are substantially different, warranting use of both measures in MIPS. Measure Q286 is intended to ensure appropriate follow-up was taken to remove and address patient concerns that may lead to unintended injury of patients and caregivers. Measure Q288 is intended to address the unique mental health and burdens faced by caregivers for patients with dementia who are more at risk for their own mental health issues as a result of caring for patients.

Response: We thank the commenter for their comment and agree that by removing measure Q288 there may be gap in care for the dementia patient population. The health of a caregiver may directly impact the health of the patient and this may be missed in the quality action within measure Q286. As a result, we are not finalizing the removal of measure Q288 and will finalize the substantive change for this measure outlined in the 2020 PFS proposed rule (84 FR 41171) shown under Table D.80 of this final rule.

Comment: One commenter was concerned by the proposed removal of measure Q325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions from the MIPS program and therefore from the Mental/Behavioral Health set. As the steward of this measure, its clinical experts are responsible for the oversight of quality measures and maintain this measure's importance in assuring the delivery of high-quality care for those with MDD and medical comorbidities. The commenter understood the rationale for the measure's proposed removal and will work with its measure development team and clinical experts to determine whether this is a minimal change to the measure's technical specifications, or if this will require a more substantive update.

The commenter disagreed with the assertion that this measure is duplicative to Q374: Closing the Referral Loop: Receipt of Specialist Report. To meet Q374's numerator, a referral must occur. Without a referral, a report is not sent, no matter the reason for the encounter. Further, measure Q374 is strictly applicable to the initial encounter. In contrast, measure Q325 is intended to capture communication regarding patients treated for MDD and a comorbid condition over time.

Response: We thank the commenter for their concern regarding the removal of measure Q325. We believe, based on stakeholder's feedback, as outlined in the removal rationale, that measure Q325 is burdensome to find and review the reports sent by the MDD treating clinician, Therefore, the physician treating the co-morbid condition may not be looking for, aware of, and/or considering the patient's MDD status. Though we agree that this is an important topic, we do not believe that the quality action ensures coordination of care. Measure Q374 does need to have a referral associated with it, but ensures that there is receipt of the report, ensuring that the clinician treating the comorbid condition has received the specialist report. We encourage the commenter to submit a revised measure to the Call for Measures that addresses clinician burden while also ensuring the quality action assesses complete care coordination between clinicians.

Comment: Two commenters requested that CMS maintain four nephrology measures to promote better care coordination and alignment among the providers caring for patients receiving dialysis: measures Q328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin (Hgb) Level < 10 g/dL, Q329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis, measure Q330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days, and measure Q403: Adult Kidney Disease: Referral to Hospice. To advance the quality of care for patients with kidney disease, it is critical that nephrologists are measured by specific, relevant, and clinically meaningful measures.

Regarding measure Q328, anemia management is a critical component of managing the care for patients with kidney failure. Consistent with the comments submitted on the ESRD QIP on August 30, 2019, the commenter supported using a Hgb < 10 g/dL measure for dialysis facilities and, thus, called on CMS to use a similar measure for nephrologists. Regarding measure Q329, the use of catheters increases the risk of infection, morbidity, mortality, hospitalizations, and readmission. The ESRD QIP contains a similar measure to reduce the use of catheters in dialysis patients. Therefore, to coordinate the care among facilities and nephrologists, it is important to maintain this measure as measure Q330 is designed to be paired with Q329. Regarding measure Q403, a nephrologist is best positioned to work with the patient and through shared decision-making determine whether hospice is an appropriate option. Measure Q403 is also directly linked to the meaningful measure area

TABLE C: Summary of Comments and Responses

of End of Life Care According to Preferences. It seems inappropriate to eliminate measures that more closely align with those used in the ESRD QIP in favor of primary care measures that are not aligned.

Response: We thank the commenters for their comments and agree that care coordination for patients receiving dialysis is important; however, measures Q328, Q329, Q330, and Q403 have limited adoption over multiple programs years, this has not allowed for the creation of benchmarks that provide a meaningful impact to quality improvement. We believe that low reported measures are an indicator of measure concepts that do not provide meaningful measurement to most clinicians. Additionally, measures that do not meet benchmarking criteria do not allow for MIPS eligible clinicians to maximize their potential quality performance score. We continue to work with measure stewards to implement measures applicable to the nephrology specialty and plan to gather stakeholder feedback at the next MAP meeting.

Comment: One multi-society commenter requested that measure Q343: Screening Colonoscopy Adenoma Detection Rate (ADR) remain in MIPS until meaningful alternatives can be developed. The adenoma detection rate is the best-established colorectal neoplasia-related quality indicator available The measure as specified accounts for a heterogeneous population of patients and purposely excludes patients at higher (prior history of polyps or cancer) risk of adenoma. The commenter failed to see how the current measure cannot be benchmarked, stating that that an adenoma detection rate of 25 percent is considered the floor, not the ceiling, by gastroenterologists. The commenter is also unaware of any studies demonstrating a relationship between adenoma detection rate and patient population. The only measure that may capture missed adenomas is a measure relative to interval cancer rate, which is not feasible to calculate for an individual clinician given the progression from adenomatous polyp to cancer occurs over an estimated 5 to 10 years in average-risk populations, lack of interoperability among electronic medical records, and patient migration. Measure Q343 establishes the framework for the Screening/Surveillance Colonoscopy episode-based cost measure such that, if removed, its absence would have unintended consequences across multiple programs.

Another commenter requested that measure Q343 not be removed from the MIPS program until the CQMC has completed its maintenance cycle review of this measure expected by the end of 2019. Another commenter opposed the removal of measure Q343 given ADR's well-established role in gastroenterology practices' quality improvement programs nationwide and the proposal to introduce MVPs.

Response: We thank the commenters, but disagree as measure Q343 is considered an incidence measure that does not assess the quality of the care provided. In essence, the measure is based on happenstance rather than the eligible clinician providing a thorough examination. The numerator is capturing the rate of adenoma(s) or colorectal cancer. Based on the measure specification's rationale "performance targets for adenoma detection rate of 25 percent for a mixed gender population (20 percent in women and 30 percent in men)." Under the current MIPS scoring methodology, a MIPS eligible clinician with a 90 percent performance rate would score higher than those that fall near the benchmark set by expert consensus. We agree with the comment that an alternative measure that addresses the scoring and benchmarking challenges should be developed. However, we do not agree that measure Q343 should be maintained in the interim.

According to the risk factors outlined by the American Cancer Society, African Americans have the highest colorectal cancer incidence and mortality rates of all racial groups in the US. In addition, dietary factors, such as consumption of highly processed meats will contribute to an increased risk of colorectal cancer. This diet is more prevalent in lower socioeconomic areas which could influence the outcome of the measure. There are other patient factors like education, health literacy, etc. that might also affect things like the adequacy of bowel preparation, which in turn could affect performance. We refer the commenter to review the response for measure Q185 as we are not finalizing the removal of the measure based on further communication with the measure steward. Lastly, in response to the inclusion of this measure within Core Quality Measures Collaborative, we have determined this measure may be appropriate for other programs, but does not align with the scoring logic within MIPS. When this measure was introduced, it was under the legacy program, Physician Quality Reporting System (PQRS). PQRS was a pay-for-reporting program which did not have the same scoring implications as MIPS transitioned to pay-for-performance.

Comment: One commenter supported the removal of two measures impacting the neurosurgical specialty because they are duplicative of other measures in the program. The commenter agreed that measure Q345: Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive is duplicative in concept and patient population to measure Q344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients without Major Complications (Discharged to Home by Post -Operative Day #2).

The commenter also agreed that measure Q346: Rate of Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) Who Are Stroke Free or Discharged Alive is duplicative in concept and patient population to measure Q260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post -Operative Day #2). If measures Q345 and Q346 are removed from the Neurosurgical set due to removal from the MIPS program, the commenter requested that measures Q344 and Q260 be added to the Neurosurgical set as their replacements.

Response: We thank the commenter supporting the removal of measures Q345 and Q346. We are unable to include measures Q344 and Q260 in the Neurosurgical set at this time as they were not proposed to be added, but encourage the commenter to submit their recommendations during the Call for Specialty Measure Sets.

Comment: One commenter opposed the removal of measure Q353: Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report, which was proposed for removal because CMS said it is considered standard of care that has limited opportunity to improve clinical outcomes. The commenter encouraged CMS to retain this measure, as it encourages the provision of valuable data in the total knee replacement operative report. Another commenter opposed the removal of measure Q353, stating that this measure includes valuable data on the specific types of implants, which is relevant to tracking patient outcomes. Further, as physicians routinely report registry data, the commenter did not believe reporting of this measure contributes to physician burden.

Response: As the performance on measure Q353 is extremely high and unvarying, it does not allow meaningful benchmarks to be established. By removing measures that are extremely topped out, we are attempting to reduce reporting burden where there is little room for improvement. Additionally, this allows eligible clinicians to maximize their potential quality performance score as this measures' topped out status would limit the score awarded per the 2019 Benchmark File. Removing this measure does not preclude clinicians from documenting this information and using it for their tracking purposes in regard to patient outcomes. However, given the topped out status of this measure, keeping the measure in the program does not align with the Meaningful Measure initiative.

Comment: Several commenters did not support removal of measure Q371: Depression Utilization of the PHQ-9 Tool as removal of measure Q371 would disincentivize providers from collecting PHQ-9 data. Allowing clinicians to continue to report on measure Q371 allows clinicians to integrate patient reported outcome data incrementally, driving improvement over time that might not be demonstrable in first year performance of an outcome measure. It is essential to incentivize use of

TABLE C: Summary of Comments and Responses

measures such as the PHQ-9 on a regular basis. The PHQ-9 also includes a question related to suicidal ideas, which is an important element of assessment, independent of whether an individual meets other criteria for depression, particularly with the continued increase in suicide rates nationally.

Another commenter opposed the removal of measure Q371, available for eCQM reporting, as it is the most popularly reported measure with its customers. The commenter noted that the measure is being removed because a similar registry reportable measure exists as an alternative to this measure. The commenter understood that outcome measures are preferred and would ask that CMS work with measure developers to create an outcome depression measure to replace this popular measure prior to its removal.

Another commenter suggested that measure Q371 be retained in addition to measure Q370. Although measure Q370 would seem to encompass measures Q371 and Q411: Depression Remission at Six Months and make them superfluous, there are significant advantages to retaining all of these measures. Given the current fragmentation of the health care delivery system, it is essential to incentivize use of measures such as the PHQ-9 on a regular basis and measure Q371 accomplishes this goal. Retaining measure Q371 will give clinicians appropriate credit for making the PHQ-9 a routine and integral part of their workflow and will foster enhanced screening for depression and suicidal ideas as well as ongoing assessments of depression severity to guide measurement-based care.

One commenter supported removal of measure Q371 and agreed that measure Q370 is a more robust outcome measure, requiring depression remission for numerator compliance.

Response: We agree that PHQ-9 is clinically useful as a tool to support eligible clinicians with assessment of depression for patients. However, we believe that for MIPS, measure Q371 is duplicative to measure Q370: Depression Remission at Twelve Months. We are actively attempting to reduce measures that are duplicative in measurement to reduce burden and support the meaningful measure initiative. We agree with the commenter that measure Q371 is a more robust measure since performance is met upon the completion of a PHQ-9 and remission of depression at twelve months. Removing measure Q411 does not preclude clinicians from administering the PHQ-9 at any point during the patient's course of treatment and does not discourage clinicians from continuing to check symptoms using the PHQ-9 at six months. According to the clinical recommendation statement found within measure Q411 "all patients should be monitored on a monthly basis for 6 to 12 months after the full resolution of symptoms" regardless of treatment length for ongoing management of depression. This, in addition to relapse being most common in the initial six months after depression remission align with retaining measure Q370 to ensure patients are still in remission at 12 months. Despite the removal of this quality measure, we believe it does not preclude the creation of clinical processes that drive positive outcomes for patients. Additionally, the duplicative measure Q370: Depression Remission at Twelve Months is offered for the eCQM specifications collection type.

We do not believe the removal of measure Q371 will disincentivize or preclude clinicians from completing PHQ-9 since this is an easily performed screening tool for depression. As stated in the clinical recommendation of measure Q371 "Clinicians should establish and maintain follow-up with patients. Appropriate, reliable follow-up is highly correlated with improved response and remission scores. It is also correlated with the improved safety and efficacy of medications and helps prevent relapse."

Comment: One commenter opposed the removal of measure Q372: Maternal Depression Screening, stating that the measure is appropriate for use in episode-based care attributed to obstetrician-gynecologists. One commenter supported the removal of measure Q372 from the eCQM measure type.

Response: We thank the commenter supporting the removal of measure Q372. We disagree with the commenter as the denominator is constructed to assess maternal depression screening during a child's face-to-face visit in the first six months of life. This visit would be provided by the pediatric or family medicine specialty and not attributed to the obstetrician-gynecologists. During this visit the eligible clinician would be providing care for the newborn, not focus on the maternal screening.

Comment: One commenter urged CMS to reconsider the topped-out designation for measure Q407: Appropriate Treatment of Methicillin-Susceptible *Staphylococcus aureus* (MSSA) Bacteremia. Although this measure is considered standard-of-care, the commenter believed that it is inappropriate to consider removing a quality measure that promotes the appropriate use of antibiotics at a time when antimicrobial resistance is a global health emergency. Additionally, 2019 is the first year that this measure has had a benchmark. In the upcoming 2020 MIPS performance year, revisions to the measure were approved to include patients that are diagnosed with *S. aureus* bacteremia rather than only sepsis due to MSSA. This patient population expansion may allow for a more accurate measure of performance for the appropriate treatment of MSSA bacteremia.

Response: We thank the commenter for their comment. Measure Q407 has limited adoption and the benchmark is reflective of the performance of the MIPS eligible clinicians who have chosen to report on the measure. These same MIPS eligible clinicians will likely continue to submit measure Q407 and we do not believe there will be variances in the high performing data submitted if we were to retain measure Q407. Additionally, we believe that low reported measures are an indicator of measure concepts that do not provide meaningful measurement to most clinicians.

Comment: One commenter recommended retaining measure Q411: Depression Remission at Six Months. The rationale for removing this measure quotes the American Psychiatric Association's practice guideline on treatment of patients with MDD in noting that relapse is common in the initial six months after depression remission and in providing a definition of continuation therapy. While these quotations are accurate, they do not support a rationale for removal of this measure. The measure of depression at 12 months (measure Q370) includes individuals who are seen and have a PHQ-9 completed within 30 days (+/-) of the 12-month time point. This may not capture all patients who have been treated for depression (e.g., patients seen by a psychiatrist who have remitted and then returned to their primary care physician for ongoing care).

Another commenter supported the removal of measure Q411 as it found the measure to be invalid.

Response: We thank the commenter for supporting the removal of measure Q411. We thank the other commenter for their concern regarding the removal of measure Q411. Removing measure Q411 does not preclude clinicians from administering the PHQ-9 at any point during the patient's course of treatment and does not discourage clinicians from continuing to check symptoms using the PHQ-9 at six months. According to the clinical recommendation statement found within measure Q411 "all patients should be monitored on a monthly basis for 6 to 12 months after the full resolution of symptoms" regardless of treatment length for ongoing management of depression. This, in addition to relapse being most common in the initial six months after depression remission align with retaining measure Q370 to ensure patients are still in remission at 12 months.

TABLE C: Summary of Comments and Responses

Comment: One commenter disagreed with the removal of measure Q442: Persistence of Beta-Blocker Treatment After a Heart Attack by replacing the measure with Q007: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%). Measure Q442 assesses whether patients get persistent medication over six months; however, the proposed replacement assesses only if patients get the drug once.

Another commenter opposed not implementing the exclusion for adults 80 and older with frailty for measure Q442 (if retained in MIPS). This exclusion is critical for focusing the measures on the population most likely to benefit from the measured services. Without this exclusion, these measures will be out of alignment with what is required for reporting. Another commenter believed that measure Q442 should not be removed, stating that it is a valid measure and is based on high-quality evidence from multiple specialty organizations, while another commenter requested that the measure be retained until the CQMC has completed its maintenance cycle review of this measure expected by the end of 2019.

Response: We disagree with the commenters as measure Q007 is reflective of beta-blocker use and overlaps with the population of patients captured within the denominator of measure Q442. Measure Q442 focuses the denominator on those patients that have experienced acute myocardial infarction which is narrower than Measure Q007. Additionally, the numerator in measure Q442 requiring six months of medication compliance further narrows the denominator to the first six months of the performance period. The denominator in measure Q007 represents a broader patient population and may be evaluated throughout the entirety of the performance period. Therefore measure Q007 represents a more robust measure that supports the meaningful measure initiative. As we are finalizing removal of this measure, we will not be implementing the substantive change for this measure outlined in 84 FR 41180.

Comment: One commenter opposed the removal of measure Q449: HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies. This measure would have a substantive change if the measure is not finalized for removal, and the commenter stated that the measure has had substantive changes due to updates in recent guidelines and given that it is not possible to know whether the measure is topped out under these circumstances, the commenter recommended measure Q449 be retained in the MIPS program.

Response: We thank the commenter for their comment, but do not believe that the change in current clinical guidelines will change performance rates in the measure. We believe that eligible clinicians will most likely quickly update their practice in the treatment of breast cancer to support quality outcomes with these patients based on the new clinical guidelines. We encourage the measure steward to collect performance data based on the updated guidelines, in the event it substantiates a performance gap, a new measure could be submitted to the Call for Measures.

Comment: One commenter opposed the removal of measure Q454: Percentage of Patients who Died from Cancer with More than One Emergency Department Visit in the Last 30 Days of Life (lower score – better). The commenter stated that the evidence supports existence of a significant gap and variation in care related to the measure. For patients with cancer at the end of life, the use of unnecessary services such as the emergency department can negatively impact a patient and family's quality of life and satisfaction with end of life care. Emergency department visits in the last 30 days of life are one indicator that supportive care may not be provided effectively to these patients.

Response: We thank the commenter for their comment and agree that end of life care and care coordination for patients with cancer is important to assess, however, we believe that this may be outside of the eligible clinician's control. We believe that measure Q455: Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better) is more indicative of the supportive care provided and its efficacy as admittance to the ICU would be based on clinical factors and not the patient's decision. It is also likely that many of the patients within the eligible population for measure Q455 were admitted to the ICU through the emergency department, meaning this population would be accounted for in multiple measures.

Comment: One commenter opposed the removal of measure Q456: Percentage of Patients who Died from Cancer Not Admitted to Hospice (lower score – better). The commenter stated that although the use of hospice and other palliative care services at the end of life has increased, many patients are enrolled in hospice less than three weeks before their death, which limits the benefit they may gain from these services. There remains significant value and demonstration of quality care in ensuring a low percentage of patients dying from cancer who are not receiving hospice care through this measure. For these reasons, the commenter requested that measure Q456 be retained in the MIPS program.

Response: We thank the commenter for their comment and agree that increasing hospice utilization in cancer patients is important. We believe that measure Q457 is a better indicator of hospice usage as it has a more stringent numerator by assessing the number of patients who spent less than three days in hospice whereas measure Q456 assesses all patients not admitted to hospice, allowing patients admitted to hospice less than three days to be Performance Not Met (representing better clinical quality as this in an inverse measure).

Comment: One commenter recommended that CMS delay removing measure Q467: Developmental Screening in the First Three Years of Life measures from the MIPS program until the CQMC has completed its maintenance cycle review of these measures expected by the end of 2019.

Response: We thank the commenter for their comment and disagree with delaying removal of measure Q467. The measure steward submitted a substantive change that would expand the denominator to include well-child visits. The well-child visit encounters would likely include the attestation of screening for risk of developmental, behavioral, and social delays using a standardized tool, which is the quality action for measure Q467, thereby inflating performance of the measure. This would lead to a less meaningful assessment for MIPS eligible clinicians.

Comment: One commenter supported the removal of measure Q474: Zoster (Shingles) Vaccination as it found the measure to be invalid.

Response: We thank the commenter for supporting the removal of measure Q474.

After consideration of the comments, we are finalizing the removal of these measures as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the exception of the following measures, which are being retained: Q110, Q111, Q146, Q178, Q185, Q225, Q249, Q250, Q264, Q282, Q288, Q395, and Q396. Our decisions not to finalize these measures for removal in this final rule are detailed in our responses to the public comments for these measures. We are also finalizing substantive changes for measures Q110, Q111, Q178, Q282, and Q288 (See Tables D.79, D.80, D.81, D.82, and D.83).

TABLE Group D: Previously Finalized Quality Measures with Substantive Changes Finalized for the 2022 MIPS Payment Year and Future Years

NOTE: Electronic Clinical Quality Measures (eCQMs) that are National Quality Forum (NQF) endorsed are shown in Table D as follows: NQF # / eCQM NQF #.

D.1 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Category	Description
NQF # / eCQM NQF #:	0059 / N/A
Quality#:	001
CMS eCQM ID:	CMS122v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0 percent during the measurement period.
Substantive Change:	**Updated denominator exclusions: For eCQM Specifications collection type:** Added the following: (1) Patients 66 years of age and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days during the measurement period. **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Added the following: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	The measure steward believes it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might be harmful for patients to receive a particular service when they should prioritize other services. The measure steward also believes that some of the services in this measure are not appropriate for patients 66 years of age and older who are living in a long-term institutional setting. We agree with the measure steward and believe that by removing these patient populations, the burden to submit data is lessened for these MIPS eligible clinicians.

Comment: One commenter supported the proposed changes to measure Q001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). Another commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q001 and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for 2019 and 2020 MIPS performance periods.

Response: We thank the commenter for supporting the revision to measure Q001. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measure Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For this substantive change, we disagree with the second commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the updated denominator exclusions do not significantly change the patient population, but work to create a more relevant patient population for the quality action, which remains unchanged.

Comment: One commenter supported the denominator exclusions added for frailty for ACO-27 (measure Q001): Diabetes A1c Poor Control. The commenter also requested that the age restriction is removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age.

Response: We thank the commenter for supporting the revision to measure Q001. We encourage the commenter to reach out to the measure steward and collaborate regarding further refinement of the denominator exclusions.

For the eCQM Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

Category	Description
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q001 and does not affect the intent of the proposed substantive change. For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state: **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Added the following: (1) Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 days during the measurement period This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q001 and does not affect the intent of the proposed substantive change. There were no additional refinements to substantive changes: **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Added the following; (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine After consideration of the comments, we are finalizing the changes as indicated to measure Q001 for the 2020 MIPS performance period/2022 MIPS payment year and future years with the refinements noted above.	

D.2. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Category	Description
NQF # / eCQM NQF #:	0081 / 0081e
Quality #:	005
CMS eCQM ID:	CMS135v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.
Substantive Change:	**The measure title is revised to read:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD). **The measure description is revised to read:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12- month period when seen in the outpatient setting OR at each hospital discharge. **Updated denominator:** For the MIPS CQMs Specifications collection type for Submission Criteria 1 – "At least on additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters. **Updated numerator:** Added language for ARNI therapy. **Updated definition:** Added language for ARNI therapy.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	This measure already includes ARNI therapy in the specifications and coding as well as a statement about the fact that ARNIs are a numerator compliant clinical action. The measure was proposed to be globally updated to include ARNI therapy language in the title, description, numerator, definition, denominator exception, and rate aggregation to align with the intent of the measure. With the inclusion of ARNI therapy, the intent of this measure is aligned with the most current clinical guidelines for ACE/ARB therapies for patient's diagnoses with heart failure. Telehealth visits, for the additional denominator eligible encounters, were added for Submission Criteria 1 in the MIPS CQMs Specifications collection type.
We received no comments on the substantive changes proposed for measure Q005: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD). Therefore, we are finalizing the changes to measure Q005 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.3. Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)

Category	Description
NQF # / eCQM NQF #:	0070 / 0070e
Quality #:	007
CMS eCQM ID:	CMS145v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have prior MI or a current or prior LVEF < 40 percent who were prescribed beta-blocker therapy.
Substantive Change:	**Updated calculation method:** For the MIPS CQMs Specifications collection type: To be submitted as a single performance rate. **Updated denominator:** For the MIPS CQMs Specifications collection type, "At least one additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the measure performance calculation for the MIPS CQMs Specifications collection type so that it is submitted as a single performance rate as opposed to two performance rates. This change allows for better alignment between the collection types. We also proposed to add telehealth visits for the additional denominator eligible encounters for the MIPS CQMs Specifications collection type. This change is in alignment with the eCQM Specifications collection type. We believe these changes will allow for data congruency between the collection types while also lessening burden for implementation of the measure across these collection types.
We received no comments on the substantive changes proposed for measure Q007: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%). Therefore, we are finalizing the changes to measure Q007 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.4. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Category	Description
NQF # / eCQM NQF #:	0083 / 0083e
Quality #:	008
CMS eCQM ID:	CMS144v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.
Substantive Change:	**For the eCQM Specifications collection type:** The timing for cardiac pacer in situ diagnosis logic has been changed to 'overlaps after'. **Updated denominator: For the MIPS CQMs Specifications collection type**: For Submission Criteria 1, "At least one additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	For the eCQM Specifications collection type: the logic regarding the cardiac pacer in situ diagnosis was proposed to be updated to change the timing to 'overlaps after' to ensure it is present at the time of the end of the encounter and for harmonization with CMS145v8. For the MIPS CQMs Specifications collection type: we proposed to add telehealth encounters for the additional patient encounter as denominator eligible encounters for Submission Criteria 1. This change is in alignment with the eCQM Specifications collection type. We believe these changes will allow for data congruency between the collection types while also lessening burden for implementation of the measure across these collection types.
Comment: One commenter supported proposed revisions to measure Q008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) that would add in telehealth encounters to be included as eligible encounters. **Response:** We thank the commenter for supporting the revision to measure Q008. After consideration of the comments, we are finalizing the changes to measure Q008 as proposed for the 2020 MIPS performance period/2022 MIIPS payment year and future years.	

D.5. Anti-Depressant Medication Management

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	009
CMS eCQM ID:	CMS128v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).
Substantive Change:	**Updated guidance:** Guidance statement updated to reflect the 105 day negative medication history. **Updated denominator:** The required visit needs to be in the 60 days before or after the initial patient population antidepressant medication dispensing event. The initial patient population dispensing period will be from May 1st of the year prior to the measurement period to April 30th of the measurement period. Added nursing home encounters to list of qualifying encounters. **Updated denominator exclusion:** Changed timing to 'overlaps' so that medications that are active in the 105 days prior may count.
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to expand the denominator to include nursing home encounters as this measure is applicable to that setting and this will increase the number of MIPS eligible clinicians who can report on the measure. The required visit for the initial patient population is proposed to be in the 60 days before or after the initial patient population antidepressant medication dispensing event as the intent is for a physician who has influence over the medication choice and follow-up to report the measure. The measure steward feels, and we agree, that associating the visit with the medication dispensing event is more in line with the intent of the measure. The initial patient population dispensing period is also being updated. We proposed to update the denominator exclusion logic so that medications that are active in the 105 days prior will also count as an exclusion. We proposed to update the guidance as well to reflect the change in the denominator exclusion.
We received no comments on the substantive changes proposed for measure Q009: Anti-Depressant Medication Management. Therefore, we are finalizing the changes to measure Q009 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.6. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Category	Description
NQF # / eCQM NQF #:	0089 / 0089e
Quality #:	019
CMS eCQM ID:	CMS142v8
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
Substantive Change:	**Modified collection type:** eCQM Specifications, MIPS CQMs Specifications
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to remove the Medicare Part B Claims Measure Specifications collection type as the benchmarking data shows that this measure meets the extremely topped out definition, specifically for the Medicare Part B Claims Measure Specification collection type. However, the benchmarking data continues to show a gap for the eCQM Specifications collection type and the MIPS CQMs Specifications collection type, as such, the measure will be retained for these two collection types.
Comment: One commenter opposed the removal of the Medicare Part B Claims Measure Specifications collection type for measure Q019: Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetes Care. The commenter encouraged CMS to retain this collection type, because its removal from the measure would adversely impact ophthalmologists, particularly those in small and rural practices that rely on claims reporting because they cannot afford to adopt CEHRT. Removing this collection type would result in an even fewer measures relevant to ophthalmologists' scope of practice. A second commenter opposed this change and recommended that CMS retain the measure and increase the data completeness criteria as the Agency discusses as a possible way forward for topped out measures. **Response:** We appreciate the commenter's feedback and disagree that removal of measure Q019 from the Medicare Part B Claims collection type will adversely impact ophthalmologists. Clinicians who elect to participate via Medicare Part B claims collection type, and choose to submit extremely topped out measures, are penalized in their quality score under current methods by receiving a maximum of 7 of 10 points for each topped out measure; therefore clinicians may not have an opportunity to maximize incentive with the submission of topped out measures. CMS encourages the commenter to explore other collection types such as Qualified Registries or QCDRs in order to submit measures to CMS. After consideration of the comments, we are finalizing the changes to measure Q019 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.7. Appropriate Testing for Children with Pharyngitis

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	066
CMS eCQM ID:	CMS146v8
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.
Substantive Change:	**Updated numerator: For the eCQM Specifications collection type:** Removed Ambulatory/ED grouping value set, instead using the individual value sets. **Updated denominator exclusions:** Added exclusion for competing diagnosis at the same encounter as the pharyngitis diagnosis or in the 3 days after the pharyngitis diagnosis.
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	For the eCQM Specifications collection type: The Ambulatory/ED grouping value sets were proposed to be removed so that individual value sets will be used in order to increase transparency regarding which encounter value set is being utilized. A denominator exclusion for a competing diagnosis that occurs at the same encounter or 3 days after the pharyngitis diagnosis was proposed to be added to ensure the patient population being assessed is more in alignment with clinical intent of assessing whether or not children diagnosed with pharyngitis were correctly evaluated and subsequently ordered antibiotics.
We received no comments on the substantive changes proposed for measure Q066: Appropriate Testing for Children with Pharyngitis. Therefore, we are finalizing the changes to measure Q066 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.8. Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections

Category	Description
NQF # / eCQM NQF #:	2726
Quality #:	076
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.
Substantive Change:	**Updated numerator definition:** Added definition for Hand Hygiene: Washing hands with conventional soap and water or with alcohol-based hand rubs (ABHR).
Steward:	American Society of Anesthesiologists
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to add the definition for hand hygiene that is found in the Clinical Recommendation Statement as a numerator definition to make it more prominent and add clarity for measure users.
Comment: One commenter supported the updated definition of Hand Hygiene, which has been added to measure Q076: Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections through the NQF measure maintenance process. **Response:** We thank the commenter for supporting the revision to measure Q076, however, we would like to remind the commenter that this revision occurred during MIPS annual quality measure revision process and not the NQF measure maintenance process. After consideration of the comments, we are finalizing the changes to measure Q076 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.9. Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients

Category	Description
NQF # / eCQM NQF #:	0389 / 0389e
Quality #:	102
CMS eCQM ID:	CMS129v9
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
Substantive Change:	**The measure description is revised to read:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer. **Updated denominator:** Removed cryotherapy from denominator statement/header. **Updated denominator definition:** Removed "Note: Patients with multiple adverse factors may be shifted into the high/very high risk category" from definition of Intermediate Risk. **For the eCQM Specifications collection type:** removed SNOMED and CPT codes related to cryotherapy from the SNOMED CT extensional OID and CPT extensional OID "Prostate Cancer Treatment" value set.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to remove cryotherapy from the measure to align with updated clinical guidelines. Current clinical guidelines do not recommend cryotherapy as a routine primary therapy for localized prostate cancer due to the lack of long-term data comparing this to treatments such as radiation or radical prostatectomy. Given that the denominator includes treatments recommended for low/very low-risk prostate cancer patients, the measure steward's technical expert panel (TEP) agreed cryotherapy should be removed from the denominator. All coding related to cryotherapy is being removed in accordance with the updated guidelines. We proposed to update the denominator definition to align with updated guidelines.
We received no comments on the substantive changes proposed for measure Q102: Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients. Therefore, we are finalizing the changes to measure Q102 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.10. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Category	Description
NQF # / eCQM NQF #:	0104e
Quality #:	107
CMS eCQM ID:	CMS161v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
Substantive Change:	**Updated denominator:** Added telehealth data element to "Major Depressive Disorder Encounter" definition using "Telehealth Services" value set. **Updated guidance:** Updated to reflect the inclusion of telehealth encounters. **Updated definition:** The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: (1) Suicidal ideation (2) Patient's intent of initiating a suicide attempt AND, if either is present, (3) Patient plans for a suicide attempt (4) Whether the patient has means for completing suicide Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	The measure was reviewed by PCPI's technical expert panel and it was recommended to include telehealth encounters. We proposed to add telehealth data element to "Major Depressive Disorder Encounter" as telehealth encounters are directly applicable to this measure and these patients should be included in the denominator to allow for numerator compliance to be measured. We proposed to reflect this change in the guidance header for additional clarity. We proposed to add clarifying language in the definition header regarding suicide risk assessments that could be appropriate to meet the measure. It is still intended that the MIPS eligible clinician use their discretion when choosing the specific type and magnitude of the suicide risk assessment, based upon the patient's specific needs, but the suicide risk assessments should include, at minimum, certain criteria.

Comment: One commenter supported proposed revisions to measure Q107: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment that would add in telehealth encounters to be included as eligible encounters.

Response: We thank the commenter for supporting the revision to measure Q107.

After consideration of the comments, we are finalizing the changes to measure Q107 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.11. Breast Cancer Screening

Category	Description
NQF # / eCQM NQF #:	2372 / N/A
Quality #:	112
CMS eCQM ID:	CMS125v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of women 51 - 74 years of age who had a mammogram to screen for breast cancer.
Substantive Change:	**The measure description is revised to read:** Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period. **The numerator is revised to read:** Women with one or more mammograms 27 months prior to the end of the measurement period. **Updated denominator exclusions: For eCQM Specifications collection type:** (1) Patients 66 years of age and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days during the measurement **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Added the following: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine **Updated numerator guidance: For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications collection types**: Added "This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening. Mammography screening is defined as a bilateral screening (both breasts) of breast tissue. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast."
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to add a timing component to the description for better clarity and alignment throughout the measure. The numerator was revised to state the timing in the same manner as the description, however, the timing itself has not been changed only stated differently. The measure steward believes it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might even be harmful for patients to receive a particular service when they should prioritize other services. The measure steward also believes that some of the services in this measure are not appropriate for patients 66 years of age and older who are living in a long-term institutional setting. We believe that by removing these patient populations, the burden to submit data is lessened for these MIPS eligible clinicians. We proposed to update the numerator guidance for the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection types to clarify the intent of the measure. The measure logic for the Medicare Part B Claims Measure Specifications will remain the same from prior years to allow a 27-month look back from the denominator eligible visit.

Category	Description

Comment: One commenter supported the denominator exclusions added for frailty for ACO-20 (measure Q112): Breast Cancer Screening. The commenter also requested that the age restriction be removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age. The commenter recommended the following exclusion: Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting.
Response: We thank the commenter for supporting the revision of measure Q112. We encourage the commenter to reach out to the measure steward and collaborate regarding further refinement of the denominator exclusions.

Comment: One commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q112 and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for the 2019 and 2020 MIPS performance periods.

Response: We thank the commenter for their comment. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measure Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For these substantive changes, we disagree with the commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the updated denominator exclusions do not significantly change the patient population, but work to create a more relevant patient population for the quality action, which remains unchanged. All other updates were for language alignment and clarity of intent and therefore would not necessitate exclusion from MIPS scoring.

For the eCQM Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated denominator exclusions: For eCQM Specifications collection type:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q112 and does not affect the intent of the proposed substantive change.
For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:
Added the following:
(1) Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 days during the measurement period.

This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q112 and does not affect the intent of the proposed substantive change.
We proposed a substantive change to the numerator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

The numerator is revised to read: Women with one or more mammograms during the 27 months prior to the end of the measurement period. This additional refinement does not affect the intent of the proposed substantive change.

This additional refinement was to ensure clarity in language for measure Q112 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
The measure description is revised to read: Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:
Added the following:
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
(4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine
Miscellaneous central nervous system agents: Memantine

Updated numerator guidance: For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications collection types: Added "This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening. Mammography screening is defined as a bilateral screening (both breasts) of breast tissue. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast."

After consideration of the comments, we are finalizing the changes to measure Q112 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the refinements noted above.

D.12. Colorectal Cancer Screening

Category	Description
NQF # / eCQM NQF #:	0034 / N/A
Quality #:	113
CMS eCQM ID:	CMS130v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.
Substantive Change:	**Updated denominator exclusions: For eCQM Specifications collection type:** Added the following: (1) Patients aged 66 years and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period. **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Added the following: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine **Updated numerator guidance: For Medicare Part B Claims Measure Specification and MIPS CQMs Specifications collection types:** Do not count DRE, FOBT tests performed in an office setting or performed on a sample collected via DRE.
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to add denominator exclusions for patients aged 66 years and older with advanced illness and frailty, taking certain dementia medications, or who are living in a long-term institutional setting for more than 90 days. The measure steward believes it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might even be harmful for patients to receive a particular service when they should prioritize other services. The measure steward believes the measure reflects services that may not be appropriate for patients in long-term institutional settings. We believe that by removing these patient populations, the burden to submit data is lessened for these MIPS eligible clinicians. We also proposed to update guidance for numerator compliance for the Medicare Part B Claims Measure Specification and MIPS CQMs Specifications collection types to align with eCQM Specifications and CMS Web Interface Measure Specifications collection types. The update would not allow fecal occult blood test (FOBT) via tests performed in an office setting or performed on a sample collected via DRE to be numerator compliant. This update aligns with a more effective method as FOBT by stool passed spontaneously (SPS) appears to be statistically superior to FOBT by DRE. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

Category	Description

Comment: One commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q113 (PREV-6): Colorectal Cancer Screening and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for 2019 and 2020 MIPS performance periods.

Response: We thank the commenter for their comment. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measure Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. However, this measure will maintain its current benchmark for the CMS Web Interface Measure Specification collection type for the 2019 performance period. The revisions regarding the updated guidance for DRE of FOBT proposed to Medicare Part B Claims Measure and MIPS CQMs specifications collections types were already present in the CMS Web Interface Measure specification collection type, and the updated denominator exclusions do not significantly change the patient population, but work to create a more relevant patient population for the quality action. Therefore allowing the CMS Web Interface Measure Specification collection type benchmark to remain stable for the 2020 MIPS performance period/2022 MIPS payment year. New benchmarks will be created for the Medicare Part B Claims Measure and MIPS CQMs specifications collections types for the 2020 MIPS performance period, as this revision impacts those collection types.

Comment: One commenter supported the denominator exclusions added for frailty for ACO-19 (measure Q113): Colorectal Cancer Screening. The commenter also requested that the age restriction is removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age. The commenter recommended the following exclusion: Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting.

Response: We thank the commenter for supporting the revision of measure Q113. We encourage the commenter to reach out to the measure steward and collaborate regarding further refinement of the denominator exclusions.

For the eCQM Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q113 and does not affect the intent of the proposed substantive change.

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:
(1) Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 Days during the measurement period.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q113 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
(4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine
Miscellaneous central nervous system agents: Memantine

Updated numerator guidance: For Medicare Part B Claims Measure Specification and MIPS CQMs Specifications collection types: Do not count DRE, FOBT tests performed in an office setting or performed on a sample collected via DRE.

After consideration of the comments, we are finalizing the changes to measure Q112 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the refinements noted above.

D.13. Diabetes: Eye Exam

Category	Description
NQF # / eCQM NQF #:	0055 / N/A
Quality #:	117
CMS eCQM ID:	CMS131v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
Substantive Change:	**The measure description is revised to read:** Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period. **Updated denominator exclusions: For eCQM Specifications collection type:** Added the following: (1) Patients 66 years of age and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period. **For Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection type:** Added the following: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine **Updated numerator:** Allows use of a diagnosis of retinopathy as a proxy for a positive eye exam. • If the patient has a diagnosis of retinopathy that overlaps the measurement period, the patient will be required to have an eye exam in the measurement period. • If the patient does not have a diagnosis of retinopathy that overlaps the measurement period, the patient will be required to have an eye exam in the 24 months prior to the end of the measurement period.
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the measure description to better align with changes to logic. We agree with this update as it clarifies the intent of the measure. We proposed to add denominator exclusions for patients aged 66 years and older with advanced illness and frailty, taking certain dementia medications, and for patients who are living in a long-term institutional setting, such as a nursing home. The measure steward believes it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might even be harmful for patients to receive a particular service when they should prioritize other services and that services within this measure may not be appropriate for older patients living in a long-term institutional setting for longer than 90 days during the measurement period. In response to reports from EHR vendors that the measure was not reportable due to the results from an eye exam not being in structured data, we proposed to use the diagnosis of retinopathy as a proxy for a positive eye exam. Patients with a diagnosis of retinopathy are required to have an eye exam yearly while patients without that diagnosis are required to have an eye exam once every 24 months. We believe that by removing these two patient populations, the burden to submit data is lessened for these MIPS eligible clinicians.

Category	Description

Comment: One commenter did not support the substantive changes proposed for measure Q117: Diabetes: Eye Exam and the proposal to update the denominator exclusions and to include those individuals who are 66 and older and who are frail and those who have been living in a long-term institution setting for more than 90 days in the measurement period.

To eliminate the frail and those living in assisted living institutions from this measure is inappropriate as these patients could benefit from the type of high-quality health care that quality measurement is intended to support.

Additionally, the commenter had concerns with the proposal to update the numerator to allow for patients who do not have a diagnosis of retinopathy to be required to have an eye exam in the 24 months prior to the end of the measurement period. The commenter is concerned that this change does not fully adhere to clinical practice guidelines. The American Diabetes Association Standards of Medical Care recommend, "If there is no evidence of retinopathy for one or more annual eye exam and glycemia is well controlled, then exams every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight-threatening, then examinations will be required more frequently."

Response: We thank the commenter for their concern regarding the proposed denominator exclusions for patients who are frail or living in a long-term institution setting for more than 90 days in the performance period. We understand that there may be patients within the excluded population that could benefit from these services and we are in no way precluding clinicians from performing these services. By excluding these patients, the measure is allowing clinicians to focus on aspects of care that are more immediately necessary and will have a greater impact on the patient's overall quality of life. These exclusions allow clinicians to exercise shared decision making with the patient or care-taker in determining necessary clinical care. These quality measures are not intended to be used as clinical guidelines. We will continue to work with the measure steward to ensure that we are not excluding a critical patient population. In regards to the comment about eye exam requirements, the measure as currently specified allows for the an eye exam to occur during the current measurement period or the 12 months prior to the current measurement period to be numerator compliant in the instance the patient has a negative retinal or dilated eye exam. Therefore, the timing of the quality action has not changed due to these updates in language and use of a retinopathy diagnosis as a proxy to an eye exam. We encourage the commenter to collaborate with the measure steward on revisions to be proposed for future year implementation.

For the eCQM Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q117 and does not affect the intent of the proposed substantive change.
For Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:
(1) Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 Days during the measurement period.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q117 and does not affect the intent of the proposed substantive change.

We proposed a substantive change to the numerator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated numerator:
Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:
• Diabetic with a diagnosis of retinopathy that overlaps the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period
• Diabetic with no diagnosis of retinopathy overlapping the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period
This additional refinement was to ensure clarity in language so that the clinically appropriate quality action is identified for measure Q117 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
The measure description is revised to read: Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

For Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection type: Added the following:
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
(4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine
Miscellaneous central nervous system agents: Memantine

After consideration of the comments, we are finalizing the changes as indicated to measure Q117 for the 2020 MIPS performance period/2022 MIPS payment year and future years with the refinements noted above.

D.14. Diabetes: Medical Attention for Nephropathy

Category	Description
NQF # / eCQM NQF #:	0062 / N/A
Quality #:	119
CMS eCQM ID:	CMS134v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.
Substantive Change:	**Updated denominator exclusions: For eCQM Specifications collection type:** Added the following: (1) Patients 66 years of age and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period. **For CQMs Specifications collection type:** Added the following: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to add denominator exclusions for patients aged 66 years and older with advanced illness and frailty, taking certain dementia medications, and for patients who are living in a long-term institutional setting, such as a nursing home. The measure steward believes it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might even be harmful for patients to receive a particular service when they should prioritize other services and that services within this measure may not be appropriate for older patients living in a long-term institutional setting for longer than 90 days during the measurement period. We believe that by removing these patient populations, the burden to submit data is lessened for these MIPS eligible clinicians.

For the eCQM Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q119 and does not affect the intent of the proposed substantive change.
For CQMs Specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

For CQMs Specifications collection type: Added the following:
(1) Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for More Than 90 Days during the measurement period.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q119 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
For CQMs Specifications collection type: Added the following:
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
(4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine
Miscellaneous central nervous system agents: Memantine

We received no comments on the substantive changes proposed for measure Q119: Diabetes: Medical Attention for Nephropathy. Therefore, we are finalizing the changes to measure Q119 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the refinements noted above.

D.15. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Category	Description
NQF # / eCQM NQF #:	0421 / 0421e
Quality #:	128
CMS eCQM ID:	CMS69v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI $\geq$ 18.5 and < 25 kg/m^2.
Substantive Change:	**Updated denominator exclusions:** Added patients in hospice care. Removed "or refuse follow-up" language from denominator exclusion. **For the eCQM Specifications collection type:** Added a 'union' operator of 'Intervention, Performed' for each 'Intervention, Order' for Above and Below Normal Follow-Up Interventions, and a 'union' operator of 'Intervention, Not Performed' for each 'Intervention, Not Ordered' for Above and Below Normal Follow-up Interventions not done due to a medical reason.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	The measure steward convened an expert work group (EWG) and it was recommended that patients receiving hospice care should be removed from this measure. We agree with the EWG that this patient population should be removed as patients in hospice care would not benefit from this clinical service. Since assessment of BMI is not a valuable clinical assessment for hospice patients we believe that by removing this patient population it will reduce the burden of submission for these MIPS eligible clinicians providing care to these patients. We proposed to remove "or refuse follow-up" from the denominator exclusion for clarity. We proposed to add a union operator to the eCQM Specifications collection type to allow the intervention to be either completed or ordered, creating a new numerator option. We proposed to update the eCQM Specifications collection type by adding a 'union' operator to allow intervention to be either completed or ordered for numerator compliance. This allows for better alignment with measure intent.

Comment: One commenter supported the proposed changes to measure Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.

Response: We thank the commenter for supporting the revision to measure Q128.

After consideration of the comments, we are finalizing the changes to measure Q128 as proposed for the 2020 MPS performance period/2022 MIPS payment year and future years.

D.16. Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Category	Description
NQF # / eCQM NQF #:	0418 / 0418e
Quality #:	134
CMS eCQM ID:	CMS2v9
National Quality Strategy Domain:	Community/ Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Substantive Change:	**The measure description is revised to read:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. **Updated denominator:** Added speech language pathology MIPS eligible clinician type. **For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications:** Added physical therapy MIPS eligible clinician type. **Updated denominator exception:** Updated language to situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment. **The numerator is revised to read:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. **For the eCQM Specifications collection type:** Updated the "Depression medications – adolescent" and the "Additional evaluation for depression – adolescent" value sets to include additional medications.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the measure description for better alignment with the measure intent and clinical practices, therefore the measure, will reflect those changes within the guidance and logic. This change will not affect the denominator population, but may expand the numerator population and provides a better opportunity for compliance. Based upon requests from stakeholders physical therapy evaluation codes were proposed to be add to the denominator eligible encounters to allow for this measure to be used in an additional setting. We agree that this is a clinically relevant measure to the physical therapy setting. We proposed to update the denominator exception for better clarity to allow MIPS eligible clinicians to use cognitive capacity as a denominator exception. The measure steward based this decision on feedback from clinical subject matter experts. We agree that this is not a new denominator exception, but rather clarifies what is deemed a denominator exception for this measure. The eCQM Specifications collection type's adolescent medication value sets was proposed to be updated to include additional medications based upon recommendations from clinical subject matter experts. The additions will provide an opportunity for better compliance by expanding the list of appropriate medication codes while also improving alignment with measure intent.

Category	Description
Comment: One commenter supported the addition of the physical therapy codes to measure Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. Another commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q134 and questioned whether the changes impact the benchmarks but urged CMS to explore and consider whether this measure warrants pay-for-reporting for the 2019 and 2020 MIPS performance period. **Response:** We thank the commenter for supporting the revision to measure Q134. Under MIPS, there is no pay-for-reporting option. In these instances, we remove the benchmark for the CMS Web Interface Measure Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For these substantive changes, we disagree with the second commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the revision to allow the screening to occur up to 14 days prior to the encounter better aligns with clinical practices and provides a better opportunity for compliance however, the quality action being assessed has not changed. The updated denominator exception offers clarity for implementation and does not introduce a new concept. The additional medications within the value sets allow for better compliance and the inclusion of more clinician types allows for assessment of a more complete patient population; however, they do not significantly change measure Q134 and allow for direct comparison of performance data from prior years. **Comment:** One commenter supported the revised measure descriptor for measure Q134. The commenter understood the numerator includes patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter, the commenter requested that CMS consider screenings provided that are not necessarily associated with a face to face encounter. Allowing screenings to be considered by telephone, would allow for more opportunities in the numerator. **Response:** We thank the commenter for supporting the revision to measure Q134. We encourage the commenter to reach out to the measure steward and collaborate regarding further refinement of measure Q134 for proposal for future years. We proposed a substantive change to the description; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state: **The measure description is revised to read:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. This additional refinement ensures alignment in language across all collection types and does not affect the intent of the proposed substantive change. There were no additional refinements to substantive changes: **Updated denominator:** Added speech language pathology MIPS eligible clinician type. **For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications:** Added physical therapy MIPS eligible clinician type. **Updated denominator exception:** Updated language to situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment. **The numerator is revised to read:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. **For the eCQM Specifications collection type:** Updated the “Depression medications – adolescent” and the “Additional evaluation for depression – adolescent” value sets to include additional medications. After consideration of the comments, we are finalizing the changes as indicated to measure Q134 for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.17. Oncology: Medical and Radiation – Pain Intensity Quantified

Category	Description
NQF # / eCQM NQF #:	0384/0384e
Quality #:	143
CMS eCQM ID:	CMS157v8
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.
Substantive Change:	**Updated Guidance: For the eCQM Specifications collection type:** This measure is an episode-of-care measure; the level of analysis for this measure is every visit for patients with a diagnosis of cancer who are also currently receiving chemotherapy or radiation therapy during the measurement period. For patients receiving radiation therapy, pain intensity should be quantified at each radiation treatment management encounter where the patient and physician have a face-to-face interaction. Due to the nature of some applicable coding related to the radiation therapy (e.g., delivered in multiple fractions), the billing date for certain codes may or may not be the same as the face-to-face encounter date. In this instance, for the reporting purposes of this measure, the billing date should be used to pull the appropriate patients into the initial population. It is expected, though, that the numerator criteria would be performed at the time of the actual face-to-face encounter during the series of treatments. For patients receiving chemotherapy, pain intensity should be quantified at each face-to-face encounter with the physician while the patient is currently receiving chemotherapy. For purposes of identifying eligible encounters, patients "currently receiving chemotherapy" refers to patients administered chemotherapy within 30 days prior to the encounter AND administered chemotherapy within 30 days after the date of the encounter.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to update the guidance within the eCQM Specifications collection type to address the limitations of the radiation treatment management code 77427 and to provide clarification about the variation in how this code is applied versus how the measure performance is assessed.
We received no comments on the substantive changes proposed for measure Q143: Oncology: Medical and Radiation – Pain Intensity Quantified. Therefore, we are finalizing the changes to measure Q143 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.18. Oncology: Medical and Radiation - Plan of Care for Pain

Category	Description
NQF # / eCQM NQF #:	0383
Quality #:	144
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician.
Substantive Change:	**Updated the description to read**: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain. **Updated the denominator to read:** All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy who report having pain All visits for patients, regardless of age, with a diagnosis of cancer currently receiving radiation therapy who report having pain **Updated the numerator to read:** Patient visits that included a documented plan of care to address pain
Steward:	American Society of Clinical Oncology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to revert this measure to the 2018 performance period measure specification. The 2019 measure narrows the patient population to those who report moderate to severe pain and require the plan of care before or on the data of the second visit with the clinician. The measure steward has submitted this version to NQF for re-endorsement where the measure steward received feedback to further test the updated analytics. As such, we agree with reverting to the NQF-endorsed measure. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

Comment: One commenter supported the substantive change proposed for measure Q144: Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain and reverting this measure to the 2018 performance period measure specifications. The commenter stated that the 2019 measure narrowed the patient population to those who report moderate to severe pain and requires the plan of care before or on the data of the second visit with the clinician. The measure steward has submitted this version to NQF for re-endorsement and received feedback to further test the updated analytics. The commenter also recommended that the measure title be changed to "Oncology: Medical and Radiation - Plan of Care for Pain," in order to align with the proposed reversion to 2018 specifications.

Response: We thank the commenter for supporting the revision to measure Q144. We agree that the title should align with the finalized revisions, and have reflected this update.

We proposed a substantive change to the denominator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:
Updated the denominator to read:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain. This additional refinement does not affect the intent of the proposed substantive change.
We proposed to revert the measure to the 2018 MIPS version; however, during public comment it was noticed that the title was not updated to align with revisions being made to measure Q144. The title is being updated to state:
Oncology: Medical and Radiation - Plan of Care for Pain
These additional refinements ensure that the measure was reverted to the 2018 MIPS version of the specification and to be in alignment with the NQF-endorsed measure as proposed.

There were no additional refinements to substantive changes:
Updated the description to read: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.

All visits for patients, regardless of age, with a diagnosis of cancer currently receiving radiation therapy who report having pain

Updated the numerator to read: Patient visits that included a documented plan of care to address pain

After consideration of the comments, we are finalizing the changes to measure Q144 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.19. Rheumatoid Arthritis (RA): Tuberculosis Screening

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	176
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).
Substantive Change:	**Updated definition:** Biologic DMARD Therapy- Includes Abatacept (Orencia), Adalimumab (Humira), Adalimumab-adbm (Cyltezo), Adalimumab-atto (Amjevita), Anakinra (Kineret), Baricitinib (Olumiant), Certolizumab pegol (Cimzia), Etanercept (Enbrel), Etanercept-szzs (Erelzi), Golimumab (Simponi), Infliximab (Remicade), Infliximab-abda (Renflexis), Infliximab-dyyb (Inflectra), Infliximab-qbtx (Ixifi), Sarilumab (Kevzara), Tocilizumab (Actemra), Tofacitinib (Xeljanz).
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to add Baricitinib (olumiant) and remove Rituximab (Rituxan) to the definition of "Biologic DMARD Therapy" as it was approved in 2018 by the FDA for the treatment of rheumatoid arthritis. We agree with the inclusion of Baricitinib in order to capture the relevant patient population. This revision allows eligible clinicians to achieve performance with use of a new pharmacological therapy to treat RA.
We received no comments on the substantive changes proposed for measure Q176: Rheumatoid Arthritis (RA): Tuberculosis Screening. Therefore, we are finalizing the changes to measure Q176 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.20. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity

Category	Description
NQF # / eCQM NQF #:	2523
Quality #:	177
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment of disease activity at ≥50% of encounters for RA for each patient during the measurement year.
Substantive Change:	**Updated description:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment of disease activity using an ACR-preferred RA disease activity assessment tool at ≥50% of encounters for RA for each patient during the measurement year. **Updated definition:** Removed Patient Activity Scale (PAS) from definition of "Assessment of Disease Activity".
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	The measure steward recently conducted an assessment of available RA disease activity tools and is updating the list of tools they will endorse. The Patient Activity Scale (PAS) will no longer be an ACR-preferred rheumatoid arthritis disease activity measurement tool and as such, we proposed to remove this scale as an acceptable assessment tool within this measure and update the description to align with this revision.
We received no comments on the substantive changes proposed for measure Q177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity. Therefore, we are finalizing the changes to measure Q177 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.21. Rheumatoid Arthritis (RA): Glucocorticoid Management

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	180
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.
Substantive Change:	**The measure description is revised to read:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months. **The numerator is revised to read:** Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months.
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed that this measure be revised to expand the numerator population being assessed for improvement or no change in disease activity by dropping the prolonged doses of prednisone from ≥ 10 mg daily (or equivalent) to > 5 mg daily (or equivalent). The measure steward conducted literature review that found a nearly 2-fold greater serious infection at 5-10 mg of prednisone in RA. This change takes into consideration the dangers to patients associated with being on 5-10 mg doses of prednisone. We agree with the decision to drop the dosage of prednisone to > 5 mg daily (or equivalent) given it aligns more closely to dosing associated with patient risk and it is important to include these patients in the population being assessed for improvement or no change.
We received no comments on the substantive changes proposed for measure Q180: Rheumatoid Arthritis (RA): Glucocorticoid Management. Therefore, we are finalizing the changes to measure Q180 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.22. Elder Maltreatment Screen and Follow-Up Plan

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	181
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.
Substantive Change:	**Updated denominator:** Added physical and occupational therapy, ophthalmology, audiology and speech language pathology MIPS eligible clinician types.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed, based upon requests from stakeholders, that coding be added to the denominator eligible encounters to include physical/occupational therapy, ophthalmology, audiology and speech language pathology MIPS eligible clinician types. This expansion of the numerator allows this measure to be used in an additional setting. We agree that this measure is clinically relevant for the physical therapy setting.
Comment: One commenter supported the addition of the physical therapy codes to measure Q181: Elder Maltreatment Screen and Follow-Up Plan. **Response:** We thank the commenter for supporting the revision to measure Q181. Also, note, we acknowledge eligible clinicians providing occupational therapy services were previously eligible to submit this measure and are not being newly added to measure Q182; however, the coding for occupational therapy has been expanded within the measure. After consideration of the comments, we are finalizing the changes to measure Q181 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.23. Functional Outcome Assessment

Category	Description
NQF # / eCQM NQF #:	2624
Quality #:	182
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.
Substantive Change:	**Updated denominator:** Added mental/behavioral health, audiology, and speech language pathology MIPS eligible clinicians.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed that the denominator be expanded to include coding for more MIPS eligible clinicians. We agree with the decision to expand the MIPS eligible clinician types as it is clinically relevant to this clinician type and allows for the removal of duplicative quality measures promoting functional assessment.

Comment: One commenter requested that CMS include RA diagnosis codes in measure Q182: Functional Outcome Assessment if measure Q178: Rheumatoid Arthritis (RA): Functional Status Assessment measure was finalized for removal from MIPS, which would allow rheumatologists to be compared to peers who report this measure.

Response: We thank the commenter for their comment. Measure Q182 only includes settings without any diagnosis coding within the denominator criteria as this is a broadly applicable measure. We encourage the commenter to reach out to the measure steward in order to collaborate on revisions for proposal in future years.

After consideration of the comments, we are finalizing the changes to measure Q182 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years, with the exception of the inclusion of mental/behavioral health MIPS eligible clinicians in the denominator. The measure steward would like to further discuss this expansion with their expert work group before including these codes to ensure they are appropriate for measure Q182.

D.24. Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Category	Description
NQF # / eCQM NQF #:	0565 / 0565e
Quality #:	191
CMS eCQM ID:	CMS133v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.
Substantive Change:	**The measure description is revised to read:** Percentage of cataract surgeries for patients aged 18 and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery. **The initial population is revised to read: For the eCQM Specifications collection type:** All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria. **The denominator is revised to read: For the MIPS CQMs Specifications collection type:** All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria. **The denominator exclusion is revised to read:** Cataract surgeries in patients with significant ocular conditions impacting the visual outcome of surgery. **Update denominator exclusions:** Removed the following data elements/value sets: 'Chorioretinal Scars,' 'Moderate or Severe Impairment, Better Eye, Profound Impairment, Lesser Eye,' 'Other Corneal Deformities,' 'Other Disorders of Sclera,' 'Other Retinal Disorders,' and 'Profound Impairment, Both Eyes'. Add the following data elements/value sets: 'Cataract, Congenital,' 'Cataract, Mature or Hypermature,' 'Cataract, Posterior Polar,' 'Hypotony of Eye,' 'Macular Scar of Posterior Polar' (new value set), 'Morgagnian Cataract,' 'Posterior Lenticonus,' 'Retrolental Fibroplasias,' 'Traumatic Cataract,' and 'Vascular Disorders of Iris and Ciliary Body'. **The numerator is revised to read:** Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed that the measure language be updated to reflect that it is not a patient-based measure, but rather a measure that assesses cataract surgeries. The measure steward believes and we agree this update in language better aligns to the measure intent and implementation and also aligns with the current measure guidance. The measure steward convened an Eye Care technical expert panel (TEP) who also agreed that these language updates would provide more clarity around the intent, and be more explicit. The Eye Care TEP also reviewed and evaluated the denominator exclusions resulting in removal and addition of data elements/value sets outlined above.

Category	Description
	Comment: One commenter opposed the substantive change to measure Q191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery (eCQM: CMS133v8). Within the context of this comment, the commenter opposed the removal of measure Q192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures (eCQM: CMS132v8), including to the changes to 2020 eCQM specifications for Q191 and Q192 (see response under Table C for further details on measure Q192). The commenter stated that for the past several years, the guidance language included in these measure specifications directly conflicted with the numerator and denominator specifications, which are used for calculation. The eligible population has been very clearly defined as "All patients aged 18 years and older who had cataract surgery and did not meet any exclusion criteria", and the numerator was also very clearly specified as "patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery." The measure guidance language, however, said that every cataract surgery during the measurement period should be counted. This has been a flaw in the measure specification, and because both instructions cannot be true, the numerator and denominator language are what has been used for implementation over the past several years. For 2020, the measure owner, PCPI, changed the verbiage for these measures from "Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract…" to "Percentage of cataract surgeries for patients aged 18 years and older…". The commenter indicated this change is very concerning because it significantly increases reporting burden for ophthalmologists reporting the measure. The commenter stated that the guidance language that PCPI introduced into the specifications for the 2020 reporting year should be clarified to explain that measure evaluation should be at the per patient level. The commenter stated that the proposed change should not be finalized for the MIPS CQM versions of the measures and should be reversed for the eCQM versions of measures Q191 and Q192, which have already been published. **Response:** We thank the commenter for their comment; however, the language change aligns with the measure intent and implementation, which is episode-based and not patient-based per the measure steward. The measure steward convened an Eye Care technical expert panel (TEP) that agreed these changes would be more explicit regarding the measure intent. We believe an episode-based measure gives a more complete data set as the outcome for the operative eye from every cataract surgery should be analyzed for best-corrected visual acuity. We proposed a substantive change to the description; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state: **The measure description is revised to read:** Percentage of cataract surgeries for patients aged 18 years and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery. This additional refinement aligns language throughout the specification and does not affect the intent of the proposed substantive change. Additionally, the denominator exclusion language revision will be finalized for the eCQM Specifications collection type only as the language within the MIPS CQMs Specifications collection type correctly reflects the intent of the denominator exclusion. There were no additional refinements to substantive changes: **The initial population is revised to read: For the eCQM Specifications collection type:** All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria. **The denominator is revised to read: For the MIPS CQMs Specifications collection type:** All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria. **The denominator exclusion is revised to read:** Cataract surgeries in patients with significant ocular conditions impacting the visual outcome of surgery. **Update denominator exclusions:** Removed the following data elements/value sets: 'Chorioretinal Scars,' 'Moderate or Severe Impairment, Better Eye, Profound Impairment, Lesser Eye,' 'Other Corneal Deformities,' 'Other Disorders of Sclera,' 'Other Retinal Disorders,' and 'Profound Impairment, Both Eyes'. Add the following data elements/value sets: 'Cataract, Congenital,' 'Cataract, Mature or Hypermature,' 'Cataract, Posterior Polar,' 'Hypotony of Eye,' 'Macular Scar of Posterior Polar' (new value set), 'Morgagnian Cataract,' 'Posterior Lenticonus,' 'Retrolental Fibroplasias,' 'Traumatic Cataract,' and 'Vascular Disorders of Iris and Ciliary Body'. **The numerator is revised to read:** Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery After consideration of the comments, we are finalizing the changes as indicated to measure Q191 for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.25. Functional Status Change for Patients with Knee Impairments

Category	Description
NQF # / eCQM NQF #:	0422
Quality #:	217
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status for patients aged 14 years+ with knee impairments. The change in functional status (FS) is assessed using the Knee FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the knee impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1009) identifying the close of a Treatment Episode for the same knee deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional knee deficit, progressing through treatment without interruption (for example a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a knee deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with knee impairments who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. The numerator is revised to read: Patients who were presented with the Knee FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met.

Category	Description
	We agree with this change and believe it creates a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance rate. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the knee impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1009) identifying the close of a Treatment Episode for the same knee deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional knee deficit, progressing through treatment without interruption (for example a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a knee deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with knee impairments who have initiated a Treatment Episode.

Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Knee FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q217: Functional Status Change for Patients with Knee Impairments. Therefore, we are finalizing the changes to measure Q217 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.26. Functional Status Change for Patients with Hip Impairments

Category	Description
NQF # / eCQM NQF #:	0423
Quality #:	218
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with hip impairments. The change in functional status (FS) is assessed using the Hip FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the hip impairment successfully calculated and the score was less than zero (< 0)" will become Performance Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1010) identifying the close of a Treatment Episode for the same hip deficit identified at Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional hip deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a hip deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with hip impairments who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care no indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.). (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. **The numerator is revised to read**: Patients who were presented with the Hip FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met. We agree with this change and believe it creates a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance rate. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the hip impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1010) identifying the close of a Treatment Episode for the same hip deficit identified at Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional hip deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a hip deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with hip impairments who have initiated a Treatment Episode.

Updated denominator exceptions: Added the following:
(1) Ongoing care no indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.).
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Hip FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q218: Functional Status Change for Patients with Hip Impairments. Therefore, we are finalizing the changes to measure Q218 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.27. Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments

Category	Description
NQF # / ECQM NQF #:	0424
Quality #:	219
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with foot, ankle and lower leg impairments. The change in functional status (FS) assessed using the Foot/Ankle FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot, or ankle impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1011) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional lower leg, foot or ankle deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a foot, ankle or lower leg deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with foot, ankle or lower leg impairments who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care no indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. **The numerator is revised to read:** Patients who were presented with the Foot/Ankle FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes

Category	Description
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met. We agree with this change and believe it creates a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance rate. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot, or ankle impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1011) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional lower leg, foot or ankle deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a foot, ankle or lower leg deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with foot, ankle or lower leg impairments who have initiated a Treatment Episode.

Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care no indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Foot/Ankle FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q219: Functional Status Change for Patients with Lower Leg, Foot, or Ankle Impairments. Therefore, we are finalizing the changes to measure Q219 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.28. Functional Status Change for Patients with Low Back Impairments

Category	Description
NQF # / ECQM NQF #:	0425
Quality #:	220
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with low back impairments. The change in functional status (FS) is assessed using the Low Back FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the low back impairment successfully calculated and the score was less than zero (< 0)" will become Performance Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the low back and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a low back impairment, who has had an interruption of a Treatment Episode for the same functional low back deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1012) identifying the close of a Treatment Episode for the same low back deficit identified at Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a Discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional low back deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a low back functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with a low back impairment who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. The numerator is revised to read: Patients who were presented with the Low Back FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met. We agree with this change and believe it creates a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the low back impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the low back and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a low back impairment, who has had an interruption of a Treatment Episode for the same functional low back deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1012) identifying the close of a Treatment Episode for the same low back deficit identified at Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a Discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional low back deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a low back functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with a low back impairment who have initiated a Treatment Episode.

Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Low Back FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q220: Functional Status Change for Patients with Low Back Impairments. Therefore, we are finalizing the changes to measure Q220 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.29. Functional Status Change for Patients with Shoulder Impairments

Category	Description
NQF # / ECQM NQF #:	0426
Quality #:	221
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the shoulder impairment successfully calculated and the score was less than zero (< 0)" will become Performance Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1013) identifying the close of a Treatment Episode for the same shoulder deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional shoulder deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a shoulder functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with shoulder impairments who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. **The numerator is revised to read:** Patients who were presented with the Shoulder FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met. We agree with this change and believe it creates a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance rate. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the shoulder impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1013) identifying the close of a Treatment Episode for the same shoulder deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional shoulder deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a shoulder functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with shoulder impairments who have initiated a Treatment Episode.

Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Shoulder FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q221: Functional Status Change for Patients with Shoulder Impairments. Therefore, we are finalizing the changes to measure Q221 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.30. Functional Status Change for Patients with Elbow, Wrist or Hand Impairments

Category	Description
NQF # / ECQM NQF #:	0427
Quality #:	222
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS is assessed using the Elbow/Wrist/Hand FS patient-reported outcome measure (PROM) (©2009-2019 Focus on Therapeutic Outcomes, Inc.) The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static measure).
Substantive Change:	**Updated numerator:** Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist, or hand impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met. **Updated definitions:** Removed: (1) Admission (Option 1 & 2) (2) Admission (Option 3 & 4) (3) Discharge (Option 1 & 2) (4) Discharge (Option 3 &4) Added: (1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the elbow, wrist, or hand and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with an elbow, wrist, or hand impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation. (2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1014) for identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode. Updated: Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional elbow, wrist or hand deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician. **Updated denominator:** Consolidated all options into one denominator criteria. **The denominator is revised to read**: All patients 14 years and older with elbow, wrist or hand impairments who have initiated a Treatment Episode. **Updated denominator exclusions:** Added the following: (1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care. **Updated denominator exceptions:** Added the following: (1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown). (2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only). Moved from denominator exclusion to denominator exception (1) Patient refused to participate. **The numerator is revised to read:** Patients who were presented with the Elbow/Wrist/Hand FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes

Category	Description
Measure Type:	Patient Reported Outcome
Rationale:	We proposed the numerator be updated to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change, making a score of less zero non-compliant and thus a Performance Not Met. We agree with this change and believe it will create a more robust outcome measure as it is looking for a meets or exceeds. The denominator exclusions and exceptions are being updated with clinically relevant reasons for exclusion from the denominator or the performance rate. The current denominator exclusions are being moved to denominator exceptions as this aligns better with the measure workflow. In addition, we proposed to consolidate the denominator options 1, 2, 3, and 4 into one denominator criteria for ease of use. The denominator definitions, denominator, and numerator are being updated to align with these changes. We agree with these changes as they make implementation of the measure less burdensome for the clinician. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson's diagnosed at any time before or during the episode of care. This additional refinement does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist, or hand impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the elbow, wrist, or hand and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with an elbow, wrist, or hand impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1014) for identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional elbow, wrist or hand deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with elbow, wrist or hand impairments who have initiated a Treatment Episode.
Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Elbow/Wrist/Hand FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

We received no comments on the substantive changes proposed for measure Q222: Functional Status Change for Patients with Elbow, Wrist, or Hand Impairments. Therefore, we are finalizing the changes to measure Q222 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.31. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Category	Description
NQF # / ECQM NQF #:	0028 / 0028e
Quality #:	226
CMS eCQM ID:	CMS138v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months. b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention. c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Substantive Change:	**The measure description is revised to read:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months. b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention. c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. **Updated denominator: For the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types:** Added physical therapy MIPS eligible clinician type. **Updated Guidance: For the Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection types:** Added: (1) The denominator of population criteria 2 is a subset of the resulting numerator for population criteria 1, as population criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, population criteria 1 and 3 are applicable, but population criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the initial population criteria will only be submitted for population 1 and 3, whereas data submitted for population 2 will be for a subset of patients who meet the initial population criteria, as the denominator has been further limited to those who were identified as tobacco users. (2) To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements. **Updated instructions: For the MIPS CQM Specifications collection types:** This measure is to be submitted a minimum of once per performance period for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who provided the measure-specific denominator coding. For this implementation of the measure, the 24 month look back period includes the program year and the year prior. For Quality Payment Program (QPP) 2020, the 24 month period would be from 1/1/2019-12/31/2020. **Updated guidance: For the CMS Web Interface Measure Specifications collection types:** • If there is more than 1 patient query regarding tobacco use, use the most recent query during the 24-month period to determine tobacco status. • "Within 24 months" is defined as the 24-month look-back from the measurement period end date (1/1/2019 - 12/31/2020). • Screening for tobacco use may be completed during a telehealth encounter. • Tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician. • Screening for tobacco use and cessation intervention do not have to occur on the same encounter, but both must occur during the 24-month look-back period. • Screening for tobacco use and cessation intervention may be completed during a telehealth encounter. • Tobacco cessation intervention may be completed during a telehealth encounter.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process

Category	Description
Rationale:	We proposed that the measure description be revised to clarify the summarized intent for population criteria 2. Based upon requests from stakeholders, physical therapy evaluation codes was also proposed for addition in the denominator eligible encounters for the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection types to allow for this measure to be used in an additional setting. We agree that this preventive assessment is a clinically relevant measure for clinicians in the physical therapy setting. We proposed refinements to the guidance for the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, eCQM Specifications, and MIPS CQMs Specifications collection types in response to stakeholder feedback regarding the timing for which tobacco cessation intervention must occur. In response to our determination and stakeholder feedback for the CMS Web Interface Measure Specifications, Medicare Part B Claims Measure Specifications, and MIPS CQMs Specifications collection types, we proposed to allow a 24-month period to assess for tobacco cessation intervention. These refinements are in alignment with the clinical guidelines and will decrease burden for eligible clinicians performing tobacco screening and tobacco cessation intervention. The timing refinement as proposed would maintain the balance of clinical guideline and measure alignment, and support our effort to reduce burden for measure submission. Additionally, this timing refinement allows the clinician to create personalized, patient-centered care while still maintaining the clinical integrity of the measure and clinical guidelines. The CMS Web Interface Measure Specifications collection type was updated with additional guidance in order to add clarity regarding how this measure is implemented using that collection type. We also proposed updates to the instructions for MIPS CQMs Specifications collection types to further clarify the timing of the tobacco cessation intervention in alignment with the updated numerator guidance. We agree this proposal will maintain clinical intent, provide clarity, reduce clinician burden, and allow for personalized patient care. We also proposed updates to guidance for the Medicare Part B Claims Measure Specifications, eCQM Specifications, and MIPS CQMs Specifications collection types based upon stakeholder feedback requesting clarification regarding interpretation of the three rates included in this measure.

Category	Description
Comment: Several commenters supported the substantive change for the Web Interface for measure Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention for the 2020 Performance Period as the change adds clarity to the measure. Another commenter supported the addition of the physical therapy codes to the measure. One commenter reviewed the proposed changes to the CMS Web Interface Measure Specifications collection type for measure Q226 and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for 2019 and 2020 MIPS performance periods. One commenter indicated that CMS and the measure owner have been unable to provide sufficient clarity about this measure to make the results fair, accurate, or meaningful. There is no consistent guidance on what tobacco is. For some, it includes only cigarettes and cigars. For others, it includes snuff, snus, and other smokeless tobacco products. And, there has been a lack of clarity regard how a person must be referred following a positive initial screen. The commenter recommended that until there is a clearer understanding of PREV-10 requirements, that CMS make this pay-for-reporting measure for 2020 for MSSP and Next Generation ACOs. One commenter supported proposed revisions to measure Q226 that would add in telehealth encounters to be included as eligible encounters. One commenter recommended that physical therapists not be included in the denominator for ACO-17 (measure Q226), as this smoking cessation counseling is outside the scope of physical therapy. The commenter urged CMS to carefully study the impact of such changes on performance and benchmarks for this measure. Another commenter supported the proposed change to measures Q226 as it greatly reduce provider burden. **Response:** We thank the commenters for supporting the revision to measure Q226. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measure Specifications collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For this substantive change, we disagree with the commenter that the measure should be excluded from MIPS scoring for the 2020 MIPS performance period as these changes align with the measure intent per feedback for the measure steward as the intent "of the measure is to screen patients for any and all types of tobacco use, as the guidelines that exist support intervention for any type of tobacco use, not just limited to smoking. That being said, measures are not guidelines and there is a decision that must be made by measure developers regarding how to construct a measure keeping in mind the evidence and ensuring that the resulting measure is feasible, useable, and positively impacts patient care. Therefore, for purposes of the measure, as long as a provider has documented status for any type of tobacco (that is., smokes or uses smokeless tobacco), that meets the first component of the numerator and contributes to the aim of improving care." Additionally, the guidance states "If a patient uses any type of tobacco (that is, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy." The measure specification also gives a definition for what suffices as "tobacco cessation intervention" and the guidance includes clarity that the tobacco cessation intervention can be performed by another healthcare provider in order to promote a team-based approach to patient care. Additionally, we will continue to require this measure for groups, APM Entities, and virtual groups reporting through the CMS Web Interface Measure Specifications collection type. However, due to the mid-year change to the measure specification (as discussed in more detail under section III.E.1.b) for Q226 in program year 2019, we are redesignating the CMS Web Interface Measure Specifications collection type for measure Q226 as "pay-for-reporting" in the Shared Savings Program as provided in § 425.502(a)(5) and we will exclude the measure from MIPS scoring in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement and the measure was reported through the CMS Web Interface Measure Specifications collection type. For further discussion on how this measure will be scored under the MIPS Program Quality Performance Category see section III.K.3.c.(1) of this final rule. For further discussion on how this measure will be scored under the Shared Savings Program see section III.E.1.b of this final rule. Regarding the commenter concerned with the CMS Web Interface Measure Specifications collection type and the eCQM Specifications collection type being out of alignment if this change is finalized, we believe this change brings these two collection types in alignment. After consideration of the comments, we are finalizing the changes to measure Q226 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years, except for the expansion of the denominator to include the physical therapy MIPS eligible clinician type for the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types. However, because we value stakeholder feedback the measure steward has agreed to collect expert work group feedback regarding the request to expand the denominator to include physical therapy MIPS eligible clinician type prior to implementation.	

D.32. Controlling High Blood Pressure

Category	Description
NQF # / ECQM NQF #:	0018 / N/A
Quality #:	236
CMS eCQM ID:	CMS165v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.
Substantive Change:	**The measure description is revised to read:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period. **Updated denominator: For the eCQM Specifications collection type:** Removed Blood Pressure Visit grouping value set and added in the individual value sets. **Updated denominator exclusions: For eCQM Specifications collection type:** Added the following: (1) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period. (2) Patients 66 year of age and older with advanced illness and frailty. **For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type:** Updated: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Added: (1) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (3) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine **Updated numerator/guidance:** Updated to allow blood pressures taken by a clinician from remote monitoring devices in a medical setting or in an offsite setting (that is, patient's domicile) to count towards the measure with additional clarification regarding usable blood pressure readings: -Not requiring the numerator blood pressure reading to be during a visit or overlap with a diagnosis of hypertension. (Applicable to eCQM only). -If the day of the last blood pressure reading there are multiple blood pressure readings on that day, use the lowest systolic and diastolic on that day. -The blood pressure reading that is being used should not come from an ED or inpatient visit. -Do not include blood pressure readings reported by or taken by the patient.
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Intermediate Outcome

Category	Description
Rationale:	We proposed for the eCQM specifications collection type: In order to increase transparency of which value set is being used for encounters, the "Blood Pressure Visit" grouping value set is being removed so that individual value sets will be used. We proposed to update the allowable denominator exclusions to include patients 66 years of age and older with advanced illness and frailty, patients with dementia taking the listed medications, and patients who are living in a long-term institutional setting, such as a nursing home, for more than 90 days during the measurement period. The measure steward believes and we agree it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might be harmful for patients to receive a particular service when they should prioritize other services. Additionally, we believe that some of the services in this measure are not appropriate for patients who are living in a long-term institutional setting for more than 90 days during the measurement period. We believe that by removing these patient populations, the burden to submit data is lessened for these MIPS eligible clinicians. Additionally, we proposed the measure guidance be updated to align with the 2018 measure guideline updates making it so that a visit is no longer required for the numerator blood pressure reading with additional guidance that blood pressure should not be taken during major events as this can artificially elevate blood pressure. In alignment with this, blood pressure readings from an ED or inpatient visit should not be used as a numerator blood pressure reading. The guidance is also being updated to allow blood pressure readings taken by a clinician from remote monitoring devices in a medical setting or in an offsite setting (that is, patient's domicile) to be numerator compliant. Patient reported blood pressure readings cannot be used for numerator compliance.

Comment: One commenter opposed not implementing the exclusion for adults 80 and older with frailty for measure Q236: Controlling High Blood Pressure. This exclusion is critical for focusing the measures on the population most likely to benefit from the measured services. Without this exclusion, this measure will be out of alignment with what is required for reporting.

One commenter expressed concern with the proposal on measure Q236 to update the denominator exclusions to exclude those who are living in a long-term institution setting, such as a nursing home. Rather than excluding these patients, who could benefit from high quality care, the commenter believed it is critical to ensure these patients receive the care they need.

Response: We thank the commenter for their comment, however this revision was not proposed and would be considered substantive. We believe introducing this concept without collaboration and clarification with the measure steward may create implementation variability for eligible clinicians. Therefore, we would encourage the commenter to work with the measure steward to incorporate this revision for future years. We thank the commenter for their comment expressing concern over the proposed changes to the denominator exclusions. The denominator exclusion for patients living long term in an institution is not new to this measure, but is being updated to require the patient to have spent more than 90 days within an institution, therefore, no longer excluding all patients who have lived in an institute during the measurement period. We disagree with the commenter that the measure should be made pay-for-reporting for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the updated denominator exclusions do not significantly change the patient population, but work to create a more relevant patient population for the quality action, which remains unchanged. We do not believe the revisions to the numerator/guidance are significant and will allow for direct comparison of performance data from prior years.

Comment: One commenter supported the denominator exclusions added for frailty for ACO-28 (measure Q236): Hypertension, Controlling High Blood Pressure. The commenter also requested that the age restriction is removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age. The commenter recommended the following exclusion: Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting.

Response: We thank the commenter for supporting the revision to measure Q236. We encourage the commenter to reach out to the measure steward and collaborate regarding further refinement of the denominator exclusions.

Comment: One commenter reviewed the proposed changes to the CMS Web Interface Measures Specification type for measure Q236 and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for the 2019 and 2020 MIPS performance periods.

Response: We thank the commenter for their comment. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For this substantive change, we disagree with the commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the updated denominator exclusions do not significantly change the patient population, but work to create a more relevant patient population for the quality action, which remains unchanged. We do not believe the revisions to the numerator/guidance are significant and will allow for direct comparison of performance data from prior years.

For the eCQM specifications collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state:
(1) Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
This additional refinement does not affect the intent of the proposed substantive change.

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs collection type, we proposed a substantive change to the denominator exclusions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:
(2) Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 days during the measurement period
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified and to decrease clinician burden by outlining the coding for the denominator exclusion for measure Q001 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following;
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
(4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine
Miscellaneous central nervous system agents: Memantine

Category	Description
The measure description is revised to read: Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period. **Updated denominator: For the eCQM Specifications collection type:** Removed Blood Pressure Visit grouping value set and added in the individual value sets. **Updated numerator/guidance:** Updated to allow blood pressures taken by a clinician from remote monitoring devices in a medical setting or in an offsite setting (that is, patient's domicile) to count towards the measure with additional clarification regarding usable blood pressure readings: -Not requiring the numerator blood pressure reading to be during a visit or overlap with a diagnosis of hypertension. (Applicable to eCQM only). -If the day of the last blood pressure reading there are multiple blood pressure readings on that day, use the lowest systolic and diastolic on that day. -The blood pressure reading that is being used should not come from an ED or inpatient visit. -Do not include blood pressure readings reported by or taken by the patient. After consideration of the comments, we are finalizing the changes as indicated to measure Q236 for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.33. Use of High-Risk Medications in the Elderly

Category	Description
NQF # / ECQM NQF #:	0022 / N/A
Quality #:	238
CMS eCQM ID:	CMS156v8
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. (1) Percentage of patients who were ordered at least one high-risk medication. (2) Percentage of patients who were ordered at least two of the same high-risk medications.
Substantive Change:	**Updated numerator statement for submission criteria 2:** Percentage of patients who were ordered at least two of the same high-risk medications on different days. **Updated guidance:** Added 'on different days' to align with update to numerator submission criteria 2.
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	The numerator statement for submission criteria 2 was proposed to be updated to clarify that the assessment is looking for high-risk medications that are prescribed on different days, which is in alignment with the intent of the assessment being captured. This update is also reflected in the guidance.
We proposed a substantive change to the numerator statement for submission criteria 2; however; during the quality measure annual revision process with the measure steward, there was additional refinement. Therefore, we are finalizing the substantive change to state: **Updated numerator statement for submission criteria 2:** Patients with at least two orders for the same high-risk medication on different days during the measurement period. This additional refinement does not affect the intent of the proposed substantive change. This additional refinement was to ensure clarity in language so that the clinically appropriate quality action is identified for measure Q238 and does not affect the intent of the proposed substantive change. We received no comments on the substantive changes proposed for measure Q238: Use of High-Risk Medications in the Elderly. Therefore, we are finalizing the changes to measure Q238 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.34. Childhood Immunization Status

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	240
CMS eCQM ID:	CMS117v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday
Substantive Change:	**The measure description is revised to read:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. **Updated numerator:** Added value set for Hepatitis B carriers to allow Hepatitis B carriers to meet this part of the numerator. **Updated definition:** Removed 'Three HiB Vaccinations' and added new definition statements 'HiB 3 Dose Immunizations or Procedures,' 'HiB 4 Dose Immunizations or Procedures,' 'HiB 3 or 4 Dose Immunizations,' 'All HiB Vaccinations,' and 'Has Appropriate Number of HiB Immunizations.' Revised logic to include the correct number of HiB doses depending on the manufacturer of the vaccine given to align with current guidelines. Updated the logic for the HiB vaccine to require the correct amount of doses depending on the manufacturer of the vaccine given. Create a 3 dose and a 4 dose HiB vaccine.
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed that the numerator be updated to include a value set for Hepatitis B carriers in order to allow this patient population to meet Hep B vaccine numerator compliance piece. We agree that this would suffice for the "had documented history of the illness" piece of numerator compliance. Additionally, we proposed that the measure logic be updated for the HiB vaccine to ensure the correct dosing is administered as instructed by the drug manufacturer's instructions and alignment with the current guidelines. The description is also being updated to align with this. We agree the logic should match the dosing of the vaccine given to ensure that the patient is receiving the correct and full dosage.
We received no comments on the substantive changes proposed for measure Q240: Childhood Immunization Status. Therefore, we are finalizing the changes to measure Q240 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.35. Cardiac Rehabilitation Patient Referral from an Outpatient Setting

Category	Description
NQF # / eCQM NQF #:	0643
Quality #:	243
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.
Substantive Change:	**Updated denominator exceptions:** Added (1) Documentation of patient reason(s) for not referring to an outpatient CR program (for example, no traditional CR program available to the patient, within 60 min [travel time] from the patient's home, patient does not have access to an alternative model of CR delivery that meets all criteria for a CR program, patient refused or other patient reasons).
Steward:	American Heart Association
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed a new denominator exception be added to allow for documentation of patient reason(s) for not having a CR referral. The measure stewards believes denominator exceptions are used in select cases to allow for a fairer measurement of quality for those providers with higher risk populations. Exceptions are also used to defer to the clinical judgment of the provider. A MIPS eligible clinician who recommends CR referral to an eligible patient whom then refuses at the time of referral for one or more reasons (for example, lack of transportation, patient preference), will now be able to exclude this patient from the numerator population. In such a case, the MIPS eligible clinician will not be penalized based upon patient reason(s) for not having a CR referral. If the patient has told the physician that he/she does not wish to enroll in a CR program, the MIPS eligible clinician can document in the medical record that he/she has recommended referral but that the patient has refused CR. The measure steward believes this is important because, in this scenario, the MIPS eligible clinician should not be penalized for the lack of a completed CR program referral as long as the CR referral recommendation and the patient refusal are documented. By adding this exception, reasons for patient non-compliance can be better tracked to correspond with implementing practices that may improve compliance and thereby overall clinical care.

We proposed a substantive change to add a denominator exception; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state:

Updated denominator exceptions: Documentation of patient reason(s) for not referring to an outpatient CR program. This additional refinement was to simply the concept in order to allow flexibility in application of the denominator exception identified for measure Q243 and does not affect the intent of the proposed substantive change.

We received no comments on the substantive changes proposed for measure Q243: Cardiac Rehabilitation Referral from an Outpatient Setting. Therefore, we are finalizing the changes to measure Q243 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.36. Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	268
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	All female patients of childbearing potential (12 - 44 years old) diagnosed with epilepsy who were counseled or referred for counseling for how epilepsy and its treatment may affect contraception OR pregnancy at least once a year.
Substantive Change:	**The measure description is revised to read:** Percentage of all patients of childbearing potential (12 years and older) diagnosed with epilepsy who were counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy. **Updated denominator:** All females aged 12 years and older with a diagnosis of epilepsy. **Updated numerator:** Female patients or caregivers counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy **Updated denominator exceptions:** Removed (1) Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy (4340F with 1P) **Updated definition of "Counseling" -** Counseling must include a discussion of at least two of the following three counseling topics: • Need for folic acid supplementation, • Drug to drug interactions with contraception medication, • Potential anti-seizure medications effect(s) on fetal/child development and/or pregnancy.
Steward:	American Academy of Neurology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed that the denominator be expanded to include all females aged 12 years and older and that the denominator exception of "Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy" be removed as there is no longer an exception for patients with a diagnosis of neurodevelopmental disorder, encephalopathy, hydrocephalus, brain injury, cerebral palsy, severe cognitive impairment, or severe intellectual disability. The description is being updated to reflect the changes made to the denominator. The numerator action was updated to require counseling for both contraception and pregnancy in relation to epilepsy and how its treatment may affect. We agree with this requirement as both clinical aspects are important to the patient. The measure steward has requested, and we agree with, the denominator expansion and the removal of the denominator exception as they believe all women diagnosed with epilepsy at risk for pregnancy and/or pregnancy complications should be counseled.

We proposed a substantive change to the denominator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state:

Updated denominator: All females of childbearing potential (12 years and older) with a diagnosis of epilepsy. This additional refinement does not affect the intent of the proposed substantive change.
This additional refinement was to ensure clarity in language so that the clinically appropriate patient population is identified for measure Q268 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
The measure description is revised to read: Percentage of all patients of childbearing potential (12 years and older) diagnosed with epilepsy who were counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy.

Updated numerator: Female patients or caregivers counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy

Updated denominator exceptions: Removed
(1) Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy (4340F with 1P)

Updated definition of "Counseling" - Counseling must include a discussion of at least two of the following three counseling topics:
- Need for folic acid supplementation,
- Drug to drug interactions with contraception medication,
- Potential anti-seizure medications effect(s) on fetal/child development and/or pregnancy.

We received no comments on the substantive changes proposed for measure Q268: Counseling for Women of Childbearing Potential with Epilepsy. Therefore, we are finalizing the changes to measure Q268 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.37. Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	283
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients with dementia for whom there was a documented screening for behavioral and psychiatric symptoms, including depression, and for whom, if symptoms screening was positive, there was also documentation of recommendations for management in the last 12 months.
Substantive Change:	**Update denominator:** Added physical therapy MIPS eligible clinician type.
Steward:	American Psychiatric Association and American Academy of Neurology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed that the denominator coding be expanded to include physical therapy as a denominator eligible encounter. We agree with the decision to expand this measure to physical therapy MIPS eligible clinicians as it is clinically relevant to this clinician type.
We received no comments on the substantive changes proposed for measure Q283: Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management. Therefore, we are finalizing the changes to measure Q283 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.38. Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	286
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients with dementia or their caregiver(s) for whom there was a documented safety concerns screening in two domains of risk: 1) dangerousness to self or others and 2) environmental risks; and if safety concerns screening was positive in the last 12 months, there was documentation of mitigation recommendations, including but not limited to referral to other resources.
Substantive Change:	**Updated denominator:** Added physical therapy MIPS eligible clinician type.
Steward:	American Psychiatric Association and American Academy of Neurology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed that the denominator coding be expanded to include physical therapy as a denominator eligible encounter. We agree with the decision to expand this measure to physical therapy MIPS eligible clinicians as it is clinically relevant to this clinician type.
We received no comments on the substantive changes proposed for measure Q286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia. Therefore, we are finalizing the changes to measure Q286 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.39. Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	290
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of all patients with a diagnosis of Parkinson's Disease [PD] who were assessed for psychiatric symptoms in the past 12 months.
Substantive Change:	**Updated numerator options:** Performance Met: Psychosis, depression, anxiety, apathy, AND impulse control disorder assessed Performance Not Met: Psychosis, depression, anxiety, apathy, AND impulse control disorder not assessed
Steward:	American Academy of Neurology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the numerator options to better align with the intent of the measure, which requires assessment of five individual components of psychiatric symptoms. We agree with the measure steward that this update to the numerator options aligns with the intent of the measure.
We received no comments on the substantive changes proposed for measure Q290: Psychiatric Symptoms Assessment for Patient's with Parkinson's Disease. Therefore, we are finalizing the changes to measure Q290 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.40. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	305
CMS eCQM ID:	CMS137v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. • Percentage of patients who initiated treatment within 14 days of the diagnosis. • Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Substantive Change:	**The measure description is revised to read:** Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. b. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention. **Updated initial population:** Changed intake period for the initial population to January 1 to November 14. Added telehealth services to initial population encounter value sets. **Updated numerator:** Added telehealth services to the numerator encounter value sets. Added Opiate Antagonists for numerator compliance **Numerator 1 is revised to read:** Initiation of treatment includes either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. **Numerator 2 is revised to read:** Engagement in ongoing treatment includes two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention (that is, engagement for these members cannot be satisfied with medication treatment alone).
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed that the initial population and numerator value sets be updated to include telehealth services. We agree with including telehealth services as they are appropriate for this measure and patients using these services should be included in the initial population as well as be considered for numerator compliance. Both numerators are being updated to add pharmacotherapy as a numerator compliant clinical quality action. Numerator 2 is also being updated to reflect the change in the time period for follow-up, which is increasing to 34 days from 30 days and to align with pharmacotherapy addition; patients who initiated treatment with a medication need two or more engagement events where only one can be a medication treatment event.
Comment: One commenter supported proposed revisions to measure Q305: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment that would add in telehealth encounters to be included as eligible encounters. **Response:** We thank the commenter for supporting the revision to measure Q305. After consideration of the comments, we are finalizing the changes to measure Q305 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.41. Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	317
CMS eCQM ID:	CMS22v8
National Quality Strategy Domain:	Community /Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.
Substantive Change:	**Updated numerator: For the eCQM Specifications collection type:** Updated logic to allow for the documentation of a reason (finding of elevated blood pressure or hypertension) for scheduling a follow up visit and added value set "Finding of Elevated Blood Pressure or Hypertension". Added Potassium and Sodium codes to the Dietary Recommendation value set. **Updated numerator definition:** Added potassium and sodium for dietary/lifestyle recommendations.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the logic to allow for the documentation of a reason (finding of elevated blood pressure or hypertension) for scheduling a follow up visit which improves alignment with measure intent. This logic change will include the addition of a new values set "Finding of Elevated Blood Pressure or Hypertension" strengthening alignment with measure intent. We also proposed to add clinically relevant potassium and sodium codes to expand documentation options that align with the measure intent. This will also be reflected in the numerator definition.
Comment: One commenter supported the proposed changes to measure Q317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Document to update the logic to allow for the documentation of a reason for scheduling a follow-up visit. **Response:** We thank the commenter for supporting the revision to measure Q317. After consideration of the comments, we are finalizing the changes to measure Q317 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years except for the updated numerator definition. This update will be made to the logic of the eCQM Specifications collection type through updates within the Dietary Recommendation value set. The definitions as indicated in the 2020 MIPS specification remain appropriate for purposes of implementation.	

D.42. Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

Category	Description
NQF # / eCQM NQF #:	1525
Quality #:	326
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.
Substantive Change:	**Updated denominator:** Removed emergency medicine setting.
Steward:	American College of Cardiology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed and agree with the measure steward's request to remove the emergency department setting. Chronic anticoagulation therapy would be managed by a clinician providing continuous medical care which would not be applicable to the emergency medicine specialty.
We received no comments on the substantive changes proposed for measure Q326: Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy. Therefore, we are finalizing the changes to measure Q326 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.43. Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	332
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.
Substantive Change:	**Updated denominator:** Changed requirements for denominator eligibility Patients aged ≥ 18 years on date of encounter AND **Diagnosis for bacterial and infectious agent** **OR** **Sinusitis caused by, or presumed to be caused by, bacterial infection** AND Patient encounter WITHOUT Telehealth Modifier AND Antibiotic regiment prescribed
Steward:	American Academy of Otolaryngology – Head and Neck Surgery
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed the measure no longer requires a diagnosis for bacterial and infectious agent to be denominator eligible as long as the sinusitis is caused by, or presumed to be caused by, bacterial infection. We agree that this change will not change the intent of the measure, but could lessen the burden to MIPS eligible clinicians by removing the requirement for a diagnosis.

Comment: One commenter responded to the substantive change proposed for measure Q332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) to make the bacterial/infectious agent codes optional. In 2019, these codes are required.

The commenter requested that the substantive change proposed for 2020 be made retroactively to the 2019 measure. The definition of Acute Bacterial Rhinosinusitis (ABRS) in the measure is that it is caused by, or presumed to be caused by, bacterial infection. Providers can diagnosis ABRS based on patient symptomology, thereby presuming it to be caused by a bacterial infection. The provider is prescribing an antibiotic based on that presumption. No culture is necessary. Additionally, requiring the culture results in undue and unnecessary costs for the patient. The commenter indicated the ICD10 codes included in the measure specifications allow for an unspecified diagnosis: J01.00 = acute maxillary sinusitis unspecified; J01.20 = acute ethmoidal sinusitis unspecified. If no culture is done but the provider diagnosis ABRS based on its definition and codes the visit using one of the "unspecified" ICD10 codes, the measure is met, or at least the intent of the measure. The commenter also specified that the measure steward intended the bacterial/infectious agent code to be optional; not required.

Response: We thank the commenter for supporting the revision to measure Q332. As this revision was proposed for the 2020 Performance Period only, it cannot be made retroactively to the 2019 measure specification.

After consideration of the comments, we are finalizing the "Sinusitis caused by, or presumed to be caused by, bacterial infections" denominator criteria be moved to an "OR" statement with "Diagnosis for bacterial and infectious agent" to measure Q332 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

We are not finalizing the removal of the denominator criteria "Diagnosis for acute sinusitis" as this is necessary for determining the correct eligible patient population. The finalized denominator criteria will be as follows:

Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis
AND
Diagnosis for bacterial and infectious agents
OR
Sinusitis caused by, or presumed to be caused by, bacterial infection
AND
Patient encounter
WITHOUT
Telehealth Modifier
AND
Antibiotic regiment prescribed

D.44. Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse)

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	335
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at ≥ 37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication.
Substantive Change:	**The measure title is revised from Elective Delivery or Early Induction Without Medical Indication ≥ 37 and < 39 Weeks (Overuse) to read:** Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse). **The measure description is revised to read:** Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication. **Updated denominator:** Changed to include all deliveries at < 39 weeks of gestation. **Updated numerator:** Numerator options will be updated to reflect the measure now including all deliveries at < 39 weeks gestation.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed the measure population be expanded to include all deliveries at < 39 weeks of gestation. We agree with this change as delivery prior to 39 weeks of gestation increases risk to both the mother and baby. Induction prior to 39 weeks of gestation should only be performed when clinically indicated. It is important to have a complete population to ensure that all instances of early induction are being captured and assessed for proper clinical action.
We received no comments on the substantive changes proposed for measure Q335: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse). Therefore, we are finalizing the changes to measure Q335 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.45. Maternity Care: Postpartum Follow-up and Care Coordination

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	336
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth who received a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, and family and contraceptive planning.
Substantive Change:	**Updated description to read:** Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth and who received a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update. **Updated numerator:** Added clinical actions necessary for numerator compliance (1) Tobacco use screening and cessation education (2) Healthy lifestyle behavioral advice to bring the BMI within healthy limits (3) Immunization review and education
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	Three more components have been added to the list of clinical actions needed at a post-partum visit in order to be numerator compliant. The measure steward convened an expert work group (EWG) who, upon literature review, recommended adding these three clinical activities. The description was updated to align with the additional clinical actions. We agree and proposed that that these clinical actions should be included in a post-partum visit as they will positively impact patient health and are clinically valuable in supporting post-partum patients.

We proposed a substantive change to the numerator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the numerator substantive change to state:
Updated numerator: Added clinical actions necessary for numerator compliance

Updated numerator:
(1) Tobacco use screening and cessation education
(2) Healthy lifestyle behavioral advice
(3) Immunization review and update
This additional refinement was to ensure clarity in language so that the intent of the measure is appropriately captured for measure Q336 and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
Updated description to read: Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth and who received a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.

For clarity of numerator compliance, additional definitions were provided within the Definition Section of the specification for each of the added numerator components.

We received no comments on the substantive changes proposed for measure Q336: Maternity Care: Postpartum Follow-Up and Care Coordination. Therefore, we are finalizing the changes to measure Q336 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.

D.46. Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	337
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.
Substantive Change:	**The description is revised to read:** Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and/or rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test. **The numerator is revised to read:** Patients who have a documented negative TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (that is, chest x-ray, CT) prior to treatment with a biologic immune response modifier.
Steward:	American Academy of Dermatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	Newly published psoriasis clinical guidelines recommend that tuberculosis (TB) screening tests be completed prior to treatment. Numerator compliance for this measure will now have a timing component associated with the TB screening tests and imaging as they need to be completed prior to treatment with a biologic immune response modifier. We agree and proposed this change as it follows the current clinical guidelines.
Comment: One commenter appreciated the substantive change to measure Q337: Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on A Biological Immune Response Modifier. **Response:** We thank the commenter for supporting the revision to measure Q337. After consideration of the comments, we are finalizing the changes to measure Q337 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.47. Pain Brought Under Control Within 48 Hours

Category	Description
NQF # / eCQM NQF #:	0209
Quality #:	342
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours.
Substantive Change:	**Updated denominator:** Added the outpatient setting.
Steward:	National Hospice and Palliative Care Organization
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed that the denominator coding be expanded to include the outpatient setting as an applicable setting. We received prior stakeholder feedback with this request and agree with the decision to expand this measure to the outpatient MIPS eligible clinicians as it is clinically relevant to this setting.
We received no comments on the substantive changes proposed for measure Q342: Pain Brought Under Control Within 48 Hours. Therefore, we are finalizing the changes to measure Q342 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.48. Implantable Cardioverter-Defibrillator (ICD) Complications Rate

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	348
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD.
Substantive Change:	**The measure title is revised from HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate to read:** Implantable Cardioverter-Defibrillator (ICD) Complications Rate.
Steward:	American College of Cardiology Foundation
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed to update the title to align with the measure steward changing from The Heart Rhythm Society to American College of Cardiology Foundation.
We received no comments on the substantive changes proposed for measure Q348: Implantable Cardioverter-Defibrillator (ICD) Complications Rate. Therefore, we are finalizing the changes to measure Q348 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.49. Depression Remission at Twelve Months

Category	Description
NQF # / eCQM NQF #:	0710 / 0710e
Quality #:	370
CMS eCQM ID:	CMS159v8
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date.
Substantive Change:	**Updated denominator:** Allow PHQ-9/PHQ9M to be administered during the index encounter or up to 7 days prior to encounter.
Steward:	Minnesota Community Measurement
High Priority Measure:	No
Measure Type:	Outcome
Rationale:	The measure steward believes that allowing flexibility for the timeframe in which a PHQ-9/PHQ-9M can be obtained will accommodate pre-visit planning or distribution of a PHQ-9/PHQ-9M tool prior to the encounter (office visit, psychiatry or psychotherapy visit, telephone or online encounter). The intent of this change includes the following principles: (1) The patient must have the corresponding diagnosis at the time of the index encounter. (2) The patient must have completed the PHQ-9/PHQ-9M and have a score greater than 9. (3) That same PHQ-9/PHQ-9M is directly tied to and used during the index encounter. We agree and proposed this change as it will allow for pre-visit planning and administration of the tool while also accounting for clinical workflow. Additionally, this revision may lessen the burden of completing the PHQ-9/PHQ-9M tool during the health visit.

Comment: One commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q370: Depression Remission at Twelve Months and questioned whether the changes impact the benchmarks, but urged CMS to explore and consider whether the measure warrants pay-for-reporting for the 2019 and 2020 MIPS performance period. One commenter supported the update to the denominator to allow PHQ-9/PHQ9M to be administered during the index encounter or up to 7 days prior to encounter for measure Q370.

Response: We thank the commenter for their comment. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measures Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For this substantive change, we disagree with the commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the update to allow the screening to occur up to 7 days prior to the encounter better aligns with clinical practices and provides a better opportunity for compliance, however, the quality action being assessed has not changed. We thank the commenter for supporting the revision to measure Q370.

After consideration of the comments, we are finalizing the changes to measure Q370 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.50. Functional Status Assessments for Congestive Heart Failure

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	377
CMS eCQM ID:	CMS90v9
National Quality Strategy Domain:	Person and Caregiver- Centered Experience and Outcomes
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.
Substantive Change:	**Updated numerator:** Added the Minnesota Living with Heart Failure Questionnaire (MLHQF) tool and the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) tool to the list of acceptable FSAs.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	The Minnesota Living with Heart Failure Questionnaire (MLHQF) tool and the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) tool were proposed to be added to the list of numerator compliant tools that may be used to complete the measure's clinical action. The MLHQF tool has previously been approved by the measure steward's expert work group for inclusion in this measure and the KCCQ-12 tool is being included based upon expert feedback and stakeholder requests, as the measure already contains the KCCQ tool. We agree and proposed that both of these tools are relevant and appropriate for inclusion in this measure and, potentially, will capture an increased number of instances that meet numerator requirements.
We received no comments on the substantive changes proposed for measure Q377: Functional Status Assessments for Congestive Heart Failure. Therefore, we are finalizing the changes to measure Q377 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.51. Children Who Have Dental Decay or Cavities

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	378
CMS eCQM ID:	CMS75v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.
Substantive Change:	**The numerator is revised to read:** Children who had cavities or decayed teeth overlapping the measurement period.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed to revise the numerator statement to include a timing component for better alignment with numerator logic.
We received no comments on the substantive changes proposed for measure Q378: Children Who Have Dental Decay or Cavities. Therefore, we are finalizing the changes to measure Q378 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.52. Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	379
CMS eCQM ID:	CMS74v9
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.
Substantive Change:	**The numerator is revised to read:** Children who receive a fluoride varnish application during the measurement period.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the numerator header to align with the numerator logic.
We received no comments on the substantive changes proposed for measure Q379: Primary Caries Prevention as Offered by Primary Care Providers, including Dentists. Therefore, we are finalizing the changes to measure Q379 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.53. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Category	Description
NQF # / eCQM NQF #:	1365e
Quality #:	382
CMS eCQM ID:	CMS177v8
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.
Substantive Change:	**Updated numerator:** Added telehealth data element to "Major Depressive Disorder Encounter" definition using "Telehealth Services" value set (OID: 2.16.840.1.113883.3.464.1003.101.12.1031). **Updated guidance:** A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone. **Updated numerator definition:** The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: (1) Risk (for example, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (for example, religious belief, concern not to hurt family) that may influence the desire to attempt suicide. (2) Current severity of suicidality. (3) Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	The measure steward's Technical Expert Panel (TEP) recommended adding telehealth services to the numerator eligible encounters. We agree and proposed that performing suicide risk assessments is a clinically relevant action that should be completed by MIPS eligible clinicians providing telehealth services for patients diagnosed with major depressive disorder. It is important for patient safety that this clinical action is being performed on all patients with this diagnosis regardless of setting. The guidance and numerator definition are being updated per TEP recommendations to clarify that while sample assessments are listed, they are not reflected in the coding of this measure because the assessments do not meet all of the requirements for the suicide risk assessment.

Comment: One commenter supported proposed revisions to measure Q382: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment that would add in telehealth encounters to be included as eligible encounters.

Response: We thank the commenter for supporting the revision to measure Q382.

After consideration of the comments, we are finalizing the changes to measure Q382 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.54. Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	385
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.
Substantive Change:	**Updated denominator exclusion:** Added an exclusion to remove patients with a pre-operative visual acuity of better than 20/40.
Steward:	American Academy of Ophthalmology
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed to revise this measure to include a denominator exclusion to account for patients with a pre-operative visual acuity better than 20/40, as these patients would not be expected to show an improvement in visual acuity following surgical intervention. We believe these patients should be excluded based upon expected visual acuity outcomes. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
Comment: One commenter supported the substantive change to add the exclusion to measure Q385, Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery, for patients with a pre-operative visual acuity of better than 20/40. This change was suggested by the commenter because, for these patients with good preoperative visual acuity, a successful retinal detachment repair will maintain this, and so thus, there could not be a measurable improvement in visual acuity. Therefore, it is appropriate to exclude these patients from the measure. **Response:** We thank the commenter for supporting the revision to measure Q385. After consideration of the comments, we are finalizing the changes to measure Q385 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.55. Follow-up After Hospitalization for Mental Illness (FUH)

Category	Description
NQF # / eCQM NQF #:	0576
Quality #:	391
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication/Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted: • The percentage of discharges for which the patient received follow-up within 30 days after discharge. • The percentage of discharges for which the patient received follow-up within 7 days after discharge.
Substantive Change:	**Updated denominator:** Added self-harm as a denominator eligible diagnosis. **The measure description is revised to read:** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted: • The percentage of discharges for which the patient received follow-up within 30 days after discharge. • The percentage of discharges for which the patient received follow-up within 7 days after discharge.
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed the denominator be expanded to include patients diagnosed with self-harm. We agree that this patient population is relevant to this measure and follow-up after hospitalization for patients with a self-harm diagnosis is directly applicable to patient safety.
We received no comments on the substantive changes proposed for measure Q391: Follow-Up After Hospitalization for Mental Illness (FUH). Therefore, we are finalizing the changes to measure Q391 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.56. Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

Category	Description
NQF # / eCQM NQF #:	2474
Quality #:	392
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation. This measure is submitted as four rates stratified by age and gender: • Submission Age Criteria 1: Females 18-64 years of age • Submission Age Criteria 2: Males 18-64 years of age • Submission Age Criteria 3: Females 65 years of age and older • Submission Age Criteria 4: Males 65 years of age and older
Substantive Change:	**The measure title is revised from HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation to read:** Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation.
Steward:	American College of Cardiology Foundation
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed to update the title to align with the measure steward changing from The Heart Rhythm Society to American College of Cardiology Foundation.
We received no comments on the substantive changes proposed for measure Q392: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation. Therefore, we are finalizing the changes to measure Q392 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.57. Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	393
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Infection rate following CIED device implantation, replacement, or revision.
Substantive Change:	**The measure title is revised from HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision to read:** Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision.
Steward:	American College of Cardiology Foundation
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We proposed to update the title to align with the measure steward changing from The Heart Rhythm Society to American College of Cardiology Foundation.
We received no comments on the substantive changes proposed for measure Q393: Infection within 180 Days of Cardiac Electronic Device (CIED) Implantation, Replacement, or Revision. Therefore, we are finalizing the changes to measure Q393 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.58. Immunizations for Adolescents

Category	Description
NQF # / eCQM NQF #:	1407
Quality #:	394
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Community/ Population Health
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.
Substantive Change:	**Updated denominator exclusions:** Added exclusion for encephalopathy due to Tdap vaccine. **Updated numerator to specify compliant serogroups:** Serogroups A, C, W, Y
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed the denominator exclusion be expanded to include encephalopathy as an eligible reason to exclude the patient from the Tdap vaccine clinical action. Both Adacel® and Boostrix® list progressive or unstable neurologic conditions, which would include encephalopathy, as reasons to defer their administration. The numerator was updated to specify the required serogroup. According to the Centers for Disease Control, all 11 to 12 year olds should be vaccinated with a meningococcal conjugate vaccine (Serogroups A, C, W, Y), with a booster dose given at 16 years old. All teens may also be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years old. This measure is assessing a younger patient population. We agree with adding specificity to the numerator to align with the current guidelines.
We received no comments on the substantive changes proposed for measure Q394: Immunization for Adolescents. Therefore, we are finalizing the changes to measure Q394 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.59. Appropriate Follow-up Imaging for Incidental Abdominal Lesions

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	405
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of final reports for abdominal imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with follow-up imaging recommended • Liver lesion ≤ 0.5 cm. • Cystic kidney lesion < 1.0 cm. • Adrenal lesion ≤ 1.0 cm.
Substantive Change:	**Updated measure assessment:** The measure analytic is being updated and will no longer be inverse. **The measure description is revised to read:** Percentage of final reports for abdominal imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow-up imaging recommended based on radiological findings: • Cystic renal lesion that is simple appearing* (Bosniak I or II) • Adrenal lesion ≤ 1.0 cm • Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols **The denominator is revised to read:** All final reports for imaging studies for patients aged 18 years and older with one or more of the following incidentally noted: • Cystic renal lesion that is simple appearing* (Bosniak I or II) • Adrenal lesion ≤ 1.0 cm • Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols **Updated denominator note: For the MIPS CQMs Specifications collection type:** Updated to include changes in the denominator and to include: *Other "simple-appearing criteria": • Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017) • Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU. (ACR, 2017) Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017). **Updated denominator: For the MIPS CQMs Specifications collection type:** Updated criteria: Incidental finding: Cystic renal lesion that is simple appearing* (Bosniak I or II), or Adrenal lesion ≤ 1.0 cm or Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols **Updated numerator note: For the Medicare Part B Claims Measure Specifications collection type:** Updated to include changes in the denominator and to include: *Other "simple-appearing criteria": • Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017) • Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU. (ACR, 2017) Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017). **Updated numerator instructions:** Removed inverse measure instructions. Added: A short note can be made in the final report, such as: "No follow-up imaging is recommended as incidental lesions are likely benign " or "No follow-up imaging is recommended per consensus recommendations based on imaging criteria. Further lab evaluation could be pursued based on clinical findings" **Updated denominator exclusion: For the Medicare Part B Claims Measure Specifications collection type:** Updated to reflect the changes to what is considered an incidental lesion.

Category	Description
	The numerator is revised to read: Final reports for imaging studies that include a description of incidental cystic renal lesion or adrenal lesion stating follow-up imaging is not recommended. **Updated numerator options:** Updated to reflect changes to the analytics of the measure and what is considered an incidental lesion. **Updated denominator exception:** Updated to read: Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has lymphadenopathy, signs of metastasis or an active diagnosis or history of cancer, and other medical reason(s).
Steward:	American College of Radiology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to update all aspects of this measure based upon the American College of Radiology's Technical Expert Panel (TEP) recommendations in order to bring the measure into alignment with current guidelines. The measure analytic is also being updated so that it is no longer an inverse measure. In addition, liver lesions have been removed from the denominator and the denominator exception has been updated to reflect the intent of the measure. We agree with these changes as they will bring the measure in better alignment with current clinical guidelines. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

We proposed a substantive change to the description and denominator; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state:

The measure description is revised to read for the MIPS CQMs Specifications and Medicare Part B claims collection type:

Percentage of final reports for imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow-up imaging recommended based on radiological findings:

- Cystic renal lesion that is simple appearing* (Bosniak I or II)
- Adrenal lesion less than or equal to 1.0 cm
- Adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols

This additional refinement does not affect the intent of the proposed substantive change and aligns the language throughout the specification. Additionally, during the annual revision process the measure steward replaced all symbols (e.g., <, >, ≤) referencing lesion size with wording for clarification. This additional refinement was to ensure clarity in language so that there is consistency in the language of the specification and does not affect the intent of the proposed substantive change.

The denominator is revised to read for the MIPS CQMs and Medicare Part B claims collection types:

All final reports for imaging studies for patients aged 18 years and older with one or more of the following incidentally noted:

- Cystic renal lesion that is simple appearing *(Bosniak I or II)*
  or
- Adrenal lesion less than or equal to 1.0 cm
  or
- Adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols

This additional refinement does not affect the intent of the proposed substantive change and aligns the language throughout the specification. Additionally, during the annual revision process the measure steward replaced all symbols (e.g., <, >, ≤) referencing lesion size with wording for clarification. This additional refinement was to ensure clarity in language so that there is consistency in the language of the specification and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:

Updated denominator note: For the MIPS CQMs Specifications collection type: Updated to include changes in the denominator and to include:

*Other "simple-appearing criteria":

• Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017)

• Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU. (ACR, 2017)

Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017).

Updated denominator: For the MIPS CQMs Specifications collection type: Updated criteria:

Incidental finding: Cystic renal lesion that is simple appearing* (Bosniak I or II), or Adrenal lesion ≤ 1.0 cm or Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols

Updated numerator note: For the Medicare Part B Claims Measure Specifications collection type: Updated to include changes in the denominator and to include:

*Other "simple-appearing criteria":

Category	Description
• Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017) • Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU. (ACR, 2017) Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017). **Updated numerator instructions:** Removed inverse measure instructions. Added: A short note can be made in the final report, such as: "No follow-up imaging is recommended as incidental lesions are likely benign " or "No follow-up imaging is recommended per consensus recommendations based on imaging criteria. Further lab evaluation could be pursued based on clinical findings" **Updated denominator exclusion: For the Medicare Part B Claims Measure Specifications collection type:** Updated to reflect the changes to what is considered an incidental lesion. We received no comments on the substantive changes proposed for measure Q405: Appropriate Follow-Up Imaging for Incidental Abdominal Lesions. Therefore, we are finalizing the changes to measure Q405 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.60. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	415
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care clinician who have an indication for a head CT.
Substantive Change:	**Modified collection type:** MIPS CQMs Specifications **Update description:** Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT. **Update denominator exclusions:** Removed pregnancy and revised list of antiplatelets applicable to the exclusion.
Steward:	American College of Emergency Physicians
High Priority Measure:	Yes
Measure Type:	Efficiency
Rationale:	We proposed to remove the Medicare Part B Claims Measure Specifications collection type. The benchmarking data shows that this measure is meets the extremely topped out definition for the Medicare Part B Claims Measure Specification collection type. However, the benchmarking data continues to show a gap for the MIPS CQMs Specifications collection type, as such, the measure will be retained for this collection type. Additionally, we proposed the denominator exclusions be updated to remove pregnancy as an eligible exclusion due to the low count of exclusion instances, and the list of antiplatelets was revised based upon an in depth review by the quality measures committee and measure leads and now aligns more closely with the current clinical workflow. The description was updated to align with the measure language throughout the specification.
We received no comments on the substantive changes proposed for measure Q415: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older. Therefore, we are finalizing the changes to measure Q415 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.61. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	416
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury.
Substantive Change:	**Updated denominator exclusions:** Removed thrombocytopenia.
Steward:	American College of Emergency Physicians
High Priority Measure:	Yes
Measure Type:	Efficiency
Rationale:	We proposed due to the low count of exclusion instances, to remove thrombocytopenia from the list of eligible denominator exclusions.
We received no comments on the substantive changes proposed for measure Q416: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years. Therefore, we are finalizing the changes to measure Q416 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.62. Osteoporosis Management in Women Who Had a Fracture

Category	Description
NQF # / eCQM NQF #:	0053
Quality #:	418
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.
Substantive Change:	**Updated denominator exclusions**: Updated: (1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period. Added: (1) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. (2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (3) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed and agree with the measure steward that the denominator exclusions be updated because it is unlikely patients with dementia requiring listed medications or advanced illness and frailty need some services and, in some cases, it might even be harmful for patients to receive a particular service when they should prioritize other services. We are also proposing to update the exclusion for living long term in an institution to include the criteria for more than 90 days during the measurement period. We agree with the measure steward as this would ensure the correct patient population is being removed from the eligible population and will lessen the burden to submit data for these MIPS eligible clinicians.
Comment: One commenter opposed not implementing the exclusion for adults 80 and older with frailty for measure Q418: Osteoporosis Management in Older Women Who Had a Fracture. This exclusion is critical for focusing the measures on the population most likely to benefit from the measured services. Without this exclusion, these measures will be out of alignment with what is required for reporting. **Response:** We thank the commenter for their comment, however this revision was not proposed and would be considered a substantive change. We believe introducing this concept without collaboration and clarification with the measure steward may create implementation variability for eligible clinicians. Therefore, we would encourage the commenter to work with the measure steward to incorporate this revision for future years. After consideration of the comments, we are finalizing the changes to measure Q418 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.63. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	438
CMS eCQM ID:	CMS347v3
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.
Substantive Change:	**Updated denominator exception:** Added hospice care.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	The measure steward proposed to add patients receiving hospice care to the eligible denominator exceptions to align with the intent of the measure. We agree with the measure steward that this patient population should be removed as patients in hospice care would not benefit from this clinical service and we believe that by removing this patient population it will reduce the burden of submission for these MIPS eligible clinicians providing care to these patients.

Comment: One commenter reviewed the proposed changes to the CMS Web Interface Measure Specification collection type for measure Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease and believed there are impacts to the benchmarks and a need to provide pay-for-reporting for 2019 and 2020 MIPS performance periods.

Response: We thank the commenter for their comment. Under MIPS, there is no pay-for-reporting option. In these instances, we exclude the measure from MIPS scoring for the CMS Web Interface Measures Specification collection type in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement for the impacted performance period. For this substantive change, we disagree with the commenter that the measure should be excluded from MIPS scoring for the 2019 MIPS performance period as these revisions will be implemented for the 2020 MIPS performance period and do not affect the 2019 MIPS performance period. Additionally, we do not believe that the revisions necessitate an updated benchmark for the MIPS 2020 performance period as the updated denominator exception for hospice care does not significantly impact measure Q438 and allows for direct comparison of performance data from prior years.

Comment: One commenter requested that the denominator exclusions added for measure Q113: Colorectal Cancer Screening, measure Q112: Breast Cancer Screening, measure Q001: Diabetes A1c Poor Control, and measure Q236: Hypertension, Controlling High Blood pressure, also be added to ACO-42 (measure Q438), Statin Therapy for Treatment of Cardiovascular Disease measures. The commenter also requested that the age restriction is removed from these exclusions, as many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age. The commenter recommended the following exclusion: Add Frailty, Dementia, and Advanced Illness in a Long-Term Care Setting.

Response: We thank the commenter for their comment and encourage them to reach out to the measure steward and collaborate with them regarding inclusion of these denominator exclusions.

After consideration of the comments, we are finalizing the changes to measure Q438 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.64. Age Appropriate Screening Colonoscopy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	439
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.
Substantive Change:	**Updated denominator:** Removed exclusion for modifiers 52, 53, 73, and 74.
Steward:	American Gastroenterological Association
High Priority Measure:	Yes
Measure Type:	Efficiency
Rationale:	We proposed that the denominator be expanded to include coded colonoscopy procedures that are indicated as incomplete or discontinued with modifiers 52, 53, 73, or 74 as denominator eligible. We agree that these procedures should be included in the denominator as the measure is looking to assess whether a colonoscopy was clinically indicated for the patient. Even if the colonoscopy was indicated as incomplete or discontinued, we would want that instance included in the denominator to determine if there was a valid medical reason for it to be performed.

We received no comments on the substantive changes proposed for measure Q439: Age Appropriate Screening Colonoscopy. Therefore, we are finalizing the changes to measure Q439 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.65. Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	440
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC) (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist.
Substantive Change:	**The measure title is revised from Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma (SCC): Biopsy Reporting Time – Pathologist to Clinician to read:** Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician. **The measure description is revised to read:** Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC) (including in situ disease), or melanoma in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist. **Updated denominator:** Added melanoma diagnosis codes. **Updated numerator:** Included language to reflect the addition of melanoma to the denominator.
Steward:	American Academy of Dermatology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed that the denominator be expanded to include melanoma diagnosis codes. The measure steward believes this will allow for a broader patient population to reflect communication and care coordination of skin cancers, not just non-melanoma skin cancer. The measure title, description, denominator, and numerator language is being updated to align with the inclusion of a melanoma diagnosis.

Comment: One commenter supported the substantive changes to measure Q440: Basal Cell Carcinoma (BCC)!Squamous Cell Carcinoma (SCC): Biopsy Reporting Time- Pathologist to Clinician impacting the measure title, description, and numerator/denominator as these changes are consistent with recommendations by the measure steward.

Another commenter supported the changes to Q440, but stated there is an error in the description. This is the measure as it was approved: "Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), **or melanoma** (including in situ disease), ~~or melanoma~~ in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist."

Response: We thank the commenters for supporting the revision to measure Q440. We agree that the description needed revised to align with the intent of the measure, and have reflected this update.

We proposed a substantive change to the description; however, during public comment it was noticed that the title was not updated to align with revisions being made to measure. Based on this comment, there was additional language refinement to state:

The measure description is revised to read: Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist. This additional refinement does not affect the intent of the proposed substantive change. This additional refinement was to ensure clarity and consistency within the measure and does not affect the intent of the proposed substantive change.

There were no additional refinements to substantive changes:
The measure title is revised from Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma (SCC): Biopsy Reporting Time – Pathologist to Clinician to read: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician.

Updated denominator: Added melanoma diagnosis codes.

Updated numerator: Included language to reflect the addition of melanoma to the denominator.

After consideration of the comments, we are finalizing the changes as indicated to measure Q440 for the 2020 MIPS performance period/2022 MIPS payment year and future years.

D.66. Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	441
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: • Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- AND • Most recent tobacco status is Tobacco Free -- AND • Daily Aspirin or Other Antiplatelet Unless Contraindicated -- AND • Statin Use Unless Contraindicated
Substantive Change:	**Updated denominator exceptions:** Added Procedure-Related BP's not taken during an outpatient visit. Examples of Procedure-related BP Locations: Same Day Surgery, Ambulatory Service Center, G.I. Lab, Dialysis, Infusion Center, Chemotherapy.
Steward:	Wisconsin Collaborative for Healthcare Quality (WCHQ)
High Priority Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	We proposed and agree with the WCHQ Measurement Advisory Committee that procedure-related blood pressures should be excluded from this measure. We agree with the inclusion of the denominator exception as procedure-related blood pressures can be artificially elevated. This change also aligns with other blood pressure related measure exclusions.
We received no comments on the substantive changes proposed for measure Q441: Ischemic Vascular Disease (IVD) All of None Outcome Measure (Optimal Control). Therefore, we are finalizing the changes to measure Q441 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.67. Appropriate Workup Prior to Endometrial Ablation

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	448
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of women, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results documented before undergoing an endometrial ablation.
Substantive Change:	**The measure description is revised to read:** Percentage of patients, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results are documented before undergoing an endometrial ablation. **Updated denominator:** Replace the word "women" with "patients". **Updated numerator:** Replace the word "women" with "patients".
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to update the measure description to read "percentage of patients" in order to be gender inclusive. This change will also be reflected throughout the measure for consistency.
We received no comments on the substantive changes proposed for measure Q448: Appropriate Workup Prior to Endometrial Ablation. Therefore, we are finalizing the changes to measure Q448 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.68. Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy

Category	Description
NQF # / eCQM NQF #:	1858
Quality #:	450
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of female patients (aged 18 years and older) with AJCC stage I (T1c) – III, human epidermal growth factor receptor 2 (HER2) positive breast cancer receiving adjuvant chemotherapy who are also receiving trastuzumab.
Substantive Change:	**Updated denominator definition:** Use the 2018 ASCO/CAP guideline definitions to determine HER2 status- HER2 Positive: • If result is IHC 3+ based on circumferential membrane staining that is complete, intense and in >10% of the invasive tumor cells • If result is ISH positive based on: • Single-probe average HER2 copy number ≥= 6. 0 signals/cell • Dual-probe HER2/CEP17 ratio ≥= 2. 0 with an average HER2 copy number ≥= 4. 0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number = 6. 0 signals/cell HER2 Equivocal: • If result is IHC 2+ based on circumferential membrane staining that is incomplete and/or weak/moderate and within > 10% of the invasive tumor cells • If result is ISH equivocal based on: • Single-probe ISH average HER2 copy number ≥= 4. 0 and < 6. 0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number ≥= 4. 0 and < 6. 0 signals/cell HER2 Negative: • If result is IHC 1+ based on incomplete membrane staining that is faint/barely perceptible and within > 10% of the invasive tumor cells • If result is IHC 0 based on no staining observed or membrane staining that is incomplete and is faint/barely perceptible and ≤= 10% of the invasive tumor cells • ISH negative based on: • Single-probe average HER2 copy number < 4. 0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number < 4. 0 signals/cell HER2 Indeterminate: Report HER2 test result as indeterminate if technical issues prevent one or both tests (IHC and ISH) from being reported as positive, negative, or equivocal. Conditions may include: • Inadequate specimen handling • Artifacts (crush or edge artifacts) that make interpretation difficult • Analytic testing failure.
Steward:	American Society of Clinical Oncology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We proposed to update the denominator definition so that it aligns with the 2018 ASCO/CAP guidelines.

Category	Description
We proposed a substantive change to the denominator definition; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state: **Updated denominator definition:** Use the 2018 ASCO/CAP guideline definitions to determine HER2 status- HER2 Positive: • If result is IHC 3+ based on circumferential membrane staining that is complete, intense and in >10% of the invasive tumor cells • If result is ISH positive based on: • Single-probe average HER2 copy number ≥ 6.0 signals/cell • Dual-probe HER2/CEP17 ratio ≥ 2. 0 with an average HER2 copy number ≥ 4.0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number = 6.0 signals/cell HER2 Equivocal: • If result is IHC 2+ based on circumferential membrane staining that is incomplete and/or weak/moderate and within > 10% of the invasive tumor cells • If result is ISH equivocal based on: • Single-probe ISH average HER2 copy number ≥ 4.0 and < 6.0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number ≥4.0 and < 6.0 signals/cell HER2 Negative: • If result is IHC 1+ based on incomplete membrane staining that is faint/barely perceptible and in > 10% of the invasive tumor cells • If result is IHC 0 based on no staining observed or membrane staining that is incomplete and is faint/barely perceptible and in ≤ 10% of the invasive tumor cells • ISH negative based on: • Single-probe average HER2 copy number < 4.0 signals/cell • Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number < 4.0 signals/cell HER2 Indeterminate: Report HER2 test result as indeterminate if technical issues prevent one or both tests (IHC and ISH) from being reported as positive, negative, or equivocal. Conditions may include: • Inadequate specimen handling • Artifacts (crush or edge artifacts) that make interpretation difficult • Analytic testing failure. This additional refinement was to ensure clarity in language for eligible clinicians that chose to implement measure Q450 and does not affect the intent of the proposed substantive change. We received no comments on the substantive changes proposed for measure Q450: Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy. Therefore, we are finalizing the changes to measure Q450 with the exception of removing duplication of symbols (that is, update ≥= to ≥) for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.69. Back Pain After Lumbar Discectomy/Laminectomy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	459
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to three months postoperative) in back pain for patients 18 years of age or older who had a lumbar discectomy /laminotomy procedure.
Substantive Change:	**The measure title is revised from Average Change in Back Pain Following Lumbar Discectomy / Laminotomy to read:** Back Pain After Lumbar Discectomy/Laminectomy. **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at three months (6 to 20 weeks) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated denominator:** Added discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047. Removed diagnosis of disc herniation. **Updated denominator exclusions:** Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis. **Updated numerator:** For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op pain assessment is greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being back pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at 3 months postoperatively (6 to 20 weeks). **Updated definitions:** Added: (1) Back Pain Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure who rates their back pain as less than or equal to 3.0. (2) Back Pain Target #2 - A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 5.0 points. **Updated numerator note:** It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9943 is submitted. • VAS Pain Scale is not administered postoperatively at three months (6 to 20 weeks) • Back pain is measured using a different patient reported tool or via telephone screening • Postoperative VAS Pain Scale is administered less than six weeks or more than 20 weeks (3 month window) • Postoperative VAS value is greater than 3.0 and no valid preoperative to measure change • Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward chose the targets based on a 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the "acceptable symptom state" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is less than or equal to 2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of change (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. The measure steward's measure development workgroup reached a consensus to expand the denominator to more broadly include all patients undergoing discectomy/laminectomy procedures by removing the diagnosis of disc herniation and adding procedure codes. As a part of this decision, it was decided to add a denominator exclusion as the measure steward believes this will help to create a more heterogeneous population. We agree with the expansion of the denominator to capture all patients undergoing discectomy/laminectomy procedures. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
The measure steward has postponed the inclusion of spine related neuromuscular conditions in order to continue testing and implement this concept consistently through all similar measure concepts within MIPS. As such we will not be finalizing the spine related neuromuscular conditions denominator exclusion. We are finalizing the denominator exclusion to include: Spine related cancer, acute fracture or infection, idiopathic or congenital scoliosis. Additionally, we proposed a substantive change to the definitions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the Back Pain Target #2 substantive change to state: A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the improvement is greater than or equal to 5.0 points. This additional refinement does not affect the intent of the proposed substantive change and aligns with the measure language. We received no comments on the substantive changes proposed for measure Q459: Back Pain After Lumbar Discectomy/Laminectomy. Therefore, we are finalizing the changes to measure Q459 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the exception of the denominator exclusion.	

D.70. Back Pain After Lumbar Fusion

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	460
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to one year postoperative) in back pain for patients 18 years of age or older who had a lumbar fusion procedure.
Substantive Change:	**The measure title is revised from Average Change in Back Pain Following Lumbar Fusion to read:** Back Pain After Lumbar Fusion. **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being back pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months). **Updated definitions:** Added: (1) Back Pain Target #1 – A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their back pain as less than or equal to 3.0. (2) Back Pain Target #2 – A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the change is greater than or equal to 5.0 points. **Updated numerator note;** It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9946 is submitted. • VAS Pain Scale is not administered postoperatively at one year (9 to 15 months) • Back pain is measured using a different patient reported tool or via telephone screening • Postop VAS Pain Scale is administered less than nine months or more than 15 months (1 year window) • Postoperative VAS value is greater than 3.0 and no valid preop to measure change • Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward base the target on a 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the "acceptable symptom state" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is ≤2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of change (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

Category	Description
We proposed a substantive change to the definitions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the Back Pain Target #2 substantive change to state: **Updated definitions:** Added: (2) Back Pain Target #2: A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the improvement is greater than or equal to 5.0 points. This additional refinement was to ensure clarity in language support understanding in the guidance to implement quality measure Q460 and does not affect the intent of the proposed substantive change. There were no additional refinements to substantive changes: **The measure title is revised from Average Change in Back Pain Following Lumbar Fusion to read:** Back Pain After Lumbar Fusion. **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being back pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months). **Updated definitions:** Added: (1) Back Pain Target #1 – A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their back pain as less than or equal to 3.0. **Updated numerator note;** It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9946 is submitted. • VAS Pain Scale is not administered postoperatively at one year (9 to 15 months) • Back pain is measured using a different patient reported tool or via telephone screening • Postop VAS Pain Scale is administered less than nine months or more than 15 months (1 year window) • Postoperative VAS value is greater than 3.0 and no valid preop to measure change • Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure) We received no comments on the substantive changes proposed for measure Q460: Back Pain After Lumbar Fusion. Therefore, we are finalizing the changes to measure Q460 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.71. Leg Pain After Lumbar Discectomy/Laminectomy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	461
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to three months postoperative) in leg pain for patients 18 years of age or older who had a lumbar discectomy/laminotomy procedure.
Substantive Change:	**The measure title is revised from Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy to read:** Leg Pain After Lumbar Discectomy/Laminectomy. **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at three months (6 to 20 weeks) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated denominator:** Added the following discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047. Removed diagnosis of disc herniation. **Updated denominator exclusions:** Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis. **Updated numerator:** For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being leg pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at 3 months postoperatively (6 to 20 weeks). **Updated definitions:** Added: (1) Leg Pain Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure who rates their leg pain as less than or equal to 3.0. (2) Leg Pain Target #2 - A patient who does not meet Leg Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 5.0 points. **Updated numerator note:** It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9949 is submitted. • VAS Pain Scale is not administered postoperatively at three months (6 to 20 weeks) • Leg pain is measured using a different patient reported tool or via telephone screening • Postoperative VAS Pain Scale is administered less than six weeks or more than 20 weeks (3 month window) • Postoperative VAS value is greater than 3.0 and no valid preop to measure change • Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward based the target on a 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the "acceptable symptom state" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is less than or equal to 2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of change (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0.We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. The measure steward's measure development workgroup reached a consensus to expand the denominator to more broadly include all patients undergoing discectomy/laminectomy procedures by removing the diagnosis of disc herniation and adding procedure codes. As a part of this decision, it was decided to add a denominator exclusion as the measure steward believes this will help to create a more heterogeneous population. We agree with the expansion of the denominator to capture all patients undergoing discectomy/laminectomy procedures. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
The measure steward has postponed the inclusion of spine related neuromuscular conditions in order to continue testing and implement this concept consistently through all similar measure concepts within MIPS. As such, we will not be finalizing the spine related neuromuscular conditions denominator exclusion. We are finalizing the denominator exclusion to include: Spine related cancer, acute fracture or infection, idiopathic or congenital scoliosis. Additionally, we proposed a substantive change to the definitions; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the Leg Pain Target #2 substantive change to state: A patient who does not meet Leg Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the improvement is greater than or equal to 5.0 points. This additional refinement does not affect the intent of the proposed substantive change and aligns with the measure language. We received no comments on the substantive changes proposed for measure Q461: Leg Pain After Lumbar Discectomy/Laminectomy. Therefore, we are finalizing the changes to measure Q461 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the exception of the denominator exclusion.	

D.72. Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	462
CMS eCQM ID:	CMS645v3
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater (indicated by HCPCS code) and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.
Substantive Change:	**The measure description is revised to read:** Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.
Steward:	Oregon Urology Institute
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the measure description to align with the removal of the custom HCPCS, J code J1950, which previously denoted the practitioner's intent of androgen deprivation therapy (ADT) for a period of 12 months or greater. The intent of the measure remains intact, but no longer requires the HCPCS to identify the intended patient population.
We received no comments on the substantive changes proposed for measure Q462: Bone Density for Patients with Prostate Cancer and Receiving Androgren Deprivation Therapy. Therefore, we are finalizing the changes to measure Q462 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years	

D.73. Functional Status After Lumbar Fusion

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	469
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to postoperative) in functional status using the Oswestry Disability Index (ODI version 2.1a) for patients 18 years of age and older who had a lumbar fusion procedure.
Substantive Change:	**The measure title is revised from Average Change in Functional Status Following Lumbar Fusion Surgery to read:** Functional Status After Lumbar Fusion. **The measure description is revised to read:** For patients 18 years of age and older who had a lumbar fusion procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a)* at one year (9 to 15 months) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 22, need a pre and post-op assessment to hit the change target of 30 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being functional status is less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI) at one year postoperatively (9 to 15 months). **Added numerator definition:** Functional Status Target #1 - A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their functional status as less than or equal to 22. Functional Status Target #2 - A patient who does not meet Functional Status Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the change is greater than or equal to 30 points. **Updated numerator note:** It is recommended that both a preoperative and postoperative tool be administered to the patient to increase the chance that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met M1043 is submitted. • ODI is not administered postoperatively at one year (9 to 15 months) • Functional status is measured using a different patient reported functional status tool or ODI version • Postoperative ODI is administered less than 9 months or greater than 15 months (1 year window) • Postoperative ODI is greater than 22 and no valid preoperative ODI to measure change • Preoperative ODI (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure.) NQF endorsement removed until the measure can be evaluated with the new analytics.
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward based the target on a study Determination of the Oswestry Disability Index score equivalent to a "satisfactory symptom state" in patients undergoing surgery for degenerative disorders of the lumbar spine-a Spine Tango registry-based study. vanHooff, ML et al Spine J. 2016 Oct;16 (10):1221-1230. Patient Acceptable Symptom State (PASS), the highest level of symptom beyond which patients consider themselves well. PASS was compared to post-op ODI to determine an equivalent ODI threshold. ODI score less than or equal to 22 indicates the achievement of an acceptable symptom state and can be used as a criterion for treatment success. [AUC]: 0.89 [sensitivity: 78.3%, specificity: 82.1%] for 1 year follow-up]. The OR benchmark of change (30) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 22. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
We received no comments on the substantive changes proposed for measure 469: Functional Status After Lumbar Fusion. Therefore, we are finalizing the changes to measure Q469 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years	

D.74. Functional Status After Primary Total Knee Replacement

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	470
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to postoperative) in functional status using the Oxford Knee Score (OKS) for patients age 18 and older who had a primary total knee replacement
Substantive Change:	**The measure title is revised to read:** Functional Status After Primary Total Knee Replacement. **The measure description is revised:** For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) at one year (9 to 15 months) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance patients need a post-op OKS assessment. The measure will now be target-based with performance met being functional status is greater than or equal to 37 on the Oxford Knee Score (OKS) at one year postoperatively (9 to 15 months). Patients who are missing an assessment will be considered numerator non-compliant. **Added numerator definition:** OKS Target - A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their functional status score as greater than or equal to 37. **Updated numerator note:** The following situations are those in which the numerator targets cannot be reached and Performance Not Met (M1046) is submitted: • Oxford Knee Score (OKS) is not administered postoperatively at one year (9 to 15 Months) • Functional status is measured using a different patient-reported functional status tool or Oxford Knee Score (OKS) version • Postoperative Oxford Knee Score (OKS) is administered less than 9 Months or greater than 15 Months • Postoperative Oxford Knee Score (OKS) score is less than 37 NQF endorsement removed until the measure can be evaluated with the new analytics.
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that this measure assessment will be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward derived the target from a study "Patient acceptable symptom states after total hip or knee replacement at mid-term follow-up" [Kuerentjes JC, Van Tol FR Bone Joint Res 2014; 3:7–13]. Receiver operating characteristic (ROC) curves identified a PASS threshold of 42 for the OHS after THR and 37 for the OKS after TKR. THR patients with an OHS greater than or equal to 42 and TKR patients with an OKS greater than or equal to 37 had a higher NRS for satisfaction and a greater likelihood of being willing to undergo surgery again. The Patient Acceptable Symptom State (PASS), the highest level of symptom beyond which patients consider themselves well. PASS was compared to post-op OKS to determine an equivalent OKS threshold. OKS score greater than or equal to 37 indicates the achievement of an acceptable symptom state and correlates with a higher numeric rating scale for satisfaction [ROC curves PASS threshold of 37 with sensitivity of 76.3% and specificity of 76.5%]. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
We received no comments on the substantive changes proposed for measure Q470: Functional Status After Primary Total Knee Replacement. Therefore, we are finalizing the changes to measure Q470 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years	

D.75. Functional Status After Lumbar Discectomy/Laminectomy

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	471
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to postoperative) in functional status using the Oswestry Disability Index (ODI version 2.1a) for patients age 18 and older who had lumbar discectomy/laminotomy procedure
Substantive Change:	**The measure title is revised from Average Change in Functional Status Following Lumbar Discectomy/Laminotomy Surgery to read:** Functional Status After Lumbar Discectomy/Laminectomy. **The measure description is revised to read:** For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) * at three months (6 to 20 weeks) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated denominator:** Added the following discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047. **Update denominator exclusions:** Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis. Removed diagnosis of disc herniation. **Updated numerator:** For numerator compliance patients need either a post-op functional assessment (to meet the target portion) or if post-op greater than 22, need a pre and post-op assessment to hit the change target of 30 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being functional status is less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI) at 3 months postoperatively (6 to 20 weeks). **Added numerator definition:** Functional Status Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure rates their functional status as less than or equal to 22. Functional Status Target #2 - A patient who does not meet Functional Status Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 30 points. **Updated numerator note:** It is recommended that both a preoperative and postoperative be administered to the patient increasing chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met M1049 is submitted. • ODI is not administered postoperatively at three months (6 to 20 weeks) • Functional status is measured using a different patient reported functional status tool or ODI version • Postoperative ODI is administered less than 6 weeks or greater than 20 weeks (3 month window) • Postoperative ODI is greater than 22 and no valid preoperative ODI to measure change Preoperative ODI (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome

Category	Description
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward derived the target from a study Determination of the Oswestry Disability Index score equivalent to a "satisfactory symptom state" in patients undergoing surgery for degenerative disorders of the lumbar spine-a Spine Tango registry-based study. vanHooff, ML et al Spine J. 2016 Oct;16(10):1221-1230. Patient Acceptable Symptom State (PASS), the highest level of symptom beyond which patients consider themselves well. PASS was compared to post-op ODI to determine an equivalent ODI threshold. ODI score less than or equal to 22 indicates the achievement of an acceptable symptom state and can be used as a criterion for treatment success. [AUC]: 0.89 [sensitivity: 78.3%, specificity: 82.1%] for 1 year follow-up]. The OR benchmark of change (30) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 22. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. The measure steward's measure development workgroup reached a consensus to expand the denominator to more broadly include all patients undergoing discectomy/laminectomy procedures by removing the diagnosis of disc herniation and adding procedure codes. As a part of this decision, it was decided to add a denominator exclusion as the measure steward believes this will help to create a more heterogeneous population. We agree with the expansion of the denominator to capture all patients undergoing discectomy/laminectomy procedures. Additionally, the definitions and the numerator note were proposed to be updated to align with the other changes and to add clarity. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.
The measure steward has postponed the inclusion of spine related neuromuscular conditions in order to continue testing and implement this concept consistently through all similar measure concepts within MIPS. As such, we will not be finalizing the spine related neuromuscular conditions denominator exclusion. We are finalizing the denominator exclusion to include: Spine related cancer, acute fracture or infection, idiopathic or congenital scoliosis. We received no comments on the substantive changes proposed for measure Q471: Functional Status After Lumbar Discectomy/Laminectomy. Therefore, we are finalizing the changes to measure Q471 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the exception of the denominator exclusion.	

D.76. Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	472
CMS eCQM ID:	CMS249v2
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.

Category	Description
Substantive Change:	**Updated guidance:** There are two ways that a patient can be excluded from the measure: 1. The patient has a specific number of "combination" risk factors (the number of risk factors varies by age). 2. The patient has one or more of the "independent" risk factors, including a 10-year probability of major osteoporotic fracture of 8.4 percent or higher as determined by the FRAX. Denominator exclusions statement: Exclude patients with a combination of risk factors (as determined by age) or one of the independent risk factors Ages: 50-54 (>=4 combination risk factors) or 1 independent risk factor Ages: 55-59 (>=3 combination risk factors) or 1 independent risk factor Ages: 60-64 (>=2 combination risk factors) or 1 independent risk factor COMBINATION RISK FACTORS [The following risk factors are all combination risk factors; they are grouped by when they occur in relation to the measurement period]: The following risk factors may occur any time in the patient's history but must be active during the measurement period: White (race) BMI <= 20 kg/m2 (must be the first BMI of the measurement period) Smoker (current during the measurement period) Alcohol consumption (> two units per day (one unit is 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor)) The following risk factor may occur any time in the patient's history and must not start during the measurement period: Osteopenia The following risk factors may occur at any time in the patient's history or during the measurement period: Rheumatoid arthritis Hyperthyroidism Malabsorption Syndromes: celiac disease, inflammatory bowel disease, ulcerative colitis, Crohn's disease, cystic fibrosis, malabsorption Chronic liver disease Chronic malnutrition The following risk factors may occur any time in the patient's history and do not need to be active at the start of the measurement period: Documentation of history of hip fracture in parent Osteoporotic fracture Glucocorticoids (>= 5 mg/per day) [cumulative medication duration >= 90 days] INDEPENDENT RISK FACTORS (The following risk factors are all independent risk factors; they are grouped by when they occur in relation to the measurement period): The following risk factors may occur at any time in the patient's history and must not start during the measurement period: Osteoporosis The following risk factors may occur at any time in the patient's history prior to the start of the measurement period, but do not need to be active during the measurement period: Gastric bypass FRAX[R] ten-year probability of all major osteoporosis related fracture >= 8.4 percent Aromatase inhibitors The following risk factors may occur at any time in the patient's history or during the measurement period: Type I Diabetes End stage renal disease Osteogenesis imperfecta Ankylosing spondylitis Psoriatic arthritis Ehlers-Danlos syndrome Cushing's syndrome Hyperparathyroidism Marfan syndrome Lupus **Updated denominator exclusions:** Changed FRAX[R] ten-year probability of all major osteoporosis related fracture result from 9.3% to 8.4%.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	Yes
Measure Type:	Process

Category	Description
Rationale:	We proposed that the denominator exclusion for the Fracture Risk Assessment Tool FRAX® ten-year probability of all major osteoporosis related fracture result be changed from 9.3% to 8.4% to align with the US Preventive Services Task Force (USPSTF) recommendations. We agree with this change as it keeps the measure in alignment with the current clinical guidelines. The guidance is being updated for better alignment with the measure and to align with the updated denominator exclusion.
We received no comments on the substantive changes proposed for measure Q472: Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture. Therefore, we are finalizing the changes to measure Q472 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.77. Leg Pain After Lumbar Fusion

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	473
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The average change (preoperative to one year postoperative) in leg pain for patients 18 years of age or older who had a lumbar fusion procedure
Substantive Change:	**The measure title is revised from Average Change in Leg Pain Following Lumbar Fusion Surgery to read:** Leg Pain After Lumbar Fusion. **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance Patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months).
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We proposed that this measure assessment be updated to a target-based measure and will no longer look at the average change. Multiple aspects of the measure are being updated to reflect this change, including requiring all eligible patients undergoing the procedure to be assessed for numerator compliance. The measure steward based the target score on a 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the "acceptable symptom state" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is less than or equal to 2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of improvement (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0. We agree with this change as it allows for benchmarking and does not allow denominator self-selection which could skew the results, as patients who do not complete the required assessments will now be considered numerator non-compliant. As finalized, the substantive changes do not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the minimum reliability requirements, a new benchmark will be generated.

Category	Description
Comment: One commenter requested that omitted text for measure Q473: Average Change in Leg Pain Following Lumbar Fusion Surgery be added to this measure. This text was included in the final measure specification but omitted from the 2020 PFS proposed rule (84 FR 41272). The substantive change in the proposed rule is correct with the additional language below to be added. Updated definitions: Added: (1) Leg Pain Target #1 A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their leg pain as less than or equal to 3.0. (2) Leg Pain Target #2 A patient who does not meet Leg Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the change is greater than or equal to 5.0 points. Updated numerator note: It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met M1052 is submitted. VAS Pain Scale is not administered postoperatively at one year (9 to 15 months) Leg pain is measured using a different patient reported tool or via telephone screening Postop VAS Pain Scale is administered less than nine months or more than 15 months (1 year window) Postoperative VAS value is greater than 3.0 and no valid preop to measure change Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure) **Response:** We thank the commenter for their consideration and agree this additional detail will aid in the clarification of implementation. We do encourage measure stewards to submit these substantive changes during the Call for Substantive Changes, which typically occurs at the beginning of each year. We proposed a substantive change to the Description; however, during the quality measure annual revision process with the measure steward, there was additional language refinement. Therefore, we are finalizing the substantive change to state: **The measure description is revised to read:** For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain. This additional refinement was to ensure clarity in language so that the quality action is defined for measure Q473 and does not affect the intent of the proposed substantive change. There were no additional refinements to substantive changes: **The measure title is revised from Average Change in Leg Pain Following Lumbar Fusion Surgery to read:** Leg Pain After Lumbar Fusion. **Updated measure assessment:** Changed measure assessment from continuous variable to a proportional measure. **Updated numerator:** For numerator compliance Patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months). After consideration of the comments, we are finalizing the changes to measure Q473 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years with the revisions noted above.	

D.78. HIV Screening

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	475
CMS eCQM ID:	CMS349v2
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	eCQM Specifications
Current Measure Description:	Percentage of patients 15-65 years of age who have been tested for HIV within that age range.
Substantive Change:	**The measure description is revised to read:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV. **The numerator is revised to read:** Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday.
Steward:	Centers for Disease Control and Prevention
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the measure description to better align the measure specification. We agree with this update as it clarifies the intent of the measure. We proposed that the numerator be revised to add clarity and to align the wording with logic used. Neither the intent of the measure nor the numerator action will be changed.
We received no comments on the substantive changes proposed for measure Q475: HIV Screening. Therefore, we are finalizing the changes to measure Q475 as proposed for the 2020 MIPS performance period/2022 MIPS payment year and future years.	

D.79. Dementia: Functional Status Assessment

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	282
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.
Substantive Change:	**Updated denominator:** Added physical therapy MIPS eligible clinician type.
Steward:	American Psychiatric Association and American Academy of Neurology
High Priority Measure:	No
Measure Type:	Process
Rationale:	Based upon requests from measure steward physical therapy evaluation codes were proposed to be add to the denominator eligible encounters to allow for this measure to be used in an additional setting. We agree that this is a clinically relevant measure to the physical therapy setting.
After consideration of the comments received on this measure under Table C, we are finalizing the changes to measure Q282 as proposed (see 84 FR 41171) for the 2019 MIPS performance period/2021 MIPS payment year and future years because we did not finalize removal of this measure.	

D.80. Dementia: Education and Support of Caregivers for Patients with Dementia

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	288
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months.
Substantive Change:	**Updated denominator:** Added physical therapy MIPS eligible clinician type.
Steward:	American Psychiatric Association and American Academy of Neurology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	Based upon requests from measure steward physical therapy evaluation codes were proposed to be add to the denominator eligible encounters to allow for this measure to be used in an additional setting. We agree that this is a clinically relevant measure to the physical therapy setting.
After consideration of the comments received on this measure under Table C, we are finalizing the changes to measure Q288 as proposed (see 84 FR 41171) for the 2019 MIPS performance period/2021 MIPS payment year and future years because we did not finalize removal of this measure.	

D.81. Preventive Care and Screening: Influenza Immunization

Category	Description
NQF # / eCQM NQF #:	0041 / 0041e
Quality #:	110
CMS eCQM ID:	CMS147v9
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Substantive Change:	**Updated numerator instructions:** Due to the changing nature of the CDC/ACIP recommendations regarding the live attenuated influenza vaccine (LAIV) for a particular flu season, this measure will not include the administration of this specific formulation of the flu vaccination. Given the variance of the timeframes for the annual update cycles, program implementation, and publication of revised recommendations from the CDC/ACIP, it has been determined that the coding for this measure will specifically exclude this formulation, so as not to inappropriately include this form of the vaccine for flu seasons when CDC/ACIP explicitly advise against it. However, it is recommended that all eligible professionals or eligible clinicians review the guidelines for each flu season to determine appropriateness of the LAIV and other formulations of the flu vaccine. If the LAIV is recommended for administration for a particular flu season, an eligible professional or clinician may consider one of the following options: 1) satisfy the numerator by reporting previous receipt, 2) report a denominator exception, either as a patient reason (e.g., for patient preference) or a system reason (e.g., the institution only carries LAIV).
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	We agree with the update to the numerator instructions as it would allow for shared decision making between the patient and the eligible clinician, as well as align with the current performance period's CDC/ACIP guidelines without negatively affecting clinicians providing LAIV.
After consideration of the comments received on this measure under Table C, we are finalizing the changes to measure Q110 as proposed (see 84 FR 41158) for the 2019 MIPS performance period/2021 MIPS payment year and future years because we did not finalize removal of this measure.	

D.82. Pneumococcal Vaccination Status for Older Adults

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	111
CMS eCQM ID:	CMS127v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
Substantive Change:	**Updated denominator:** Added the skilled nursing facility and domiciliary settings.
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed that the denominator coding be expanded to include the skilled nursing facility and domiciliary settings as applicable settings. We agree with the measure steward's decision to expand this measure to include these MIPS eligible clinicians as it is clinically relevant to this setting.
After consideration of the comments received on this measure under Table C, we are finalizing the changes to measure Q111 as proposed (see 84 FR 41159) for the 2019 MIPS performance period/2021 MIPS payment year and future years because we did not finalize removal of this measure.	

D.83. Rheumatoid Arthritis (RA): Functional Status Assessment

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	178
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.
Substantive Change:	**Numerator statement revised to read:** Patients for whom a standardized functional status assessment using an ACR-preferred, patient-reported functional status assessment tool was performed at least once within 12 months. **Updated definition:** **Functional Status Assessment:** This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of tool to assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2, and American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis. Functional status should be assessed using a measurement tool assigned preferred status by the ACR. The instruments listed are the ACR-preferred tools that fulfill the measure requirements: PROMIS Physical Function 10-item (PROMIS PF10a), Health Assessment Questionnaire-II (HAQ-II), and Multi-Dimensional Health Assessment Questionnaire (MD-HAQ).
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	The measure steward proposed to update the measure to require the use of ACR-preferred functional status assessment tools for numerator compliance. According to the ACR's RA treatment guidelines, functional status assessment using a standardized, validated measure should be performed routinely for RA patients, at least once per year, but more frequently if disease is active. We agree that it is important to utilize the proper assessment to ensure that the patient is being accurately assessed which will aid in clinical decisions regarding ongoing care.

Comment: One commenter stated that the requested changes to be made to measure Q178 are incorrectly captured. It appears the language in the change request document was copied and pasted without regard to formatting, which provided a visualization of deletions and additions.
The requested changes should appear as follows:
o New numerator statement: Patients for whom a functional status assessment using an ACR-preferred, patient-reported functional status assessment tool was performed at least once within 12 months
o New numerator definition: Functional Status Assessment – This measure assesses if physicians are using a standardized tool to assess the impact of RA on patient activities of daily living. Functional status should be assessed using a measurement tool assigned preferred status by the ACR. The instruments listed are the ACR-preferred tools that fulfill the measure requirements:
§ PROMIS Physical Function 10-item (PROMIS PF10a)
§ Health Assessment Questionnaire-II (HAQ-II)
§ Multi-Dimensional Health Assessment Questionnaire (MD-HAQ)

Response: We appreciate the comment clarifying the substantive changes for measure Q178 and agree that these refinements to language add clarity.

We proposed a substantive change to the numerator statement and definition; however, during the quality measure annual revision process with the measure steward, there was additional language refinement to state:

Numerator statement is revised to read: Patients for whom a functional status assessment using an ACR-preferred, patient-reported functional status assessment tool was performed at least once within 12 months.

Updated definition:
Functional Status Assessment – This measure assesses if physicians are using a standardized tool to assess the impact of RA on patient activities of daily living. Functional status should be assessed using a measurement tool assigned preferred status by the ACR. The instruments listed are the ACR-preferred tools that fulfill the measure requirements:
- PROMIS Physical Function 10-item (PROMIS PF10a)
- Health Assessment Questionnaire-II (HAQ-II)
- Multi-Dimensional Health Assessment Questionnaire (MD-HAQ)

These additional refinements were to ensure clarity in numerator assessment and how numerator compliance can be met for measure Q178 and does not affect the intent of the proposed substantive change.

After consideration of the comments received on this measure under Table C, we are finalizing the changes to measure Q178 as proposed (see 84 FR 41164) for the 2019 MIPS performance period/2021 MIPS payment year and future years because we did not finalize removal of this measure.

TABLE Group DD: Previously Finalized Quality Measures with Substantive Changes Finalized for the 2021 MIPS Payment Year and Future Years

NOTE: Electronic Clinical Quality Measures (eCQMs) that are National Quality Forum (NQF) endorsed are shown in Table DD as follows: NQF # / eCQM NQF #.

DD.1. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Category	Description
NQF # / ECQM NQF #:	0028 / 0028e
Quality #:	226
CMS eCQM ID:	CMS138v8
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months. b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention. c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Substantive Change:	**Updated numerator guidance: for the 2019 performance period: For the CMS Web Interface Measure Specification collection type:** Removed "and the cessation intervention must occur during or after the most recent tobacco user status is documented" language from the guidance.
Steward:	Physician Consortium for Performance Improvement Foundation (PCPI®)
High Priority Measure:	No
Measure Type:	Process
Rationale:	We proposed to update the numerator guidance in the CMS Web Interface Measure Specifications collection type for the 2019 performance period to remove the guidance given regarding the timing of the tobacco cessation intervention as this does not align with the intent of the measure. The refinements are in alignment with the clinical guidelines and will decrease burden for eligible clinicians performing tobacco screening and tobacco cessation intervention. The timing refinement proposed would maintain the balance of clinical guideline and measure alignment and support our effort to reduce burden for measure submission. Additionally, this timing refinement would allow the clinician to create personalized, patient-centered care while still maintaining the clinical integrity of the measure and clinical guidelines. To the extent this proposed change constituted a change in methodology after the start of the 2019 MIPS performance period, we stated that we believe that consistent with section 1871(e)(1)(A)(ii) of the Social Security Act, it would be contrary to the public interest not to modify the measure because the current guidance is inconsistent with the intent of the CMS Web Interface version of this measure and unduly burdensome for clinicians. The proposal was to update the CMS Web Interface Measure Specifications collection type numerator guidance previously stated in the current posted 2019 measure specification for PREV-10 (NQF #0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, available at https://qpp.cms.gov/about/resource-library, in response to extensive stakeholder feedback regarding the timeframe during which the tobacco cessation intervention must occur. Specifically, stakeholders expressed concern that this additional language would not be comparable to the historic benchmark as it changed how the quality action of tobacco cessation intervention was abstracted in terms of numerator compliance. Additionally, stakeholders voiced concern regarding how this change would fit into the current clinical workflow as patients are asked about tobacco use on most if not all encounters, but clinicians do not feel it is necessary to provide tobacco cessation intervention at all encounters especially if it was already completed earlier in the year. Based on this feedback and our review, we explained that we had determined that the previously stated guidance is inconsistent with the intent of the CMS Web Interface Measure Specifications collection type version of this measure and unduly burdensome for clinicians. In response to our determination and stakeholder feedback, we proposed to update the CMS Web Interface Measure Specifications collection type numerator guidance to clarify that screening for tobacco use and tobacco cessation intervention do not have to occur on the same encounter, but must occur during the 24-month look-back period. We agree this proposal would maintain clinical intent, provide clarity, reduce clinician burden, and allow for personalized care.

Category	Description
Comment: Two commenters supported the substantive change to the Web Interface for measure Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention as corrected for the 2019 Performance Period. However, one commenter stated that if CMS is not fully confident that the logic and data collected in previous years for this metric matches the proposed logic and data to be collected, this metric should be Reporting Only in 2019, or at the very least, have the decile benchmarks revert back to 30, 40, 50, 60, 70, 80, and 90. With respect to ACO-17, Smoking Cessation (MIPS measure Q226), one commenter applauded CMS for making this measure pay-for-reporting in 2018 as it had requested. The commenter reiterated that this measure should be made pay-for-reporting in 2019 as well given the impact of measure specification changes and resulting effect on the benchmarks for this measure. The commenter urged CMS to finalize changes to the measure specification numerator requirements which better reflect clinical guidelines. Another commenter indicated that the revisions to measure Q226 were proposed to take effect starting in the 2019 reporting year for the CMS Web Interface Specifications collection type but apply starting in the 2020 reporting year for the eCQM Specifications collection type. Because of this difference, healthcare organizations that report using both collection types, such as organizations where some providers report as part of an APM and other providers report as individual eligible clinicians, would need to monitor and track two different versions of the measure for the 2019 reporting year. The commenter requested that the measure modifications for all collection types take effect starting in 2020 to improve measure alignment. Another commenter concurred with CMS that the numerator definition needs to be updated to "clarify that screening for tobacco use and tobacco cessation intervention do not have to occur in the same encounter, but must occur during the 24-month look-back period", but the denominator population (population '2') CMS uses for this measure differs widely from the benchmarked measure definition (the total population). Specifically, the benchmarked denominator includes patients who were not tobacco users, while the new measure (with updated numerator specifications) does not include those patients, thus changing the population and performance rate to a substantial degree. Therefore, the commenter stated that CMS should acknowledge that this is a material change and should classify this measure as pay-for-reporting for ACO and MIPS group submissions until an appropriate benchmark can be established. **Response:** We thank the commenters for supporting the revision to measure Q226. We appreciate the commenters concerns that the measure should be calculated as pay-for-reporting for the 2019 MIPS performance period. The revision to the CMS Web Interface Measure Specifications collection type aligns with the intent of the measure and brings it into alignment with the other collection types. However, due to the mid-year change to the measure specification (as discussed in more detail under section III.E.1.b) we intend to redesignate the CMS Web Interface Measure Specifications collection type for measure Q226 as pay-for-reporting in the Shared Savings Program for performance years starting in 2019 as provided in § 425.502(a)(5). Additionally, we will exclude the measure from MIPS scoring for the 2019 MIPS performance period in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement and the measure was reported through the CMS Web Interface Measure Specifications collection type. Regarding the commenter concerned with the CMS Web Interface Measure Specifications collection type and the eCQM Specifications collection type being out of alignment if this change is finalized, we believe this change brings these two collection types in alignment. The guidance regarding multiple screenings within a performance period "If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements" will remain within the specification of both collection types. The change to the CMS Web Interface Measure Specifications collection type only impacts the timing of the quality action and not the denominator eligible encounter. This measure underwent a substantive change in 2018 MIPS which revised this measure to have three performance rates rather than one performance rate. At that time, a new benchmark was created since the second performance rate was utilized for benchmark: b. Percentage of patients aged 18 years and older who identified as a tobacco user who received tobacco cessation intervention. Therefore, the benchmark was more focused on the population of patients screened as tobacco users that were provided cessation. The performance rate being utilized for benchmark has not changed between the 2018 and 2019 performance period. After consideration of the comments, we are finalizing the changes to measure Q226 as proposed for the 2019 MIPS performance period/2021 MIPS payment year and future years. We will continue to require this measure for groups, APM Entities, and virtual groups reporting through the CMS Web Interface Measure Specifications collection type. However, we are redesignating it as "pay-for-reporting" in the Shared Savings Program for performance years starting in 2019 as provided in § 425.502(a)(5), and we will exclude the measure from MIPS scoring for the 2019 MIPS performance period in accordance with § 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement and the measure was reported through the CMS Web Interface Measure Specifications collection type. For further discussion on how this measure will be scored under the Shared Savings Program see section III.E.1.b of this final rule. For further discussion on how this measure will be scored under the MIPS Program Quality Performance Category see section III.K.3.c.(1) of this final rule.	

Appendix 2: Improvement Activities

NOTE: In this final rule, for the CY 2020 performance period and future years, we are finalizing our proposals to: (1) add two new improvement activities; (2) modify seven existing improvement activities; and (3) remove 15 improvement activities from the Inventory. These are discussed in greater detail below.

Table A: New Improvement Activities for the MIPS CY 2020 Performance Period and Future Years

Proposed Improvement Activity	
Proposed Activity ID:	**IA_BE_XX**
Proposed Subcategory:	Beneficiary Engagement
Proposed Activity Title:	Drug Cost Transparency
Proposed Activity Description:	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).[1])
Proposed Weighting:	High
Rationale:	The costs of prescription drugs is a driving cost of overall health care spending in the United States and of out-of-pocket health care expenses for patients. As we consider broader efforts to increase transparency for patients, payers, provider organizations, and clinicians, as well as begin to drive down drug prices, this activity serves as a mechanism for drug price transparency at the clinician-patient level and may protect patients from unforeseen costs. By discussing drug pricing with patients, clinicians may better prescribe medications patients can afford, which could have the effect of increasing patient medication compliance and adherence. Thus, we believe this activity has the potential to improve clinical practice or care delivery and is likely to result in improved outcomes, per the improvement activity definition which has been codified at § 414.1305. This activity is weighted as high due to difficulties clinicians may have in identifying drug costs and out-of-pocket costs of drugs for individual patients as costs and reimbursement amounts vary by drug and payer, as well as challenges with identifying the appropriateness of patient assistance programs.[2] [3] As stated previously, we have given certain improvement activities high-weighting due to the intensity of the activity (81 FR 77194). To summarize, we believe that an activity that requires significant investment of time and resources should be high-weighted.
Comments:	Several commenters supported the inclusion of this improvement activity. One commenter stated that many practices provide this type of financial counseling without reimbursement, and this improvement activity would be a way of recognizing eligible clinicians and practices for these services. One commenter stated that in addition to drug costs, the improvement activity should include a screening tool to identify additional barriers to medication adherence for patients. Another commenter stated their support for this activity in that discussing drug costs can help increase patient access to these therapies.

Response:	We appreciate the commenters' support. This improvement activity is meant to incentivize clinicians to provide counseling about drug costs so patients and their caregivers are aware of out-of-pocket costs. We disagree that the improvement activity should include a screening tool to identify additional barriers to medication adherence for patients; it is limited to drug costs in an effort to prioritize drug cost transparency.
Final Action:	After consideration of the public comments received, we are finalizing this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BE_25**
Subcategory:	Beneficiary Engagement
Activity Title:	Drug Cost Transparency
Activity Description:	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).[1])
Weighting:	High
Proposed Improvement Activity	
Proposed Activity ID:	**IA_CC_XX**
Proposed Subcategory:	Care Coordination
Proposed Activity Title:	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
Proposed Activity Description:	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.
Proposed Weighting:	High
Rationale:	The patient relationship categories and codes define and distinguish the relationship and responsibilities of a clinician with a patient at the point of furnishing an item or service. These codes provide insight into clinician interactions with patients and identify the clinician's relationship to and responsibility for the patient at the time of furnishing an item or service. These codes were developed, as required under section 1848(r)(3) of the Act, to facilitate the attribution of patients and episodes to one or more clinicians. Beginning in 2018, clinicians started voluntarily reporting the patient relationship codes using the applicable HCPCS modifiers (82 FR 53232 through 53234). To properly report the code modifiers, clinicians must add one of the modifiers to each claim line. We proposed that, for the CY 2020 performance period and beyond, clinicians who choose to report the modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period would earn one (1) high-weighted improvement activity. We believe reporting these modifiers would provide the minimum sample of data necessary to access the modifiers' ability to capture the clinician's relationship with the patient and whether the clinician is appropriately reporting the modifiers. This improvement activity is weighted as high

	due to the intensity of the activity. We believe reporting the modifiers to each claim line for 50 percent or more of Medicare claims continuously for 90 days requires significant investment of time and resources and should be weighted high. For the initial and current period of voluntary reporting the PRC modifiers, where clinicians gain familiarity, data collected will be used to provide aggregate feedback on the performance of clinicians in using the codes within different clinical scenarios and specialties. Data collected from this activity will be used to test the reliability and validity of the modifiers in measuring the clinician's relationship to and responsibility for the Medicare patient before we consider whether to propose in future rulemaking to require the reporting of the PRC modifiers on claims. In the event that we do decide to require such reporting, we would likely propose to remove this improvement activity from MIPS.
Comments:	Several commenters supported the inclusion of this improvement activity. Commenters stated that this would provide us with a better understanding of the types of relationships clinicians have with their patients without imposing a regulatory burden. One commenter stated that increasing the number of eligible clinicians who report patient relationship codes will help to facilitate the creation of meaningful cost measures and alternative payment models. A commenter stated that this improvement activity will be useful for clinicians that are part of large care coordination teams treating patients with complex chronic disease. An additional commenter supported weighting this improvement activity as High due to the significant investment of time and resources required. A commenter suggested that we amend claim forms to allow for more space for PRC modifiers, and recommended considering using HCPCS codes instead of HCPCS modifiers.
Response:	We appreciate the commenters' support. We anticipate this improvement activity will provide clinicians and us with a better understanding of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. We intend to keep improving clinician and patient relationships by consulting with stakeholders and experts, and through testing and research, to use the proper reporting mechanism for clinician-patient relationships. Before implementing the PRC, we sought stakeholder input which included consulting the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel, which is responsible for maintaining the CPT code set. They recommended CPT Modifiers as the best way to operationalize the reporting of patient relationship codes.[4] We also received public comments indicating that CPT Modifiers would be the best way to operationalize the reporting of patient relationship codes.[5] We plan to continue to improve the reporting of the Patient Relationship Categories and Codes through testing and feedback from stakeholders before possibly incorporating it into cost measures. Depending on the recommendations from the testing, we will consider improving the reporting of the PRC which may include modifying the claim forms through reporting patient relationship through CPT codes. Changes or updates to the improvement activity would be through the notice and comment rulemaking process.
Final Action:	After consideration of the public comments received, we are finalizing this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_CC_18**
Subcategory:	Care Coordination
Activity Title:	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
Activity Description:	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a

	continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.
Weighting:	High

1/ See the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses, Final Rule, 84 FR 23832, 23883 (May 23, 2019).

2/Allan GM, Lexchin J, Wiebe N. *Physician awareness of drug cost: a systematic review*. PLoS Med. 2007 Sep; 4(9):e283. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17896856.

3/ Arora V, Moriates C, Shah N. *The challenge of understanding health care costs and charges*. AMA Journal of Ethics. 2015; 17(11): 1046. doi: 10.1001/journalofethics.2015.17.11.stas1-1511.

4/ See CMS Patient Relationship Categories and Codes. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf.

5/ See CMS Patient Relationship Categories and Codes. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf

TABLE B: Changes to Previously Adopted Improvement Activities for the MIPS CY 2020 Performance Period and Future Years

Current Improvement Activity	
Current Activity ID:	**IA_PSPA_28**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Completion of an Accredited Safety or Quality Improvement Program
Current Activity Description:	Completion of an accredited performance improvement continuing medical education program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.
Current Weighting:	Medium
Proposed Change and Rationale:	Addition of "An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain)" as an example of an accredited continuing medical education (CME) program that could meet this improvement activity. Due to the importance of safe prescribing to prevent opioid misuse and opioid use disorder, CME programs related to opioid analgesic REMS may be especially useful to MIPS eligible clinicians in their attempts to prevent opioid misuse among their patients and combat the opioid epidemic.
Proposed Revised Activity Description:	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).
Comments:	Several commenters supported the modification of this improvement activity. Two commenters stated that the addition of opioid analgesic REMS is especially important due to the current public health challenges in addressing opioid misuse.
Response:	We appreciate the commenters' support. The modification to this improvement activity provides an additional example that clinicians can use to meet this activity that may improve safe prescribing to prevention opioid misuse and opioid use disorder.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_28**

Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Completion of an Accredited Safety or Quality Improvement Program
Activity Description:	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PM_2**
Current Subcategory:	Population Management
Current Activity Title:	Anticoagulant Management Improvements
Current Activity Description:	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up; and patient communication of results and dosing decisions; and/or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Current Weighting:	High

Proposed Change and Rationale:	Addition of "anti-coagulation medications (oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors)"; and "Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program)." This language was consolidated from IA_PM_1, which was proposed for removal in Table C. We believe IA_PM_1 is duplicative in content to, but less robust than IA_PM_2, with overall fewer examples of actions that can be undertaken to satisfy the intent of the improvement activity. However, IA_PM_1 contained more detail about the type of anti-coagulation medication that could be prescribed to satisfy this activity and an additional example of an action that can be undertaken to satisfy the intent of IA_PM_2, participation in systematic anticoagulation program; so these elements of IA_PM_IA were added to IA_PM_2. Removal of ", for 60 percent of practice patients in the transition year … in Quality Payment Program Year 2 and future years." These time references to transition year and Quality Payment Program Year 2 are now irrelevant because they are in the past. We note that this proposed change was made in conjunction with finalization of the removal of IA_PM_1 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_PM_1.
Proposed Revised Activity Description:	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity with five relevant examples. Additionally, the removal of reference to the transition year and Quality Payment Program Year 2 will minimize confusion as those time periods are now in the past.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PM_2**
Subcategory:	Population Management
Activity Title:	Anticoagulant Management Improvements

Activity Description:	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Weighting:	High
Current Improvement Activity	
Current Activity ID:	**IA_EPA_4**
Current Subcategory:	Expanded Practice Access
Current Activity Title:	Additional improvements in access as a result of QIN/QIO TA
Current Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (for example, investment of on-site diabetes educator).
Current Weighting:	Medium
Proposed Change and Rationale:	Addition of "or improve care coordination". We proposed to consolidate this language from activity IA_CC_3, which was proposed for removal in Table C. IA_CC_3 is duplicative to IA_EPA_4 in content related to Quality Innovation Network-Quality Improvement Organization technical assistance, but referred to improving care coordination. We believe the Quality Innovation Network-Quality Improvement Organization technical assistance can support both access to services and care coordination[1] and, furthermore, that care coordination and access to services are inherently related and can logically be combined into one improvement activity. We note that this proposed change was made in conjunction with the removal of IA_CC_3 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_CC_3.
Proposed Revised Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modification to this improvement activity allows clinicians to attest to one consolidated improvement activity related to QIN/QIO technical assistance. This modification makes it clear that QIN/QIO activities supports both care coordination and access to services.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_EPA_4**
Subcategory:	Expanded Practice Access

Activity Title:	Additional improvements in access as a result of QIN/QIO TA
Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_19**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Current Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.
Current Weighting:	Medium
Change and Rationale:	Addition of "Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program". This language was added to consolidate it from IA_PSPA_14, which was proposed for removal in Table C. We believe IA_PSPA_14 is duplicative in content, but less robust than IA_PSPA_19 related to adopting a model for quality improvement. However, IA_PSPA_14 contains a unique relevant example that we wish to preserve under IA_PSPA_19. We note that this proposed change was made in conjunction with the removal of IA_PSPA_14 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_PSPA_14.
Proposed Revised Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback;[2] • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence;[3] • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.[4]
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity related to formal quality improvement models with nine relevant examples.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	

Activity ID:	**IA_PSPA_19**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback;[2] • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence;[3] • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.[4]
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_BE_7**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes use of patient engagement tools.
Current Activity Description:	Participation in a QCDR, that promotes use of patient engagement tools.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the addition of activity description language from four other improvement activities related to participation in QCDR; IA_BE_11 Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan; IA_BE_2 Use of QCDR to support clinical decision making; IA_BE_9 Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement; and IA_BE_10 Participation in a QCDR, that promotes implementation of patient self-action plans. The activity description will include the current (IA_BE_7) activity description with the addition of "Participation in a Qualified Clinical Data Registry and"…, including: • "The use of processes and tools that engage patients for adherence to treatment plans" (from IA_BE_11); • "Activities that promote implementation of shared clinical decision making capabilities" (from IA_BE_2); • "Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement" (from IA_BE_9); • "Activities that promote implementation of patient self-action plans" (from IA_BE_10). This language was proposed to consolidate activity description language from improvement activities was proposed for removal in Table C (IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10). The activities proposed for removal are duplicative to IA_BE_7. We also proposed to remove the language "use of…tools" to better capture the content of the consolidated improvement activity regarding promoting patient engagement more broadly.

	We note that this proposed change was made in conjunction with and is contingent upon finalization of the removal of IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10.
Proposed Revised Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Comments:	Several commenters supported the modification of this improvement activity. One commenter recommended increasing the weighting for this improvement activity to High. Another commenter also recommended that this improvement activity be modified to include participation in nationally validated and risk-adjusted clinical data registries.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allow clinicians to attest to one consolidated improvement activity related to participation in a QCDR with four relevant examples of activities related to patient engagement. The modifications do not increase the effort required, and therefore, we do not believe the weighting of the improvement activity should be increased. We refer readers to section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59776 through 59777) where we discussed that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources. This improvement activity promotes use of QCDRs. If clinicians would like to receive credit for alternative data registries, we suggest considering attesting to another appropriate improvement activity, such as IA_PSPA_14, Participation in Quality Improvement Initiatives or IA_PSPA_19, Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BE_7**
Subcategory:	Beneficiary Engagement
Activity Title:	Participation in a QCDR, that promotes use of patient engagement tools.
Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_7**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Use of QCDR data for ongoing practice assessment and improvements
Current Activity Description:	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the addition of activity description language from four other improvement activities related to participation in QCDR; IA_CC_6 Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination; IA_AHE_4 Leveraging a QCDR for use of standard questionnaires;

	IA_AHE_2 Leveraging a QCDR to standardize processes for screening; and IA_PM_10 Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. The activity description will include the current (IA_PSPA_7) activity description with the addition of "Participation in a Qualified Clinical Data Registry and"… including: • "Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups)" (from IA_CC_6); • "Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment)" (from IA_AHE_4); • "Use of standardized processes for screening for social determinants of health such as food security, employment and housing" from (from IA_AHE_2); • "Use of supporting QCDR modules that can be incorporated into the certified EHR technology" (This language adapted from IA_AHE_2 and updated to replace "tools" with "QCDR modules" to add additional specificity to the action that can be taken in the QCDR to promote ongoing practice assessment and patient safety.); or • "Use of QCDR data for quality improvement (such as) comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes" (from IA_PM_10). This language was proposed to consolidate improvement activity description language from activities (IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10) proposed for removal in Table C. The activities we are duplicative to IA_PSPA_7. We note that this proposed change was made in conjunction with and is contingent upon finalization of the removal of IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10.
Proposed Revised Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire[5], MD Anderson Symptom Inventory[6], and/or SF-12/VR-12 functional health status assessment[7]; • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.
Comments:	Several commenters supported the modification of this improvement activity. One commenter recommended increasing the weighting for this improvement activity to High. A commenter also recommended that this improvement activity be modified to include participation in nationally validated and risk-adjusted clinical data registries.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity related to participation in a QCDR with five relevant examples of activities related to ongoing practice assessment and improvements in patient safety. The modifications do not

	increase the effort required, and therefore, we do not believe the weighting of the improvement activity should be increased. We refer readers to section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59776 through 59777) where we discussed that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources. This improvement activity promotes use of QCDRs. If clinicians would like to receive credit for alternative data registries, we suggest considering attesting to another appropriate improvement activity, such as IA_PSPA_14, Participation in Quality Improvement Initiatives or IA_PSPA_19, Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_7**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Use of QCDR data for ongoing practice assessment and improvements
Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire[5], MD Anderson Symptom Inventory[6], and/or SF-12/VR-12 functional health status assessment[7]; • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_BMH_10**
Current Subcategory:	Behavioral and Mental Health
Current Activity Title:	Completion of Collaborative Care Management Training Program
Current Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric 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.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the removal of the reference to the CMS Transforming Clinical Practice Initiative (TCPI) in the activity description. This initiative ended on September 28, 2019,[9] and therefore, is no longer be applicable to this improvement activity description. The example training program referenced, the APA Collaborative Care Model, continues to be available to the public. The revised activity description only proposes to remove reference to TCPI.
Proposed Revised Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public[8],

	in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The removal of reference to the TCPI in this improvement activity description will minimize confusion as that initiative ended on September 28, 2019.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BMH_10**
Subcategory:	Behavioral and Mental Health
Activity Title:	Completion of Collaborative Care Management Training Program
Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public[8], in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.
Weighting:	Medium

1/ Quality Improvement Organizations. About QIN-QIO. Available at https://qioprogram.org/about/why-cms-has-qios.

2/ Multisource feedback (MSF), or 360-degree employee evaluation, is a questionnaire-based assessment method in which rates are evaluated by peers, patients, and coworkers on key performance behaviors. More information available at https://www.ncbi.nlm.nih.gov/pubmed/12739254.

3/ Bridges to Excellence program. More information available at http://www.bridgestoexcellence.org/.

4/ American Board of Medical Specialties Portfolio Program. More information is available at https://mocportfolioprogram.org/about-us/.

5/ The Seattle Angina Questionnaire is a self-assessed health-related quality of life instrument for coronary artery disease. See: Spertus JA et al. *Development and evaluation of the Seattle Angina Questionnaire: a new functional status measure for coronary artery disease.* J Am Coll Cardiol. 1995 Feb;25(2):333-41. Available at https://www.ncbi.nlm.nih.gov/pubmed/7829785.

6/ The MD Anderson Symptom Inventory (MDASI) is a multi-symptom patient-reported outcome (PRO) measure for clinical and research use. Available at https://www.mdanderson.org/research/departments-labs-institutes/departments-divisions/symptom-research/symptom-assessment-tools/md-anderson-symptom-inventory.html.

7/ The Optum SF Health Surveys are patient-reported outcome (PRO) surveys across eight health domains. Available at https://www.optum.com/solutions/life-sciences/answer-research/patient-insights/sf-health-surveys.html?s=PPC&pstc=optum:ppc:LS_4.1_2018:g:ls:Frm:18wd1fk01rr23&ppcid=sf12&adid=323753202402&adgroupid=52618954298&campaignid=1036340767&o=optum:ppc:LS_4.1_2018:frm:ls:Frm:18wd1fk01rr23&gclid=Cj0KCQjwg73kBRDVARIsAF-kEH_sDfonepf7U7tsZzzLcHc15b_DxREHpFu0kNGwu2ANu-33WiGoSBIaAgIdEALw_wcB.

8/ The American Psychiatric Association (APA) Collaborative Care Model has been shown to be an effective and efficient model in delivering integrated care. More information on this model and the training program is available at https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn.

9/ Transforming Clinical Practice Initiative. Available at https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/.

TABLE C: Improvement Activities for Removal for the MIPS CY 2020 MIPS Performance Period and Future Years

We note that in the CY 2020 PFS proposed rule [84 FR 40765], we inadvertently referenced 14 improvement activities proposed for removal even though there were 15 improvement activities proposed for removal in Table C. We are correcting that typographical error here. In this final rule, we are finalizing our proposals as proposed to remove 15 previously finalized improvement activities from the MIPS Program for the MIPS CY 2020 performance period and future years. These improvement activities are discussed in detail below. Improvement activity removal factors are discussed in section III.K.3.c.(3) of this final rule.

Current Improvement Activity	
Current Activity ID:	**IA_PM_1**
Current Subcategory:	Population Management
Current Activity Title:	Participation in Systematic Anticoagulation Program
Current Activity Description:	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Current Weighting:	High
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PM_2. We proposed consolidating the unique language from IA_PM_1 into IA_PM_2 per the change in Table B. The revised IA_PM_2 adds additional detail from IA_PM_1. We note that this proposed removal was made in conjunction with our decision to modify IA_PM_2 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of this final rule.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PM_2. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PM_2, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_3**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of additional activity as a result of TA for improving care coordination
Current Activity Description:	Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of IA_CC_3 under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_EPA_4. We proposed consolidating the unique language from IA_CC_3 into IA_EPA_4 per the change in Table B. The modified language to IA_EPA_4 adds the outcome of "improve care coordination" from the removed activity to make IA_EPA_4 more robust. We note that this proposed removal was made in conjunction with our proposal to modify IA_EPA_4 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of this final rule.

Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_EPA_4. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_EPA_4, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_14**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Participation in Quality Improvement Initiatives
Current Activity Description:	Participation in other quality improvement programs such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this IA_PSPA_14 under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of the activities included in IA_PSPA_19. We proposed consolidating the unique language in IA_PSPA_14 with IA_PSPA_19 per the change in Table B. The modified language to IA_PSPA_19 adds the examples "Bridges to Excellence" and "American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program" as additional actions that an eligible clinician or group can take to participate in a quality improvement program. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_19 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_19 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_19. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_19, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_5**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Annual Registration in the Prescription Drug Monitoring Program
Current Activity Description:	Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months.

Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar in content but less robust than the currently adopted IA_PSPA_6. IA_PSPA_6 requires consultation of and specific thresholds of use for a prescription drug monitoring program instead of simply registering in a prescription drug monitoring program as described in IA_PSPA_5. Because of this, we believe IA_PSPA_6 already captures the essence of IA_PSPA_5 and directly falls into that improvement activity. We note that this proposed removal was made in conjunction with our proposal to adopt removal factors in section III.K.3c.(3) of this final rule.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_6. We understand the concern that removal of improvement activities may limit clinician options but clinicians may attest to IA_PSPA_6, as well as other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_24**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Initiate CDC Training on Antibiotic Stewardship
Current Activity Description:	Completion of greater than 50 percent of the modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis, but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is less robust than IA_PSPA_23. IA_PSPA_23 requires completion of all modules of a Centers for Disease Control and Prevention antibiotic stewardship course, instead of 50 percent of modules of a Centers for Disease Control and Prevention antibiotic stewardship course. Because of this, we believe IA_PSPA_23 already captures the essence of IA_PSPA_24 and directly fall into that improvement activity. We note that this proposal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this referenced proposal. We refer readers to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_23. We understand the concern that

	removal of improvement activities may limit clinician options but clinicians may attest to other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of the CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BMH_3**
Current Subcategory:	Behavioral and Mental Health
Current Activity Title:	Unhealthy alcohol use
Current Activity Description:	Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.
Current Weighting:	Medium
Removal Rationale:	We proposed removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to the currently adopted IA_BMH_9. We believe IA_BMH_9 is more robust because it requires a threshold of patients for which this unhealthy alcohol use screening must be completed, whereas IA_BMH_3 simply requires engagement, screening and counseling without such a threshold. Because of this, we believe IA_BMH_9 already captures the essence of IA_BMH_3 and directly fall into that improvement activity. We note that this proposal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this referenced proposal. We refer readers to section III.K.3.c.(3) in this final rule where we are finalizing our proposals to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BMH_9. We understand the concern that removal of improvement activities may limit clinician options but clinicians may attest to other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_11**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan
Current Activity Description:	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
Current Weighting:	Medium

Removal Rationale:	We proposed removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 that add "…the use of processes and tools that engage patients for adherence to treatment plan" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_11. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_2**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Use of QCDR to support clinical decision making
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we are proposed changes to IA_BE_7 that add "activities that promote implementation of shared clinical decision making capabilities" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_2. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.

Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_9**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Use of QCDR patient experience data to inform and advance improvements in beneficiary
Current Activity Description:	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 that add "use of QCDR patient experience data to inform and advance improvements in beneficiary engagement" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_9. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to sections Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_10**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes implementation of patient self-action plans.
Current Activity Description:	Participation in a QCDR, that promotes implementation of patient self-action plans.

Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 to add "[activities that] promote implementation of patient self-action plans" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_10. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_6**
Current Subcategory:	Care Coordination
Current Activity Title:	Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination
Current Activity Description:	Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups);" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_CC_6. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal adopt removal factors.

Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_AHE_4**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Leveraging a QCDR for use of standard questionnaires
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment);" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_AHE_4. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.

Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_AHE_2**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Leveraging a QCDR to standardize processes for screening
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of standardized processes for screening for social determinants of health such as food security, employment and housing…use of supporting tools that can be incorporated into the certified EHR technology" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_AHE_2. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to sections Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PM_10**
Current Subcategory:	Population Management
Current Activity Title:	Use of QCDR data for quality improvement such as comparative analysis reports across patient populations
Current Activity Description:	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (for example, comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).
Current Weighting:	Medium

Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of QCDR data for quality improvement such as comparative analysis reports across patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_PM_10. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_4**
Current Subcategory:	Care Coordination
Current Activity Title:	TCPI Participation
Current Activity Description:	Participation in CMS Transforming Clinical Practice Initiative
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 7, improvement activity is obsolete. The Transforming Clinical Practice Initiative ended on September 28, 2019[1] and therefore, clinicians are no longer be able to attest to this improvement activity. We note that this proposed removal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this proposal. We refer readers to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. Since it is no longer feasible for clinicians to attest to this improvement activity due to the TCPI ending on September 28, 2019, we do not believe removal of this improvement activity would limit clinician options.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.

Finalized Improvement Activity	
Activity ID:	N/A – Removed

1/ Transforming Clinical Practice Initiative. Available at https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/.

Appendix 2: Improvement Activities

NOTE: In this final rule, for the CY 2020 performance period and future years, we are finalizing our proposals to: (1) add two new improvement activities; (2) modify seven existing improvement activities; and (3) remove 15 improvement activities from the Inventory. These are discussed in greater detail below.

Table A: New Improvement Activities for the MIPS CY 2020 Performance Period and Future Years

Proposed Improvement Activity	
Proposed Activity ID:	**IA_BE_XX**
Proposed Subcategory:	Beneficiary Engagement
Proposed Activity Title:	Drug Cost Transparency
Proposed Activity Description:	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).[1])
Proposed Weighting:	High
Rationale:	The costs of prescription drugs is a driving cost of overall health care spending in the United States and of out-of-pocket health care expenses for patients. As we consider broader efforts to increase transparency for patients, payers, provider organizations, and clinicians, as well as begin to drive down drug prices, this activity serves as a mechanism for drug price transparency at the clinician-patient level and may protect patients from unforeseen costs. By discussing drug pricing with patients, clinicians may better prescribe medications patients can afford, which could have the effect of increasing patient medication compliance and adherence. Thus, we believe this activity has the potential to improve clinical practice or care delivery and is likely to result in improved outcomes, per the improvement activity definition which has been codified at § 414.1305. This activity is weighted as high due to difficulties clinicians may have in identifying drug costs and out-of-pocket costs of drugs for individual patients as costs and reimbursement amounts vary by drug and payer, as well as challenges with identifying the appropriateness of patient assistance programs.[2] [3] As stated previously, we have given certain improvement activities high-weighting due to the intensity of the activity (81 FR 77194). To summarize, we believe that an activity that requires significant investment of time and resources should be high-weighted.
Comments:	Several commenters supported the inclusion of this improvement activity. One commenter stated that many practices provide this type of financial counseling without reimbursement, and this improvement activity would be a way of recognizing eligible clinicians and practices for these services. One commenter stated that in addition to drug costs, the improvement activity should include a screening tool to identify additional barriers to medication adherence for patients. Another commenter stated their support for this activity in that discussing drug costs can help increase patient access to these therapies.

Response:	We appreciate the commenters' support. This improvement activity is meant to incentivize clinicians to provide counseling about drug costs so patients and their caregivers are aware of out-of-pocket costs. We disagree that the improvement activity should include a screening tool to identify additional barriers to medication adherence for patients; it is limited to drug costs in an effort to prioritize drug cost transparency.
Final Action:	After consideration of the public comments received, we are finalizing this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BE_25**
Subcategory:	Beneficiary Engagement
Activity Title:	Drug Cost Transparency
Activity Description:	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).[1])
Weighting:	High
Proposed Improvement Activity	
Proposed Activity ID:	**IA_CC_XX**
Proposed Subcategory:	Care Coordination
Proposed Activity Title:	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
Proposed Activity Description:	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.
Proposed Weighting:	High
Rationale:	The patient relationship categories and codes define and distinguish the relationship and responsibilities of a clinician with a patient at the point of furnishing an item or service. These codes provide insight into clinician interactions with patients and identify the clinician's relationship to and responsibility for the patient at the time of furnishing an item or service. These codes were developed, as required under section 1848(r)(3) of the Act, to facilitate the attribution of patients and episodes to one or more clinicians. Beginning in 2018, clinicians started voluntarily reporting the patient relationship codes using the applicable HCPCS modifiers (82 FR 53232 through 53234). To properly report the code modifiers, clinicians must add one of the modifiers to each claim line. We proposed that, for the CY 2020 performance period and beyond, clinicians who choose to report the modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period would earn one (1) high-weighted improvement activity. We believe reporting these modifiers would provide the minimum sample of data necessary to access the modifiers' ability to capture the clinician's relationship with the patient and whether the clinician is appropriately reporting the modifiers. This improvement activity is weighted as high

	due to the intensity of the activity. We believe reporting the modifiers to each claim line for 50 percent or more of Medicare claims continuously for 90 days requires significant investment of time and resources and should be weighted high. For the initial and current period of voluntary reporting the PRC modifiers, where clinicians gain familiarity, data collected will be used to provide aggregate feedback on the performance of clinicians in using the codes within different clinical scenarios and specialties. Data collected from this activity will be used to test the reliability and validity of the modifiers in measuring the clinician's relationship to and responsibility for the Medicare patient before we consider whether to propose in future rulemaking to require the reporting of the PRC modifiers on claims. In the event that we do decide to require such reporting, we would likely propose to remove this improvement activity from MIPS.
Comments:	Several commenters supported the inclusion of this improvement activity. Commenters stated that this would provide us with a better understanding of the types of relationships clinicians have with their patients without imposing a regulatory burden. One commenter stated that increasing the number of eligible clinicians who report patient relationship codes will help to facilitate the creation of meaningful cost measures and alternative payment models. A commenter stated that this improvement activity will be useful for clinicians that are part of large care coordination teams treating patients with complex chronic disease. An additional commenter supported weighting this improvement activity as High due to the significant investment of time and resources required. A commenter suggested that we amend claim forms to allow for more space for PRC modifiers, and recommended considering using HCPCS codes instead of HCPCS modifiers.
Response:	We appreciate the commenters' support. We anticipate this improvement activity will provide clinicians and us with a better understanding of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. We intend to keep improving clinician and patient relationships by consulting with stakeholders and experts, and through testing and research, to use the proper reporting mechanism for clinician-patient relationships. Before implementing the PRC, we sought stakeholder input which included consulting the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel, which is responsible for maintaining the CPT code set. They recommended CPT Modifiers as the best way to operationalize the reporting of patient relationship codes.[4] We also received public comments indicating that CPT Modifiers would be the best way to operationalize the reporting of patient relationship codes.[5] We plan to continue to improve the reporting of the Patient Relationship Categories and Codes through testing and feedback from stakeholders before possibly incorporating it into cost measures. Depending on the recommendations from the testing, we will consider improving the reporting of the PRC which may include modifying the claim forms through reporting patient relationship through CPT codes. Changes or updates to the improvement activity would be through the notice and comment rulemaking process.
Final Action:	After consideration of the public comments received, we are finalizing this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_CC_18**
Subcategory:	Care Coordination
Activity Title:	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
Activity Description:	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a

	continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.
Weighting:	High

1/ See the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses, Final Rule, 84 FR 23832, 23883 (May 23, 2019).

2/Allan GM, Lexchin J, Wiebe N. *Physician awareness of drug cost: a systematic review*. PLoS Med. 2007 Sep; 4(9):e283. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17896856.

3/ Arora V, Moriates C, Shah N. *The challenge of understanding health care costs and charges*. AMA Journal of Ethics. 2015; 17(11): 1046. doi: 10.1001/journalofethics.2015.17.11.stas1-1511.

4/ See CMS Patient Relationship Categories and Codes. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf.

5/ See CMS Patient Relationship Categories and Codes. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf

TABLE B: Changes to Previously Adopted Improvement Activities for the MIPS CY 2020 Performance Period and Future Years

Current Improvement Activity	
Current Activity ID:	**IA_PSPA_28**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Completion of an Accredited Safety or Quality Improvement Program
Current Activity Description:	Completion of an accredited performance improvement continuing medical education program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.
Current Weighting:	Medium
Proposed Change and Rationale:	Addition of "An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain)" as an example of an accredited continuing medical education (CME) program that could meet this improvement activity. Due to the importance of safe prescribing to prevent opioid misuse and opioid use disorder, CME programs related to opioid analgesic REMS may be especially useful to MIPS eligible clinicians in their attempts to prevent opioid misuse among their patients and combat the opioid epidemic.
Proposed Revised Activity Description:	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).
Comments:	Several commenters supported the modification of this improvement activity. Two commenters stated that the addition of opioid analgesic REMS is especially important due to the current public health challenges in addressing opioid misuse.
Response:	We appreciate the commenters' support. The modification to this improvement activity provides an additional example that clinicians can use to meet this activity that may improve safe prescribing to prevention opioid misuse and opioid use disorder.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_28**

Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Completion of an Accredited Safety or Quality Improvement Program
Activity Description:	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PM_2**
Current Subcategory:	Population Management
Current Activity Title:	Anticoagulant Management Improvements
Current Activity Description:	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up; and patient communication of results and dosing decisions; and/or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Current Weighting:	High

Proposed Change and Rationale:	Addition of "anti-coagulation medications (oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors)"; and "Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program)." This language was consolidated from IA_PM_1, which was proposed for removal in Table C. We believe IA_PM_1 is duplicative in content to, but less robust than IA_PM_2, with overall fewer examples of actions that can be undertaken to satisfy the intent of the improvement activity. However, IA_PM_1 contained more detail about the type of anti-coagulation medication that could be prescribed to satisfy this activity and an additional example of an action that can be undertaken to satisfy the intent of IA_PM_2, participation in systematic anticoagulation program; so these elements of IA_PM_IA were added to IA_PM_2. Removal of ", for 60 percent of practice patients in the transition year … in Quality Payment Program Year 2 and future years." These time references to transition year and Quality Payment Program Year 2 are now irrelevant because they are in the past. We note that this proposed change was made in conjunction with finalization of the removal of IA_PM_1 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_PM_1.
Proposed Revised Activity Description:	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity with five relevant examples. Additionally, the removal of reference to the transition year and Quality Payment Program Year 2 will minimize confusion as those time periods are now in the past.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PM_2**
Subcategory:	Population Management
Activity Title:	Anticoagulant Management Improvements

Activity Description:	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Weighting:	High
Current Improvement Activity	
Current Activity ID:	**IA_EPA_4**
Current Subcategory:	Expanded Practice Access
Current Activity Title:	Additional improvements in access as a result of QIN/QIO TA
Current Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (for example, investment of on-site diabetes educator).
Current Weighting:	Medium
Proposed Change and Rationale:	Addition of "or improve care coordination". We proposed to consolidate this language from activity IA_CC_3, which was proposed for removal in Table C. IA_CC_3 is duplicative to IA_EPA_4 in content related to Quality Innovation Network-Quality Improvement Organization technical assistance, but referred to improving care coordination. We believe the Quality Innovation Network-Quality Improvement Organization technical assistance can support both access to services and care coordination[1] and, furthermore, that care coordination and access to services are inherently related and can logically be combined into one improvement activity. We note that this proposed change was made in conjunction with the removal of IA_CC_3 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_CC_3.
Proposed Revised Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modification to this improvement activity allows clinicians to attest to one consolidated improvement activity related to QIN/QIO technical assistance. This modification makes it clear that QIN/QIO activities supports both care coordination and access to services.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_EPA_4**
Subcategory:	Expanded Practice Access

Activity Title:	Additional improvements in access as a result of QIN/QIO TA
Activity Description:	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_19**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Current Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.
Current Weighting:	Medium
Change and Rationale:	Addition of "Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program". This language was added to consolidate it from IA_PSPA_14, which was proposed for removal in Table C. We believe IA_PSPA_14 is duplicative in content, but less robust than IA_PSPA_19 related to adopting a model for quality improvement. However, IA_PSPA_14 contains a unique relevant example that we wish to preserve under IA_PSPA_19. We note that this proposed change was made in conjunction with the removal of IA_PSPA_14 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_PSPA_14.
Proposed Revised Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback;[2] • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence;[3] • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.[4]
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity related to formal quality improvement models with nine relevant examples.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	

Activity ID:	**IA_PSPA_19**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
Activity Description:	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback;[2] • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence;[3] • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.[4]
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_BE_7**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes use of patient engagement tools.
Current Activity Description:	Participation in a QCDR, that promotes use of patient engagement tools.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the addition of activity description language from four other improvement activities related to participation in QCDR; IA_BE_11 Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan; IA_BE_2 Use of QCDR to support clinical decision making; IA_BE_9 Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement; and IA_BE_10 Participation in a QCDR, that promotes implementation of patient self-action plans. The activity description will include the current (IA_BE_7) activity description with the addition of "Participation in a Qualified Clinical Data Registry and"…, including: • "The use of processes and tools that engage patients for adherence to treatment plans" (from IA_BE_11); • "Activities that promote implementation of shared clinical decision making capabilities" (from IA_BE_2); • "Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement" (from IA_BE_9); • "Activities that promote implementation of patient self-action plans" (from IA_BE_10). This language was proposed to consolidate activity description language from improvement activities was proposed for removal in Table C (IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10). The activities proposed for removal are duplicative to IA_BE_7. We also proposed to remove the language "use of…tools" to better capture the content of the consolidated improvement activity regarding promoting patient engagement more broadly.

	We note that this proposed change was made in conjunction with and is contingent upon finalization of the removal of IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_BE_11, IA_BE_2, IA_BE_9, and IA_BE_10.
Proposed Revised Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Comments:	Several commenters supported the modification of this improvement activity. One commenter recommended increasing the weighting for this improvement activity to High. Another commenter also recommended that this improvement activity be modified to include participation in nationally validated and risk-adjusted clinical data registries.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allow clinicians to attest to one consolidated improvement activity related to participation in a QCDR with four relevant examples of activities related to patient engagement. The modifications do not increase the effort required, and therefore, we do not believe the weighting of the improvement activity should be increased. We refer readers to section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59776 through 59777) where we discussed that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources. This improvement activity promotes use of QCDRs. If clinicians would like to receive credit for alternative data registries, we suggest considering attesting to another appropriate improvement activity, such as IA_PSPA_14, Participation in Quality Improvement Initiatives or IA_PSPA_19, Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BE_7**
Subcategory:	Beneficiary Engagement
Activity Title:	Participation in a QCDR, that promotes use of patient engagement tools.
Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_7**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Use of QCDR data for ongoing practice assessment and improvements
Current Activity Description:	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the addition of activity description language from four other improvement activities related to participation in QCDR; IA_CC_6 Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination; IA_AHE_4 Leveraging a QCDR for use of standard questionnaires;

	IA_AHE_2 Leveraging a QCDR to standardize processes for screening; and IA_PM_10 Use of QCDR data for quality improvement such as comparative analysis reports across patient populations. The activity description will include the current (IA_PSPA_7) activity description with the addition of "Participation in a Qualified Clinical Data Registry and"… including: • "Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups)" (from IA_CC_6); • "Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment)" (from IA_AHE_4); • "Use of standardized processes for screening for social determinants of health such as food security, employment and housing" from (from IA_AHE_2); • "Use of supporting QCDR modules that can be incorporated into the certified EHR technology" (This language adapted from IA_AHE_2 and updated to replace "tools" with "QCDR modules" to add additional specificity to the action that can be taken in the QCDR to promote ongoing practice assessment and patient safety.); or • "Use of QCDR data for quality improvement (such as) comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes" (from IA_PM_10). This language was proposed to consolidate improvement activity description language from activities (IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10) proposed for removal in Table C. The activities we are duplicative to IA_PSPA_7. We note that this proposed change was made in conjunction with and is contingent upon finalization of the removal of IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10 as discussed in Table C. We refer readers to Table C where we are finalizing the removal of IA_CC_6, IA_AHE_4, IA_AHE_2, and IA_PM_10.
Proposed Revised Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire[5], MD Anderson Symptom Inventory[6], and/or SF-12/VR-12 functional health status assessment[7]; • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.
Comments:	Several commenters supported the modification of this improvement activity. One commenter recommended increasing the weighting for this improvement activity to High. A commenter also recommended that this improvement activity be modified to include participation in nationally validated and risk-adjusted clinical data registries.
Response:	We appreciate the commenters' support. The modifications to this improvement activity allows clinicians to attest to one consolidated improvement activity related to participation in a QCDR with five relevant examples of activities related to ongoing practice assessment and improvements in patient safety. The modifications do not

	increase the effort required, and therefore, we do not believe the weighting of the improvement activity should be increased. We refer readers to section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59776 through 59777) where we discussed that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources. This improvement activity promotes use of QCDRs. If clinicians would like to receive credit for alternative data registries, we suggest considering attesting to another appropriate improvement activity, such as IA_PSPA_14, Participation in Quality Improvement Initiatives or IA_PSPA_19, Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_PSPA_7**
Subcategory:	Patient Safety and Practice Assessment
Activity Title:	Use of QCDR data for ongoing practice assessment and improvements
Activity Description:	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire[5], MD Anderson Symptom Inventory[6], and/or SF-12/VR-12 functional health status assessment[7]; • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.
Weighting:	Medium
Current Improvement Activity	
Current Activity ID:	**IA_BMH_10**
Current Subcategory:	Behavioral and Mental Health
Current Activity Title:	Completion of Collaborative Care Management Training Program
Current Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric 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.
Current Weighting:	Medium
Proposed Change and Rationale:	We proposed the removal of the reference to the CMS Transforming Clinical Practice Initiative (TCPI) in the activity description. This initiative ended on September 28, 2019,[9] and therefore, is no longer be applicable to this improvement activity description. The example training program referenced, the APA Collaborative Care Model, continues to be available to the public. The revised activity description only proposes to remove reference to TCPI.
Proposed Revised Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public[8],

	in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.
Comments:	Several commenters supported the modification of this improvement activity.
Response:	We appreciate the commenters' support. The removal of reference to the TCPI in this improvement activity description will minimize confusion as that initiative ended on September 28, 2019.
Final Action:	After consideration of the public comments received, we are finalizing changes to this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	**IA_BMH_10**
Subcategory:	Behavioral and Mental Health
Activity Title:	Completion of Collaborative Care Management Training Program
Activity Description:	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public[8], in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.
Weighting:	Medium

1/ Quality Improvement Organizations. About QIN-QIO. Available at https://qioprogram.org/about/why-cms-has-qios.

2/ Multisource feedback (MSF), or 360-degree employee evaluation, is a questionnaire-based assessment method in which rates are evaluated by peers, patients, and coworkers on key performance behaviors. More information available at https://www.ncbi.nlm.nih.gov/pubmed/12739254.

3/ Bridges to Excellence program. More information available at http://www.bridgestoexcellence.org/.

4/ American Board of Medical Specialties Portfolio Program. More information is available at https://mocportfolioprogram.org/about-us/.

5/ The Seattle Angina Questionnaire is a self-assessed health-related quality of life instrument for coronary artery disease. See: Spertus JA et al. *Development and evaluation of the Seattle Angina Questionnaire: a new functional status measure for coronary artery disease.* J Am Coll Cardiol. 1995 Feb;25(2):333-41. Available at https://www.ncbi.nlm.nih.gov/pubmed/7829785.

6/ The MD Anderson Symptom Inventory (MDASI) is a multi-symptom patient-reported outcome (PRO) measure for clinical and research use. Available at https://www.mdanderson.org/research/departments-labs-institutes/departments-divisions/symptom-research/symptom-assessment-tools/md-anderson-symptom-inventory.html.

7/ The Optum SF Health Surveys are patient-reported outcome (PRO) surveys across eight health domains. Available at https://www.optum.com/solutions/life-sciences/answer-research/patient-insights/sf-health-surveys.html?s=PPC&pstc=optum:ppc:LS_4.1_2018:g:ls:Frm:18wd1fk01rr23&ppcid=sf12&adid=323753202402&adgroupid=52618954298&campaignid=1036340767&o=optum:ppc:LS_4.1_2018:frm:ls:Frm:18wd1fk01rr23&gclid=Cj0KCQjwg73kBRDVARIsAF-kEH_sDfonepf7U7tsZzzLcHc15b_DxREHpFu0kNGwu2ANu-33WiGoSBIaAgIdEALw_wcB.

8/ The American Psychiatric Association (APA) Collaborative Care Model has been shown to be an effective and efficient model in delivering integrated care. More information on this model and the training program is available at https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn.

9/ Transforming Clinical Practice Initiative. Available at https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/.

TABLE C: Improvement Activities for Removal for the MIPS CY 2020 MIPS Performance Period and Future Years

We note that in the CY 2020 PFS proposed rule [84 FR 40765], we inadvertently referenced 14 improvement activities proposed for removal even though there were 15 improvement activities proposed for removal in Table C. We are correcting that typographical error here. In this final rule, we are finalizing our proposals as proposed to remove 15 previously finalized improvement activities from the MIPS Program for the MIPS CY 2020 performance period and future years. These improvement activities are discussed in detail below. Improvement activity removal factors are discussed in section III.K.3.c.(3) of this final rule.

Current Improvement Activity	
Current Activity ID:	**IA_PM_1**
Current Subcategory:	Population Management
Current Activity Title:	Participation in Systematic Anticoagulation Program
Current Activity Description:	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program) for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).
Current Weighting:	High
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PM_2. We proposed consolidating the unique language from IA_PM_1 into IA_PM_2 per the change in Table B. The revised IA_PM_2 adds additional detail from IA_PM_1. We note that this proposed removal was made in conjunction with our decision to modify IA_PM_2 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of this final rule.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PM_2. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PM_2, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_3**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of additional activity as a result of TA for improving care coordination
Current Activity Description:	Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of IA_CC_3 under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_EPA_4. We proposed consolidating the unique language from IA_CC_3 into IA_EPA_4 per the change in Table B. The modified language to IA_EPA_4 adds the outcome of "improve care coordination" from the removed activity to make IA_EPA_4 more robust. We note that this proposed removal was made in conjunction with our proposal to modify IA_EPA_4 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of this final rule.

Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_EPA_4. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_EPA_4, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_14**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Participation in Quality Improvement Initiatives
Current Activity Description:	Participation in other quality improvement programs such as Bridges to Excellence or American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this IA_PSPA_14 under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of the activities included in IA_PSPA_19. We proposed consolidating the unique language in IA_PSPA_14 with IA_PSPA_19 per the change in Table B. The modified language to IA_PSPA_19 adds the examples "Bridges to Excellence" and "American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program" as additional actions that an eligible clinician or group can take to participate in a quality improvement program. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_19 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_19 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_19. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_19, which we are retaining.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_5**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Annual Registration in the Prescription Drug Monitoring Program
Current Activity Description:	Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months.

Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar in content but less robust than the currently adopted IA_PSPA_6. IA_PSPA_6 requires consultation of and specific thresholds of use for a prescription drug monitoring program instead of simply registering in a prescription drug monitoring program as described in IA_PSPA_5. Because of this, we believe IA_PSPA_6 already captures the essence of IA_PSPA_5 and directly falls into that improvement activity. We note that this proposed removal was made in conjunction with our proposal to adopt removal factors in section III.K.3c.(3) of this final rule.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_6. We understand the concern that removal of improvement activities may limit clinician options but clinicians may attest to IA_PSPA_6, as well as other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_24**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Initiate CDC Training on Antibiotic Stewardship
Current Activity Description:	Completion of greater than 50 percent of the modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis, but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is less robust than IA_PSPA_23. IA_PSPA_23 requires completion of all modules of a Centers for Disease Control and Prevention antibiotic stewardship course, instead of 50 percent of modules of a Centers for Disease Control and Prevention antibiotic stewardship course. Because of this, we believe IA_PSPA_23 already captures the essence of IA_PSPA_24 and directly fall into that improvement activity. We note that this proposal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this referenced proposal. We refer readers to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_23. We understand the concern that

	removal of improvement activities may limit clinician options but clinicians may attest to other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of the CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BMH_3**
Current Subcategory:	Behavioral and Mental Health
Current Activity Title:	Unhealthy alcohol use
Current Activity Description:	Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.
Current Weighting:	Medium
Removal Rationale:	We proposed removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to the currently adopted IA_BMH_9. We believe IA_BMH_9 is more robust because it requires a threshold of patients for which this unhealthy alcohol use screening must be completed, whereas IA_BMH_3 simply requires engagement, screening and counseling without such a threshold. Because of this, we believe IA_BMH_9 already captures the essence of IA_BMH_3 and directly fall into that improvement activity. We note that this proposal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this referenced proposal. We refer readers to section III.K.3.c.(3) in this final rule where we are finalizing our proposals to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BMH_9. We understand the concern that removal of improvement activities may limit clinician options but clinicians may attest to other medium-weight IAs. As explained in section III.I.3.h.(4)(d)(i)(C) of CY 2019 PFS final rule (83 FR 59780 through 59781) the weighting of "medium" is in accordance with our policy, as high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and/or is of high intensity, requiring significant investment of time and resources.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_11**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan
Current Activity Description:	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
Current Weighting:	Medium

Removal Rationale:	We proposed removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 that add "…the use of processes and tools that engage patients for adherence to treatment plan" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_11. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_2**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Use of QCDR to support clinical decision making
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we are proposed changes to IA_BE_7 that add "activities that promote implementation of shared clinical decision making capabilities" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_2. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.

Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_9**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Use of QCDR patient experience data to inform and advance improvements in beneficiary
Current Activity Description:	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 that add "use of QCDR patient experience data to inform and advance improvements in beneficiary engagement" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_9. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to sections Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_BE_10**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Participation in a QCDR, that promotes implementation of patient self-action plans.
Current Activity Description:	Participation in a QCDR, that promotes implementation of patient self-action plans.

Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_BE_7. In Table B, we proposed changes to IA_BE_7 to add "[activities that] promote implementation of patient self-action plans" to make IA_BE_7 more robust and offer an additional example. Because of this, we believe the changes to IA_BE_7 capture the essence of IA_BE_10. We note that this proposed removal was made in conjunction with our proposal to modify IA_BE_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_BE_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_BE_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_BE_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_6**
Current Subcategory:	Care Coordination
Current Activity Title:	Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination
Current Activity Description:	Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups);" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_CC_6. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal adopt removal factors.

Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_AHE_4**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Leveraging a QCDR for use of standard questionnaires
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment);" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_AHE_4. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.

Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_AHE_2**
Current Subcategory:	Achieving Health Equity
Current Activity Title:	Leveraging a QCDR to standardize processes for screening
Current Activity Description:	Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of standardized processes for screening for social determinants of health such as food security, employment and housing…use of supporting tools that can be incorporated into the certified EHR technology" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_AHE_2. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to sections Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_PM_10**
Current Subcategory:	Population Management
Current Activity Title:	Use of QCDR data for quality improvement such as comparative analysis reports across patient populations
Current Activity Description:	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (for example, comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).
Current Weighting:	Medium

Removal Rationale:	We proposed the removal of this activity under removal factor 1, improvement activity is "duplicative." We believe it is duplicative, because it is similar to, but only represents a partial component of IA_PSPA_7. In Table B, we proposed changes to IA_PSPA_7 to add "use of QCDR data for quality improvement such as comparative analysis reports across patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes" to make IA_PSPA_7 more robust and offer additional examples. Because of this, we believe the changes to IA_PSPA_7 capture the essence of IA_PM_10. We note that this proposed removal was made in conjunction with our proposal to modify IA_PSPA_7 in Table B, as well as our proposals to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765).Therefore, this removal is contingent upon finalization of both referenced proposals. We refer readers to Table B of this final rule where we are finalizing our proposal to modify IA_PSPA_7 and to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice. One commenter did not oppose this removal, but expressed concern that removal of multiple QCDR-related improvement activities could lower participation in QCDRs.
Response:	We appreciate the commenters' support. We appreciate the commenters' support. We are removing this improvement activity because we believe it is "duplicative" of IA_PSPA_7. While we understand the concern that removal of improvement activities may limit clinician options, we do not believe removing this activity will limit options as it has the same components as IA_PSPA_7, which we are retaining. We do not believe removal of this improvement activity would lower participation in QCDRs, because there are still four other QCDR-related improvement activities in the Inventory.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.
Finalized Improvement Activity	
Activity ID:	N/A – Removed
Current Improvement Activity	
Current Activity ID:	**IA_CC_4**
Current Subcategory:	Care Coordination
Current Activity Title:	TCPI Participation
Current Activity Description:	Participation in CMS Transforming Clinical Practice Initiative
Current Weighting:	Medium
Removal Rationale:	We proposed the removal of this activity under removal factor 7, improvement activity is obsolete. The Transforming Clinical Practice Initiative ended on September 28, 2019[1] and therefore, clinicians are no longer be able to attest to this improvement activity. We note that this proposed removal was made in conjunction with our proposal to adopt removal factors in section III.K.3.c.(3) of the CY 2020 PFS proposed rule (84 FR 40765). Therefore, this removal is contingent upon finalization of this proposal. We refer readers to section III.K.3.c.(3) of this final rule where we are finalizing our proposal to adopt removal factors.
Comments:	Several commenters supported the removal of this improvement activity. Additional commenters expressed concern that the removal of improvement activities would limit clinician options to choose appropriate improvement activities with similar levels of effort for their practice.
Response:	We appreciate the commenters' support. Since it is no longer feasible for clinicians to attest to this improvement activity due to the TCPI ending on September 28, 2019, we do not believe removal of this improvement activity would limit clinician options.
Final Action:	After consideration of the public comments received, we are finalizing the removal of this improvement activity as proposed.

Finalized Improvement Activity	
Activity ID:	N/A – Removed

1/ Transforming Clinical Practice Initiative. Available at https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/.

[FR Doc. 2019–24086 Filed 11–1–19; 4:15 pm]
BILLING CODE 4120–01–C