ENDOCRINE SOCIETY
Hormone Science to Health

Summary of Quality Payment Program (QPP) and MIPS Provisions Included in the Medicare Physician Fee Schedule (MPFS) Proposed Rule for CY2020

Executive Summary

The Center for Medicare and Medicaid Services (CMS) finalized significant changes to improve the Quality Payment Program (QPP) by streamlining the program's requirements with the goal of reducing clinician burden. The final rule can be found here. The QPP provisions are in Section III.K of the final rule (pg. 1228-2475).

MIPS Value Pathways (pg. 1229)

CMS included a request for information (RFI) in the proposed rule on a new MIPS Value Pathways (MVP) framework that will connect measures and activities across the four MIPS performance categories (Quality, Cost, Improvement Activities and Promoting Interoperability). MVP will incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information provided to patients.

Beginning in 2021, CMS will move from reporting on activities under the four performance categories under MIPS and transition to the new MVP framework with a unified set of measures centered around a specific condition or specialty. Under the MVP framework, clinicians will report on a smaller set of measures that are outcomes-based, specialty-specific and more closely aligned with the Advanced APMs. The agency will begin to implement MVPs gradually, beginning in the 2021 performance year. Over the coming months, CMS will continue to collaborate with stakeholders to create and implement the MVPs framework using an incremental approach. The agency recognized stakeholder concerns about the timeline and remains committed to a smooth transition that does not immediately eliminate the MIPS framework. The agency also will not require MVP participation based on the comments they received.

Key Merit-Based Incentive Payment System (MIPS) Provisions (pg. 1230)

Beginning with the 2021 performance period, CMS will strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS by requiring measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. QCDRs and Qualified Registries will still be required to provide timely performance feedback at least 4 times per year on all MIPS performance categories that the QCDR or Qualified Registry reports to CMS. Starting in 2021, this feedback must include information on how participants compare to other clinicians within the QCDR or Qualified Registry cohort who have submitted data on a given measure.

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

The agency finalized several changes to the measures for 2020. CMS added new specialty sets of measures for Audiology, Pulmonology and Endocrinology, among others. The agency finalized the removal of several standard-care and process measures, consistent with the Meaningful Measures Initiative. CMS also finalized the proposal to add ten new episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide, and made changes to the interoperability measures that are discussed below.

Key Alternative Payment Model (APM) Provisions (pg. 1231)

The agency finalized the proposal to refine the APM scoring standard to improve flexibility for participants. Beginning in 2020, CMS will allow APM entities and MIPS eligible clinicians participating in APMS with the option to report a MIPS Quality measure for the MIPS Quality performance category. APM entities will receive a calculated score based on individual, TIN, or APM entity reporting based on the generally applicable MIPS reporting and scoring rules for the Quality performance category.

CMS will apply the existing uncontrollable circumstances policies to MIPS eligible clinicians participating in APMs, if they are subject to the APM scoring standard and would report on MIPS quality measures. The agency also clarified definitions and reporting requirements for APM participants.

MIPS Program Details (pg. 1235)

Transforming MIPS with MIPS Value Pathways (MVP) (pg. 1243)

CMS will outline the details of the MVP in next year's rulemaking cycle. In this final rule, CMS modified the proposed MVP framework, which will be defined by four guiding principles:

1) MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data;
2) MVPs should include measures that encourage performance improvement in high priority areas;
3) MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers when choosing care; and

4) MVPs should reduce barriers to APM participation by including measures that are part of APMs, and by linking cost and quality measurement.

CMS envisions that MVPs would be organized around clinician specialty or health condition and will encompass a set of related measures and activities. Grouping quality and cost measures and improvement activities that are highly correlated, along with the measures from the Promoting Interoperability performance category, will strengthen clinical improvement and streamline reporting.

The agency received over 2,100 comments related to the design and implementation of MVPs, which are not summarized in the final rule. The agency appreciated all of the feedback and will utilize the comments for future rulemaking on MVPs. CMS wants to engage with stakeholders as they develop the MVPs in the CY 2021 proposed rule, as well as additional ways to reduce burden in the MIPS program. For example, the agency is interested in recommendations to reduce burden across all four MIPS categories, as well as input on the number of measures included across categories, reporting timeframes, and data submission methods. CMS may hold public listening sessions and webinars as well as provide other opportunities for stakeholder engagement. CRD will monitor these opportunities and share ways to engage on this issue moving forward.

Group Reporting (pg. 1244)

CMS finalized the proposal to revise existing policy at §414.1310€(2)(ii) on group reporting related to the Promoting Interoperability performance category. The revised policy states that "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."

The agency also revised existing policy at §414.1315(d)(ii) to state that 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. For the Promoting Interoperability performance category, they 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.

MIPS Performance Category Measures and Activities (pg. 1246)

CMS finalized the proposed increase to the performance threshold to 45 points in 2020 and 60 points in 2021. The agency increased the additional performance threshold for exceptional performers to 85 points for performance year 2022 and 2023.

CMS did not finalize any changes to the MIPS performance category weights as seen below. egories

- The Quality performance category is weighted at 45 percent (no change from 2019).
    - CMS did not finalize the proposed change to decrease the quality performance category weight to 40 percent and will re-evaluate in future rulemaking.
- The Cost performance category is weighted at 15 percent (no change from 2019).
    - CMS did not finalize the proposed change to increase the cost performance category weight to 20 percent and will re-evaluate in future rulemaking.
- The Promoting Interoperability performance category is weighted at 25 percent (no change from 2019).
- The Improvement Activities performance category is weighted at 15 percent (no change from 2019).

For the Quality performance category: the agency will continue to focus on high-priority outcome measures and added new specialty sets for the following specialties: Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology.

Table 50, transcribed from the final rule, shows the final scoring policies for the quality performance category for the 2020 MIPS performance period.

Measure Type	Description	Scoring Rules
Class 1	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)*.	3 to 10 points based on performance compared to the benchmark
Class 2	Measures that are submitted and meet data completeness, but do not have either of the following: 1) A benchmark 2) At least 20 cases	3 points
Class 3	Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum.	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.

For the Cost performance category, CMS finalized the proposal to add 10 new episode-based cost measures, which will more accurately reflect the cost of care specialists provide. The agency revised two current measures (Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost). Episode-based measures, set out in the below table, are developed to represent the cost to Medicare for items and services furnished during an episode of care.

Measure Topic	Episode Measure Type
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Elective Primary Hip Arthroplasty	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute Inpatient Medical Condition

Lower Gastrointestinal Hemorrhage (proposed only for groups)	Acute Inpatient Medical Condition
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural

For the Improvement Activities performance category, CMS finalized the following changes:

- Modified the definition of a rural area at §414.1305 to mean "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," which corrects the Health Resources and Services Administration (HRSA) Area Health Resource file name;

- Removed the criteria for patient-centered medical home designation that a practice must have received accreditation from one of four accreditation organizations that are nationally recognized or comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition;
- Increased the participation threshold for group reporting to 50 percent of the clinicians in the practice, which means that at least 50 percent of the clinicians in the practice will have to participate in improvement activities;
- Removed 15 improvement activities from the Inventory; modified seven existing improvement activities; and added two new improvement activities for 2020 performance period and future years (See Appendix II of the Proposed Rule);
- Concluded the CMS Study on Factors Associated with Reporting Quality Measures at the end of the CY 19 Performance Period, which was the last year of the 3-year study (see CY19 PFS Final Rule). CMS will not continue the study during the 2020 performance period, and final results will be shared at a later date after completion of the data analysis. The report will also make recommendations to improve outcomes, reduce burden, and enhance clinical care;
    - This 3-year study was created in the CY17 QPP final rule to examine whether there were improved outcomes, reduced burden in reporting, and enhancements in clinical care by selected MIPS eligible clinicians that focused on a data driven approach to quality measurement. As an incentive, MIPS eligible clinicians who successfully participated in the study received full credit in the Improvement Activities performance category.
- Updated the Improvement Activity Inventory and established criteria for removal in the future.

The below table shows the criteria that will be considered for removal of an activity:

Factor 1	Activity is duplicative of another activity
Factor 2	There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice
Factor 3	Activity does not align with current clinical guidelines or practice
Factor 4	Activity does not align with at least one meaningful measure area
Factor 5	Activity does not align with the quality, cost or Promoting Interoperability performance categories
Factor 6	There have been no attestations of the activity for three consecutive years
Factor 7	Activity is obsolete.

For the Promoting Interoperability performance category, the agency made the following changes:

- Beginning in the 2020 performance period:
    - Include the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure (available for bonus points);
    - Remove the Verify Opioid Treatment Agreement Measure;
    - CMS will redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Electronic Access to Their Health Information measure if an exclusion is claimed.
    - Include the Query of PDMP measure as optional (beginning with 2019 only a yes/no response will be required).

<u>APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APM (pg. 1430)</u>

The agency expects that 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 Model (all tracks)
- Medicare ACO Track +1 Model
- Bundled Payments for Care Improvement Advanced
- Maryland Total Cost of Care Model (Maryland Primary Care Model)
- Vermont All-Payer ACO Model
- Primary Care First (all tracks)

Calculating MIPS APM Performance Category Scores

The APM scoring standard is intended to reduce the reporting burden for MIPS eligible clinicians participating in MIPS APMS. In order to achieve this goal, CMS finalized several updates relating to new approaches for quality performance category scoring, which include:

- Allowing MIPS eligible clinicians participating in APMS to report on MIPS quality measures in the same manner as set out in the policy for the Promoting Interoperability performance category;
- Applying a minimum score of 50 percent, called an "APM Quality Reporting Credit" for certain APM entities where APM quality data cannot be used;
- Using quality data to calculate an APM Entity group level score when an APM Entity has reported quality measures to MIPS on behalf of the APM Entity group;
- Applying any bonuses or adjustments available to MIPS groups for measures reported by the APM Entity, as applicable; and
- Applying both the application-based and the automatic extreme and uncontrollable circumstances policies to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standards and report on MIPS quality measures.

MIPS Final Score Methodology

Performance Category Scores

CMS finalized several scoring policies that will assist in the transition from MIPS to MVPs. Specifically, the agency will:

- Maintain the 3-point floor for measures that can be scored for performance;
- Develop benchmarks based on flat percentages in specific cases where the agency determines that otherwise applicable benchmarks could incentivize inappropriate treatment;
- 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;
- Maintain cap on measure bonus points for high-priority measures & end-to-end reporting; and

- Continue the improvement scoring policy.

Calculating the Final Score (pg. 1480)

CMS finalized the proposal to continue the complex patient bonus for the 2022 MIPS payment year and to establish performance category reweighting policies for the 2022, 2023, and 2024 MIPS payment years.

Table 53, transcribed from the final rule, summarizes the finalized weights for each performance category for the final score.

Performance Category	2022 MIPS Payment Year	2023 MIPS Payment Year	2024 MIPS Payment Year
Quality	45%	35%	30%
Cost	15%	25%	30%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

MIPS Payment Adjustments

Based on stakeholder feedback, CMS did not finalize the two proposals regarding the final score used in MIPS payment adjustment calculations for the 2022 and 2023 MIPS payment years, which would have

- Set the performance threshold at 45 points and 60 points respectively;
- Set the additional performance threshold for exceptional performance at 80 points and 85 points respectively.

Instead, the agency finalized the additional performance threshold at 85 points for both the 2022 and 2023 MIPS payment year.

<u>Targeted Review, Data Validation and Auditing (pg. 1555)</u>

A targeted review is a process where MIPS eligible clinicians or groups can request that CMS review the calculation of their 2019 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. CMS finalized several policies related to targeted review:

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.

Proposed Requirements for MIPS Performance Categories that Must be Supported by Third Party Intermediaries (pg. 1570)

CMS utilizes third party intermediaries as a useful way to fulfill MIPS requirements while reducing clinician reporting burden. Third party intermediaries are approved by CMS to submit MIPS data on behalf of a MIPS eligible clinician, group, or virtual group (as defined by §414.1400). Examples of a third party intermediary include a health IT vendor, a qualified registry, or a CMS-approved survey vendor. The agency modified the criteria for approval as a third party intermediary, and to established new requirements to promote continuity of services for clinicians that use third party intermediaries.

CMS finalized several changes related to QCDR measures, which include:

- Updates to QCDR approval criteria, including requirements to engage in activities to foster improvement in the quality of care and enhance performance feedback requirements; and
- Updates to QCDR measures requirements, including considerations for measure rejection, the approval process (including provisional approval), and measures that have failed to reach benchmarking thresholds.

Beginning with the 2021 performance period, QCDR measure requirements include:

- Identify a linkage between the QCDR measure to the cost measure, Improvement Activity, or CMS developed MVP at the time of self-nomination;
- Be fully developed with completed testing results at the clinician level and ready for implementation;
- QCDRs must 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;
- 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;
- 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;
- At CMS discretion, QCDR measures may be approved for two years, contingent on additional factors; and
- Additional QCDR measures considerations include:

- (a) conducting 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.

CMS finalized the proposal to update qualified registry required services, including requiring qualified registries to support all three performance categories when data submission is required. The agency also will require qualified registries to provide performance feedback to clinicians at least four times per year.

Public Reporting on Physician Compare (pg. 1687)

In order to more completely and accurately reference the data available, CMS will publicly report the following information on the Physician Compare Initiative website:

- Beginning with Year 2 (CY 2018 data, available in late CY 2019): aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians; and
- Beginning with Year 3 (2019 performance information, available for public reporting in late 2020): an indicator either on the profile page or in the database that displays if a MIPS eligible clinician is scored using facility-based measurement.

Key APM Proposals

Under MACRA, CMS is required to make an incentive payment of 5 percent to Qualifying APM Participants (QPs) for achieving threshold levels of participation in Advanced APMs. The agency finalized several provisions, discussed below, related to the APM Incentive.

CMS estimates the following participation and payment rates for the 2022 payment year:

- Between 210,000-270,000 clinicians will become Qualifying APM Participants (AP), which means they are excluded from the MIPS reporting requirements and qualify for a lump sum APM Incentive Payment.
- Total lump sum APM Incentive payment: $535-685 million.
- MIPS payment adjustments, which only apply to payments for covered professional services provided by MIPS eligible clinicians, will be equally distributed between:
  - Negative MIPS payment adjustments ($443 million); and
  - Positive MIPS payment adjustments ($443 million).

- An additional $500 million is available for exceptional performance by MIPS eligible clinicians whose final score meets or exceeds the additional performance threshold of 80 percent.

Provisions Related to APM Requirements (pg. 1705)

Bearing Financial Risks for Monetary Losses

CMS finalized several policies related to the Advanced APM criterion bearing financial risk for monetary losses. The agency modified the definition of marginal risk when determining whether a payment arrangement is an Other Payer Advanced APM. The computation would be:

> Add the marginal risk rate at each percentage level to determine participants' losses, and then dividing it by the percentage above the benchmark to get the average marginal risk.

Under the final policy, when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the agency will use the average marginal risk rate across all possible levels of actual expenditures that would be used for comparison to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30 percent, with exceptions for large losses and small losses as provided in CMS regulations.

QP and Partial QP Determinations

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. The agency did not finalize the proposal that an eligible clinician will not be considered a QP or a Partial QP for the year when an APM Entity terminates from an Advanced APM.

All-Payer Combination Options---Aligned Other Payer Medical Home Models

CMS finalized the proposal to add the term "Aligned Other Payer Medical Home Model" to the definitions section for the MIPS and APM program. This term would have the same characteristics as the terms "Medical Home Model" and "Medicaid Medical Home Model," but would apply to other payment arrangements. This term would apply to an arrangement that the agency determines 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 agency finalized changes to the marginal risk rate and expected expenditures for Advanced APMs. The Medicaid Medical Home Model financial risk and nominal amount standards also apply to Aligned Other Payer Medical Home Models.

MIPS Measures (pg. 2071)

Each year CMS makes changes to the MIPS measures set. The changes below apply to Endocrine Society members.

MIPS Quality Measures for 2022 MIPS Payment Year and Future Payment Years

- All-Cause Unplanned Admission for Patients with Multiple Chronic Diseases

Changes to Specialty Measure Sets for 2022 MIPS Payment Year and Future Payment Years (pg. 2081)

In addition to the considerations discussed in the introductory language for Table B, the specialty sets listed below take 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.

CMS may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set.

Endocrinology---Finalized for Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had HbA1c > 9.0% during the measurement period.	Intermediate Outcome/Effective Clinical Care	NCQA
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.	Process/Effective Clinical Care	NCQA
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.	Process/Effective Clinical Care	NCQA
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -Diabetes or Left Ventricular Systolic D: 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.	Process/Effective Clinical Care	American Heart Association
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.	Process/Effective Clinical Care	NCQA
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Examination: Percentage of patients aged 18 years and older with a	Process/Effective Clinical Care	American Podiatric Medical Association

diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months		
Preventive Care and Screening—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/m2.	Process/Community + Population Health	CMS
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-thecounters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Process/Patient Safety	CMS
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.	Process/Community + Population Health	CMS
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	Process/Community + Population Health	PCPI

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		
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.	Intermediate Outcome/Effective Clinical Care	NCQA
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.	Process/Communication + Care Coordination	CMS
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.	Process/Effective Clinical Care	NCQA
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 lowdensity 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	Process/Effective Clinical Care	CMS

• Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.		
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.	Process/Effective Clinical Care	Oregon Urology Institute