2020 Merit-based Incentive Payment System (MIPS) Toolkit

The AUA has summarized the key differences between the 2019 and 2020 MIPS program to enable participants to be successful in reporting.

Overall Scoring

In 2020, four components of MIPS maintain the same weights as 2019, which are:

- Quality – 45 percent
- Promoting Interoperability – 25 percent
- Improvement Activities (IAs) – 15 percent
- Cost – 15 percent

Each category is scored separately with the four component scores added together for a total score. Participants must achieve 45 points in order to avoid a negative payment adjustment (penalty). Those who do not participate will incur a 9 percent penalty on their 2022 Part B Medicare charges, and those falling between zero and 45 will face a penalty of some degree. Those scoring over 45 points will receive a positive payment adjustment (bonus) of some degree. MIPS is a budget neutral program, meaning the penalties must pay for the bonuses. So the amount of the bonuses will be determined once the Centers for Medicare & Medicaid Services (CMS) determines the amount of funds available. Those scoring 85 or more points are deemed “exceptional performers” and will receive an additional bonus. The fund for exceptional performers was designated by Congress and is separate from the MIPS bonuses, but like the regular bonuses, the size of the awards is determined by the number of people who qualify for them.

First Steps

Do I Need to Report?

A clinician is excluded from MIPS if he/she answers yes to any of the following:

- Is new to Medicare participation (first year)
- Sees 200 or fewer Medicare Part B patients
- Performs less than 200 covered professional services
- Has $90,000 or less in Part B allowed charges

CMS provides the QPP Lookup Tool to instantly allow providers to know if they must report.

If a clinician meets at least one of these criteria, they can opt-in to MIPS reporting, meaning they can voluntarily report. To do so, clinicians must log onto the QPP portal and register to opt-in. Those selecting this option will then be subject to applicable payment adjustments (positive or negative). Clinicians can also choose to voluntarily report. This means they can gain reporting experience and learn their score, but it is all for practice. These participants will not be subject to penalties or bonuses.
Reporting as an Individual or a Group

Providers may report as individuals where they are independently scored on the data they submit to CMS. Alternatively they may report as a group, which CMS defines as two or more eligible clinicians (as identified by individual National Provider Identifiers or NPIs) who have reassigned their billing rights to a single Taxpayer Identification Number (TIN). The group’s score is a composite of all the clinicians’ scores. If someone wishes to submit data for both individual and group reporting, CMS will analyze both sets of data and use the option with the higher score.

Virtual group reporting is also available, but those interested in this option must register with CMS prior to the reporting year. For more information on this option, visit CMS.gov.

Reporting Options

There are several different reporting options which may be selected to participate in the Quality Payment Program. In 2020, participants may use a combination of any of these options to complete their MIPS reporting.

Medicare Part B Claims reporting (previously known as claims reporting) has traditionally been used by many urologists. However it may only be used by those who are members of a practice with 15 or fewer providers. This reporting option involves submitting extra CPT Category II codes (also known as Quality Data Codes or G codes) along with regular billing CPT codes and diagnosis codes on electronic or paper claims submitted to Medicare. Medicare then forwards these claims files to the processor.

MIPS CQM (formerly known as Qualified Registry) reporting may be used by both individuals and groups. It is accomplished by contracting with a CMS-approved data processing service that can compile patient claims data and generate reports on a provider’s or practice’s behalf directly to the MIPS processor. Depending on the vendor, data can be transferred to the registry in a number of ways.

A Qualified Clinical Data Registry (QCDR) is a CMS-approved entity (such as a registry, certification board, specialty society, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. Individuals and groups may report via a QCDR. The AUA offers its own QCDR, the AQUA Registry. For more information, contact 855-898-AQUA (2782) or AQUA@AUAnet.org.

eCQM [formerly known as Electronic Health Record (EHR)] reporting involves either submitting one’s data directly to CMS or to a vendor who will then submit it to CMS on the provider or practice’s behalf. Check with your EHR vendor to find out what option(s) is available to you. Both individuals and groups may use EHR reporting, and this method may allow you to qualify for bonus points if all of your data is submitted via EHR.

Web Interface reporting is available to groups of 25 or more clinicians for Quality reporting. Those wishing to use the Web Interface option must register with CMS before the deadline (usually in June).

Attestation can be used for several MIPS categories. Through this option, users state they have completed the required action, but no data is required to back this up. For example, participants can attest that they have completed Improvement Activities.
Quality Reporting

Quality reporting requires completing designated actions for at least 6 Quality measures (one of which must be an outcome measure) and submitting this information to CMS. There are several hundred individual measures to consider in 2020. Participants can opt to report on more than six; if that is done, CMS will use the 6 measures with the highest scores. In order to help urologists find specialty specific measures, CMS created a Urology Measures Set. If you select 6 measures from this list, you do not need to report an outcome measure. However, you must select at least one high priority measure from the list. The AUA has also compiled a list of measures which are most applicable for urologists. Again, if you select 6 measures from this list, you must report at least one outcome measure. Regardless of which measures are selected, a participant must report 70 percent of the applicable patients for any measure (with a minimum of 20 applicable patients). If this reporting threshold is not met, participants will receive a score of 0 for the measure (unless the participant belongs to a practice with 15 or fewer providers; if so the participant will receive 3 points for the measure).

Previously the AUA recommended that participants consider the clinical conditions they treat, any practice improvement goals, work currently being done in the practice, and quality information that may already be reported to other payers or entities when selecting measures. While that remains good advice, one also needs to look at possible scoring. CMS gauges how well a participant scores on a measure and assigns the participant a point total. The points for the top six reported measures are added when tallying one’s Quality score. Some measures only allow limited scoring. (See the Benchmarking section below for more details.) Therefore, participants also need to assess how well they can score on the measures they select.

Measure Specifications and Flowcharts

- Measure #23 – Perioperative Care, Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) [Claims, Registry]
- Measure #47 – Advance Care Plan [Claims, Registry]
- Measure #48 – Urinary Incontinence, Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older [Claims, Registry]
- Measure #50 – Urinary Incontinence, Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older [Claims, Registry]
- Measure #102 – Prostate Cancer, Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients [Registry, EHR]
- Measure #104 – Prostate Cancer, Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients [Registry, EHR]
- Measure #109 – Prostate Cancer, Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients [Registry, EHR]
- Measure #110 – Preventive Care and Screening, Influenza Immunization [Claims, Registry, EHR]
- Measure #113 – Colorectal Cancer Screening [Registry, EHR]
- Measure #119 – Diabetes, Medical Attention for Nephropathy [Registry, EHR]
- Measure #128 – Preventive Care and Screening, Body Mass Index (BMI) Screening and Follow-Up [Claims, Registry, EHR]
- Measure #130 – Documentation of Current Medications in the Medical Record [Claims, Registry, EHR]
- Measure #143 – Oncology: Medical and Radiation – Pain Intensity Quantified [Registry, EHR]
- Measure #144 – Oncology: Medical and Radiation – Plan of Care for Pain [Registry]
• Measure #145 – Radiology: Exposure Time Reported for Procedures Using Fluoroscopy [Claims, Registry]
• Measure #226 – Preventive Care and Screening, Tobacco Use, Screening and Cessation Intervention [Claims, Registry, EHR]
• Measure #236 – Controlling High Blood Pressure [Claims, Registry, EHR]
• Measure #238 – Use of High-Risk Medications in the Elderly [Registry, EHR]
• Measure #265 – Biopsy Follow-Up [Registry]
• Measure #317 – Preventive Care and Screening, Screening for High Blood Pressure and Follow-Up Documented [Claims, Registry, EHR]
• Measure #357 – Surgical Site Infection (SSI) [Registry]
• Measure #358 – Patient-centered Surgical Risk Assessment and Communication [Registry]
• Measure #374 – Closing the Referral Loop [EHR, Registry]
• Measure #408 – Opioid Therapy Follow-up Evaluation [Registry]
• Measure #412 – Documentation of Signed Opioid Treatment Agreement [Registry]
• Measure #414 – Evaluation or Interview for Risk of Opioid Misuse [Registry]
• Measure #422 – Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury [Claims, Registry]
• Measure #429 – Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy [Claims, Registry]
• Measure #431 – Preventive Care and Screening, Unhealthy Alcohol Use: Screening & Brief Counseling [Registry]
• Measure #432 – Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair [Registry]
• Measure #433 – Proportion of Patients Sustaining a Major Viscus Injury at the Time of any Pelvic Organ Prolapse Repair [Registry]
• Measure #434 – Proportion of Patients Sustaining a Ureter Injury at the Time of any Pelvic Organ Prolapse Repair [Registry]
• Measure #436 – Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques [Claims, Registry]
• Measure #453 – Proportion Receiving Chemotherapy for the Last 14 Days of Life [Registry]
• Measure #455 – Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life [Registry]
• Measure #476 - International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6 -12 Months After Diagnosis of Benign Prostatic Hyperplasia

Quality Benchmarks

Under the Quality reporting program, participants are scored on how complete and successful their reporting is in comparison to other participants. For each measure and for each reporting mechanism, a series of benchmarks has been established. CMS created a matrix where each measure has been divided into deciles, ranging from 3 to 10. A participant will be able to use this matrix to determine into which decile his/her work falls and thus determine his/her score for that particular measure. For example, if a urologist is reporting Measure #130 Documentation of Current Medications in the Medical Record using Medicare Part B claims reporting, the range for this measure is:
To achieve 10 points for this measure, a participant must have a perfect score, meaning he/she correctly reported on all the patients to which this measure was applicable. If he/she missed a couple of patients, his/her score would obviously decrease. For this particular measure, the participant’s score would drop down to 5 points at the maximum for anything less than perfection, but a score could be much lower because the score would need to be very close to perfection in order to get more than 3 points.

The scoring on Measure #130 is challenging because it is considered a “topped out” measure by CMS. This means that it has been widely used, and users score very well on it. CMS will begin to phase out many of the topped out measures in the coming years. CMS is trying to discourage participants from using these measures by awarding lower point values. In contrast, Measure #236 Controlling High Blood Pressure is not topped out; therefore, the ranges are wider:

**Measure #236 Controlling High Blood Pressure, Medicare Part B Claims Reporting**

<table>
<thead>
<tr>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-20.99%</td>
<td>30-39.99%</td>
<td>40-40.99%</td>
<td>50-50.99%</td>
<td>60-60.99%</td>
<td>70-70.99%</td>
<td>80-80.99%</td>
<td>&gt;=90%</td>
</tr>
</tbody>
</table>

If a measure is new for 2020, CMS initially will award 3 points for that measure no matter how well the participant scores. The point value may change after the reporting year ends if CMS is able to collect enough data in order to calculate a benchmark; however, there is no guarantee that will happen. It is dependent on the number of participants reporting on the measure.

Each measure, and its reporting mechanism, has its own unique benchmarks. So, participants will want to assess the potential benchmarks when they contemplate which measures to report. Also, reporting a measure through Medicare Part B claims reporting will have a different benchmark than reporting it through CQM (registry) reporting. Here is an example using Measure #48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.

**Measure #48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Medicare Part B Claims Reporting)**

<table>
<thead>
<tr>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>.33-1.28%</td>
<td>1.29-5.02%</td>
<td>5.03-98.41%</td>
<td>98.42-99.99%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Measure #48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older [CQM (Registry/QCDR) Reporting]

<table>
<thead>
<tr>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>.43-4.19%</td>
<td>4.2-28.34%</td>
<td>28.35-79.24%</td>
<td>79.25-99.12%</td>
<td>99.13-99.99%</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The AUA has assembled a listing of the benchmarks for the measures on its recommended list in addition to the measures unique to the AQUA Registry (the AUA’s qualified clinical data registry of QCDR).

**Quality Bonus Points**

In 2020, it is possible to earn Quality bonus points. The following are bonus points applied to measure scores:

- 2 bonus points for each additional outcome and patient experience measure*
- 1 bonus point for each additional high-priority measure*
- 1 bonus point per measure for using Certified Electronic Health Record Technology (CEHRT) to submit measures to a registry/QCDR or CMS (end-to-end electronic reporting)
- 6 bonus points for those in a practice with 15 or fewer clinicians if data has been submitted for at least 1 quality measure
- Up to 10 percentage points can be earned for improving your score (see below)

The “improvement percent score” rewards those who have improved their Quality score from the prior year. The bonus is awarded using the formula:

\[
10\% \times \frac{\text{increase in achievement percent score from prior performance year}}{\text{prior performance year achievement percent score}}
\]

* NOTE: The high priority and outcome measure bonus points are capped at 6 points.

**Quality Reporting Program Scoring**

To figure a provider’s Quality reporting program score, one must determine the benchmark for each measure used. Those scores are added together along with any Quality bonus points which have been earned. That total is divided by total available measure points (in most cases 60 points). If an improvement percent score has been earned, it is then added to determine the final score. The score is displayed as a percentage, but a maximum score cannot exceed 100 percent. For example, if you scored perfectly on all 6 measures and achieved 10 points for each, you would have 60 divided by 60 for 100 percent. However, most people will fall below that. For example, someone’s scores could be 3, 8, 7, 4, 5, and 9 = 36 points. We’ll say that a total of 8 bonus points were earned (6 since the participant is a solo practitioner and 2 more points for an additional outcome measure). This total is 44 which is then divided by 60, which comes to 73 percent. The participant was awarded an improvement percent score of 2 percent. So, the final Quality total is 75 percent.
The formula for determining the Quality category MIPS points is:

\[(\text{Quality performance category percent score}) \times (\text{Quality category weight}) \times 100 \text{ MIPS points}\]

Using the example above, the score would be:

75 percent \times 45 percent \times 100 = 33.75 \text{ points}

One should note that the Quality category weight might change for some. For example, if someone was given an exception from Promoting Interoperability, the Quality category weight becomes 70 percent \((45 \text{ percent} + 25 \text{ percent})\) in 2020. Using the earlier example, that score would then be 75 percent \times 70 percent \times 100 = 52.5 \text{ points}.

Also, if a practice has 16 or more eligible clinicians with at least 200 cases, CMS will calculate the All-Cause Hospital Readmission measure for the claims the practice submitted for the year. Providers do not need to do any work for this calculation; it is all done by CMS. This measure evaluates the readmission rate for beneficiaries 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. Attribution for this measure uses a two-step method:

- A beneficiary is attributed to a tax identification number (TIN) if the beneficiary received more primary care services from primary care physicians, nurse practitioners, physician assistants, or clinical nurse specialists within that TIN than from clinicians in any other TIN.
- If a beneficiary cannot be attributed to a TIN using the first step, the beneficiary will be attributed to a TIN if they received more primary care services from specialist physicians within the TIN than from clinicians in any other TIN.

**Improvement Activities**

**How Are Improvement Activities Scored?**

In this program, one must participate in enough activities for a minimum of 90 days to earn 40 points. All IAs are weighted either high (20 points) or medium (10 points). Participants can complete any arrangement of activities which earns 40 points. However, if a provider belongs to a practice with 15 or fewer providers or if a provider practices in a rural or health professional shortage area, then only 20 points are needed. Participants still need to complete the activities for a minimum of 90 days. IAs account for 15 percent of the overall MIPS score.

**Do I report individually or as a group?**

IAs can be reported by individuals or through group reporting. Some IAs (such as participation in the Consumer Assessment of Healthcare Providers and Systems Survey—Patient Safety and Practice Assessment #11) can only be done by groups. If a practice is using group reporting, at least fifty percent...
of the members of the practice must complete the same IA in order to earn credit. However, they do not have to do the IA at the same time. Each person can complete the activity over a consecutive 90-day period during 2020. This is a change from previous reporting years.

How do I start?

The focus of Improvement Activities is improving the care provided to your patients, and CMS believes that focusing on specific activities for a designated time period can stimulate this care. It is important that you first do an analysis of your practice:

- What are areas that need improvement?
- What changes would patients most appreciate?
- Are you currently doing improvement activities which would qualify for this program?

Then brainstorm what you can do. Hopefully, if you do need to start new or amend existing activities, you can implement something small which will not require a significant outlay of time, staffing or other resources. For example, are there programs offered through your local hospital system or through an insurance program which could satisfy an Improvement Activities requirement?

What do I choose?

There are over 100 IAs organized into eight categories:

- Integrated Behavioral and Mental Health (BMH)
- Expanded Practice Access (EPA)
- Population Management (PM)
- Care Coordination (CC)
- Beneficiary Engagement (BE)
- Patient Safety and Practice Assessment (PSPA)
- Achieving Health Equity (AHE)
- Emergency Response and Preparedness (ERP)

The AUA has reviewed the complete list of Improvement Activities and has identified several which most urologists should be able to easily implement or adapt for their practices. These activities are highlighted in blue. However, you should review the entire list to see if there are other IAs which may be more applicable to your practice. Some practices may find that an option not selected by the AUA would be a proper fit.

Additionally, several activities are highlighted in green; these can be completed through use of the AUA’s Qualified Clinical Data Registry (QCDR), the AQUA Registry. If you are not yet a member of the AQUA Registry and wish to consider this reporting option, contact AQUA@AUAnet.org or 855-898-AQUA (2782) for more information.

Remember you must participate in whatever activities you choose for 90 consecutive days.
Key Tips

You do not need to report or submit information to CMS as part of Improvement Activities. Rather in early 2021, CMS will require you to attest to whatever action you completed in 2020. One can attest activity completion through any combination of the following options: the CMS Quality Payment Program website, a qualified clinical data registry (QCDR), qualified registry, electronic health record system (verify your EHR has this capability), or CMS Web Interface (if there are 25 or more providers in the practice). Eligible clinicians and groups only need to attest via the Quality Payment Program website that they completed the improvement activities they selected or should work with their vendor to determine the best way to submit their activities via QCDR, a qualified registry, or their electronic health record system.

The AUA recommends that you document as much information as possible about the activities you complete. For example, if you are administering a patient satisfaction survey for 90 days, note in the patient charts who received one and when. If you attend an Institute for Healthcare Improvement event, save your registration and any materials (slides, handouts, etc.) which may have been distributed regarding the event. CMS always has the ability to audit your submissions; so, it is wise to have some kind of verification to prove what you have done. Eligible clinicians are encouraged to retain documentation for six years as required by the CMS document retention policy.

If you choose to participate in MIPS via a QCDR, you must select and achieve each improvement activity separately. You will not receive credit for multiple activities just by selecting one activity that includes participation in a QCDR. However, reporting for some Quality measures will also fulfill IA reporting requirements.

Sometimes the work you will be doing will satisfy multiple Improvement Activities. You might want to consider taking advantage of this overlap.

Improvement Activity Resources

Several links and resources included in this Toolkit are available to provide more direction and guidance. It is important to note that each practice is unique, and in order to improve the care provided to patients, it is best to individualize what you will be doing as much as possible. The models and information here can serve as a basis for something that you will need to tweak slightly to make applicable to your practice.

While the AUA identified 34 activities (highlighted in blue) as achievable for urologists, some will be easier than others. Here are some details and resources available to help with these activities.

Note: The Quality Reporting measures listed on AUAnet.org are for the CQM (registry) option. Medicare Part B claims options are also available.

- IA_EPA_3 – Collection and use of patient experience and satisfaction data on access – This activity focuses on collecting feedback from your patients and then using this information to implement change in your practice. Many organizations offer patient satisfaction surveys such
as Press Ganey or the federal government through Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS. Practices can also design their own surveys focusing on questions they find more useful. The American Academy of Family Physicians offers advice and resources about such surveys. In 2020, CMS now requires some degree of patient stratification such as race/ethnicity, disability status (if available), sexual orientation (if available), sex, gender identity (if available), and geography.

After accumulating data for 90 days, the next step is reviewing it and determining how to take advantage of this resource. If all of your surveys are noting the same thing, it is either something you are doing very well or something that should be changed. Look for small steps that can make a big difference but will not greatly impact other resources. This activity will also satisfy IA_BE_13).

- **IA_PM_16** – Implementation of Medication Management Practice Improvements – While there are several ways to satisfy this activity, the AUA recommends that urologists do so through medication reviews or reconciliation. This activity can also be used for IA_PM_13. In 2020, CMS recommends that participants implement the “AHRQ Create a Safe Medicine List Together” strategy.

- **IA_CC_1** – Implementation of use of specialist reports back to referring clinicians or group to close referring loop – There are two ways to satisfy this activity and both involve documenting reports in the patient’s file (either electronic or paper). If you are referring patients to other providers, note that in the patient’s chart and make sure to document any reports or results the other provider sends you. Likewise if patients are referred to you, note that in the chart and make sure to note that you provided reports and/or results to the referring provider. This activity also satisfies IA_CC_12 as well as two Promoting Interoperability measures.

- **IA_CC_2** – Implementation of improvements that contribute to more timely communication of test results – This activity requires that you contact any patient that has an abnormal test result and that you document the result and how and when you contacted the patient, which could be by mail, phone call, etc. CMS does not define “timely,” but most offices already have a working definition of this.

- **IA_CC_7** – Regular training in care coordination – A practice must have “documentation of implemented regular care coordination training within practice.” However, this is very open. There are many organizations which offer care coordination such as the Agency for Healthcare Quality and Research’s free monthly webinar series entitled TeamSTEPPS. The webinars are also archived; so, webinars can be viewed whenever it is most convenient. In whatever program you decide to use, keep validation of registration/participation in the event. Your practice (or at least a quality improvement team) should discuss the content of the webinars and implement that which might be feasible. In 2020, CMS stresses that the mail goal of this activity is to meet patients’ needs. Thus there should be some mechanism for gathering this information. CME and other forms of accreditation are often offered for these webinars and training sessions.
• IA_CC_12 – Care Coordination agreements that promote improvements in patient tracking across settings - If you are referring patients to other providers, note that in the patient’s chart (either paper or electronic) and make sure to document any reports or results the other provider sends to you. Likewise if patients are referred to you, note that in the chart and make sure to note that you sent reports and/or results to the referring provider. This activity also satisfies IA_CC_1 and possibly IA_CC_13.

• IA_CC_13 – Practice improvements for bilateral exchange of patient information - One aspect of this activity is the use of structured referral notes, and the other is health information exchange (this can be between healthcare providers or providers and patients). Check with your electronic health record (EHR) vendor to verify the best way to include referral notes. If you are using electronic health information exchange, confirmation (such as email confirmations or screenshots) is needed to satisfy this activity. This activity can also be set up in such a way that it would also satisfy IA_CC_1 and IA_CC-12.

• IA_BE_6 – Collection and follow-up on patient experience and satisfaction data on beneficiary engagement – If you are using a patient survey administered by a third party survey administrator/vendor (as discussed in IA_EPA_3 and IA_BE_13), you can satisfy this activity by taking it to the next level. For example, your practice could follow up with patients to address any concerns they might have or your practice could use this information to design an improvement plan. The plan does not need to be implemented at this stage, but there must be concrete evidence that you have administered a patient survey and then drafted improvements based on the survey’s results.

• IA_BE_13 – Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms - This activity focuses on collection feedback from your patients and then using information to implement change in your practice. Many organizations offer patient satisfaction surveys such as Press Ganey or the federal government through Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS. CMS recommends that the surveys be administered independently.

After accumulating data for 90 days, the next step is reviewing it and determining how to take advantage of this resource. If all of your surveys are noting the same thing, it is either something you are doing very well or something that should be changed. Look for small steps that can make a big difference but will not greatly impact other resources. This activity will also satisfy IA_EPA_3.

• IA_BE_15 – Engagement of patients, family and caregivers in developing a plan of care - To complete this activity you could utilize an advanced care plan or a plan specific to the urological treatment you are providing. While you probably do not need all the information which would be noted in an advanced care plan, it is good information to have in the patient’s file. Many patients already have such plans; so, it is merely a matter of obtaining it and putting a copy in the file. In order to satisfy this activity, you must produce a report from your electronic health record showing the plan of care and engagement/inclusion of the patient, family, and/or
• **IA_BE_21** – Improved practices that disseminate appropriate self-management materials – The Urology Care Foundation (the official foundation of the AUA) has created self-management materials on numerous urologic conditions which can be provided to patients. To satisfy this activity, you must document in the patient’s record what materials were distributed as well as any accompanying instructions or results.

• **IA_PSPA_3** – Participate in Institute for Healthcare Improvement (IHI) training/forum event; National Academy of Medicine, AHRQ Team STEPPS or other similar activity – Many national organizations, including the AUA, offer seminars and events focused on quality improvement and patient safety, and participating in one (either in person or online and some free of charge) would satisfy this activity. The AUA offers the Quality Improvement Summit. Check the websites of other organizations (such as ihi.org, nam.edu, or ahrq.gov/teamstepps) for their offerings throughout the year.

• **IA_PSPA_4** – Administration of the AHRQ Survey of Patient Safety Culture – All employees of the practice would need to complete this survey and results must be submitted to AHRQ. AHRQ provides a user’s guide as well as the form to help with its administration. At this point, CMS does not require any analysis of the results or follow up on the survey. So, simply completing and submitting would be an inexpensive and quick way to complete an activity. This activity can only be done once every four years.

• **IA_PSPA_8** – Use of patient safety tools – The surgical risk calculator [such as the one available through the American College of Surgeons (ASC)], the International Prostate Symptom Score (IPSS), or AUA Symptom Index (AUA-SI) are widely used patient safety tools in urology. If you already use one of these or plan to start, document this act in a patient’s chart when appropriate in order to satisfy this activity. The ASC surgical risk calculator is also available on the AUA Guidelines app. The AUA’s white paper series on Optimizing Surgical Outcomes also highlights a variety of tools such as ERAS protocols, nutrition assessment tools, etc. Quality measure #476 also pertains to the IPSS and AUA-SI.

• **IA_PSPA_9** – Completion of the AMA STEPS Forward program – The STEPS Forward program is an online initiative geared at improving practice efficiency as well as improving care and the patient experience. This tool can be used at your convenience and allows you to customize your educational experience by focusing on both clinical and practical modules. In additional to obtaining a certificate of completion for at least one AMA STEPS Forward module, participants must have documentation that they have implemented what they learned into their processes of care. CME is available for some modules. Start by watching the overview video before beginning.

• Participation in a Qualified Clinical Data Registry (QCDR) – Many activities may be achieved through QCDR participation. The AUA offers the AQUA Registry, which is a CMS-approved QCDR. AQUA can also be used to complete the Quality reporting program as well as satisfy some
aspects of Promoting Interoperability. For more information, contact AQUA@AUAnet.org or 855-898-AQUA (2782).

Disclaimer: The AUA encourages practices to download and review CMS’ improvement activity (IA) data validation requirements. Providers should maintain documentation supporting the compilation of each activity, in the event of a future CMS audit. Additionally, the AUA and AQUA Registry cannot guarantee a positive/negative payment adjustment at any time.

Cost

In 2020, the Cost category remains 15 percent of a participant's total MIPS score. The category shows:

- The resources clinicians use to provide patient care
- Medicare’s expenses per beneficiary during an episode of care. In other words, what items and services for claims are utilized by a patient in a specified timeframe for certain procedures/care.

What do I have to do? How is the Cost category figured?

The good part about the Cost category is that you do not have to do a thing. CMS uses Medicare claims data to calculate your score. However, that may also work against you. CMS attributes patients for this category and therefore may be attributing some patients to urologists when they should not have done so. As a result, urologists have been penalized for not providing care for chronic conditions which are outside the scope of urology. It is important to review the yearly reports that CMS provides about the Cost category.

What Cost measures will be used in 2020?

There are two primary measures.

1) Total per Capita Cost (TPCC) – This measures all Medicare Part A and Part B costs during the year for attributed patients. Attribution of a given patient is based upon which clinician or group, respectively, bill allowed charges for primary care services delivered to that patient (determined by select E&M CPT/HCPCS codes). There is a 20-case minimum for this measure. CMS revised its attribution methodology for 2020. Now, urologists should not be attributed primary care patients. However, the AUA still recommends that providers review their annual reports to ensure that this has not happened.

2) Medicare Spending per Beneficiary (MSPB) - The MSPB measure determines what Medicare pays for services performed by an individual clinician during an MSPB episode: the period immediately before, during, and after a patient’s hospital stay. An MSPB episode includes most Medicare Part A and Part B claims during the episode, specifically claims with a start date between three days before a hospital admission (the “index admission” for the episode) through 30 days after hospital discharge. Under new specifications in 2020, inpatient medical episodes will be attributed separately from inpatient surgical episodes. Measure revisions also exclude costs unrelated to the primary diagnosis/reason for hospitalization. The case minimum is 35. This measure most likely will impact urologists in 2020.
In 2020, eighteen additional measures have been added to the Cost category to gauge specific procedural episodes. This includes the Renal or Ureteral Stone Surgical Treatment measure, which will be applicable for many urologists. The measure includes Medicare Parts A and B expenses and accounts for associated costs for 90 days prior to the episode through 30 days following. The measure is attributed to the clinician who bills a “trigger code” on the day of the procedure. The measure it is risk-adjusted. The case minimum for this measure is 10.

For more details about the Cost measures, check out the Cost measure information available on the QPP website.

How will I be scored?

To calculate one’s Cost performance category score, CMS will assign a score of 1-10 points to each measure. Keep in mind that some clinicians may not qualify for all or any of the Cost measures. Secondly, CMS will compare one’s performance to that of other MIPS-eligible clinicians and groups during the performance period.

\[
\text{Cost Performance} = \frac{\text{Total Points Scored on Each Measure}}{\text{Total Possible Points Available}}
\]

If someone earn 6 points for each measure, the score would be:

\[
\frac{6 + 6 + 6}{3 \times 10} = 60 \text{ percent}
\]

To determine the Cost category MIPS points, the formula is:

\[
(\text{Cost performance category percent score}) \times (\text{Cost category weight}) \times 100 \text{ MIPS points}
\]

For this example, that is: 60 percent x 15 percent x 100 MIPS points = 9 points

Promoting Interoperability (PI) (formerly known as Advancing Care Information)

“Know before you go” information

- In 2020, all participants must use 2015 Certified Electronic Health Record Technology (CEHRT) for a continuous 90-day period during the calendar year. If you are unsure what version of CEHRT you have, check with your EHR vendor.

- Those in a practice with 15 or fewer providers may apply for an exception from PI (Hardship Exception). Even if you received this exception previously, you must apply again in 2020. CMS will announce when the application process opens.
In order to report for PI, participants can use one of the following methods: a qualified registry, qualified clinical data registry (QCDR), EHR, CMS Web Interface, or attestation.

Participants can report as an individual or a group.

In addition to the PI measures, participants must provide their EHR’s CMS Identification code from the Certified Health IT Product list and submit a “yes” to the following three requirements:

- The Prevention of Information Blocking Attestation
- The ONC Direct Review Attestation
- The security risk analysis measure

For more information on the exclusions and exemptions available, contact the QPP help desk at 866-288-8292 or QPP@cms.hhs.gov.

What do I do?
Participants must accomplish the PI objectives by completing the related measures. The measures are nearly identical to the 2019 specifications. The only change is that one bonus measure was removed.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Weight</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>e-Prescribing</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 Bonus Points</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>20 points</td>
</tr>
<tr>
<td>Provide to Patient Exchange</td>
<td>Provide Patients Electronic Access to their Health Information</td>
<td>40 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Report to two different public health agencies or clinical data registries for any of the following:</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>1) Immunization Registry Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Electronic Case Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) Public Health Registry Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4) Clinical Data Registry Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5) Syndromic Surveillance Reporting</td>
<td></td>
</tr>
</tbody>
</table>
- **E-Prescribing** – This measure tracks the number of prescriptions sent electronically compared to the total number of prescriptions. Clinicians can determine if they wish to include controlled substances in this measure; however, the decision must be uniformly applied. Clinicians or groups who prescribe 100 or fewer prescriptions overall can be excluded from this measure. If that happens, the 10 points for this measure will be redistributed equally to the two Health Information Exchange measures.

- **Support Electronic Referral Loops by Sending Health Information** – For this measure, a clinician must transition care or refer a patient to another setting of care or healthcare setting. In the process, the clinician must create a summary of care using one’s EHR and electronically exchange the summary of care record. There must be some kind of proof or acknowledgement that the referral was received. If a clinician or practice does not order over 100 transitions of care or referrals annually, an exclusion can be granted. If the exclusion is granted, the 20 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

- **Support Electronic Referral Loops by Sending Health Information** – To satisfy this measure, the clinician or group who receives a referral or transition of care must conduct a clinical information reconciliation for medication, medication allergies, and current problems. The key to this measure is not the referral itself, but rather the reconciliation of the clinical information into the new practice’s EHR system. An exclusion can be granted if a clinician or practices does not receive at least 100 referrals a year; in that case, the 20 points would be transferred to the Support Electronic Referral Loops by Sending Health Information measure.

- **Provide Patients Electronic Access to their Health Information** – This measure has two parts. First, the provider or group must provide at least one patient timely access (generally defined as 4 business days) to view online, download and transmit the patient’s health information. Additionally, the clinician or practice must ensure that the patient’s health information is available for the patient (or the patient’s representative) to access using any application of their choice as long as it meets the technical specifications of the Application Programming Interface (API) in the provider’s EHR. Most providers satisfy the second requirement via a patient portal, but there are other options as well. There is no exclusion for this measure.

- **Report to two different public health agencies or clinical data registries** – There are five categories for reporting, and a participants can report to any two. The two options do not need to be in different categories. CMS defines “reporting” as one of the following three: completed registration and preparing to submit data, testing and validating the submission process, or submitting/submitted data. Reporting to the AUA’s AQUA Registry would qualify as Clinical Data Registry Reporting, and reporting to the National Ambulatory Medical Care Survey is a free option for satisfying this measure. A clinician or group may be excluded for any one of the following three:
  - Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period.
  - 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 CERHT definition at the start of the performance period.
• 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 six months prior to start of the performance. If an exclusion is granted, the 10 points are transferred to Provide Patients Electronic Access to Their Health Information.

• BONUS - Query of Prescription Drug Monitoring Program (PDMP) – If clinicians decide to complete this measure, they must do so through attestation. There is not a case minimum for this measure. As long as a clinician checks the PDMP once before prescribing a qualifying prescription, the measure is satisfied.

How Is My Score Calculated?
Participants can earn up to 105 measure points. Claiming an allowed measure exclusion causes the measure’s points to be shifted to a different measure (except in the case of Provide Patients Electronic Access to Their Health Information). If a clinician does not report either a numerator of 1 or a “yes” for a required non-bonus measure or claim an exclusion for it, then the entire category would receive a score of 0. Additionally, an annual security risk analysis must be reported; if it is not, a score will not be awarded for Promoting Interoperability.

Performance points – As noted in the chart above, measures have been designated as worth up to 10, 20, or 40 points. Performance rates are scored on a static decile scoring scale where, for instance, a performance rate of 50 percent earns 5 points out of 10, 66 percent earns 7 points out of 10 (CMS rounds 6.6 points up to 7 points), and a performance rate of less than 5 percent would receive a score of 1 if at least one patient was reported in the measure’s numerator. The Public Health and Clinical Data Exchange measures are scored as yes/no.

Bonus Measure Points – Participants can earn 5 bonus points for reporting the optional opioid-related measure. It is an attestation measure where participants either answer yes or no.

To calculate the PI category score, the measure points earned are divided by 100. The score is capped at 100 percent.

The formula to determine the PI category MIPS points is:

\[(\text{PI performance category percent score}) \times (\text{PI category weight}) \times 100 \text{ MIPS points}\]

Complex Patient Bonus Points

CMS recognizes the risk factors incurred by clinicians for caring for complex patients. Therefore, CMS will analyze participant data to determine if complex patient bonus points are appropriate. The bonus is based upon Hierarchical Condition Category (HCC) risk scores and socio-economic risk as measured based upon the proportion of patients with dual Medicare-Medicaid eligibility. Up to 5 bonus MIPS points may be awarded depending on the level of clinical complexity and risk of a clinician’s patient population. The complex patient bonus will be granted only if data is submitted for at least one of the
following MIPS performance categories: Quality, IA or PI; this bonus will not be granted if only the Cost category is scored.

Where can I get more information?

2020 Eligibility and Participation Quick Start Guide
2020 MIPS Quick Start Guide
2020 Part B Claims Reporting Quick Start Guide
2020 Quality Quick Start Guide
2020 Quality Benchmarks
2020 Cost Quick Start Guide
2020 MIPS Summary of Cost Measures
2020 Cost Measure Code List
2020 Promoting Interoperability Quick Start Guide
2020 Promoting Interoperability Measure Specifications
2020 Improvement Activities Quick Start Guide
2020 Improvement Activities Inventory

Questions?

Quality Payment Program Help Desk
Phone: 866-288-8292
Email: QPP@cms.hhs.gov

AUA
Phone: 410-689-3925
Email: quality@auanet.org