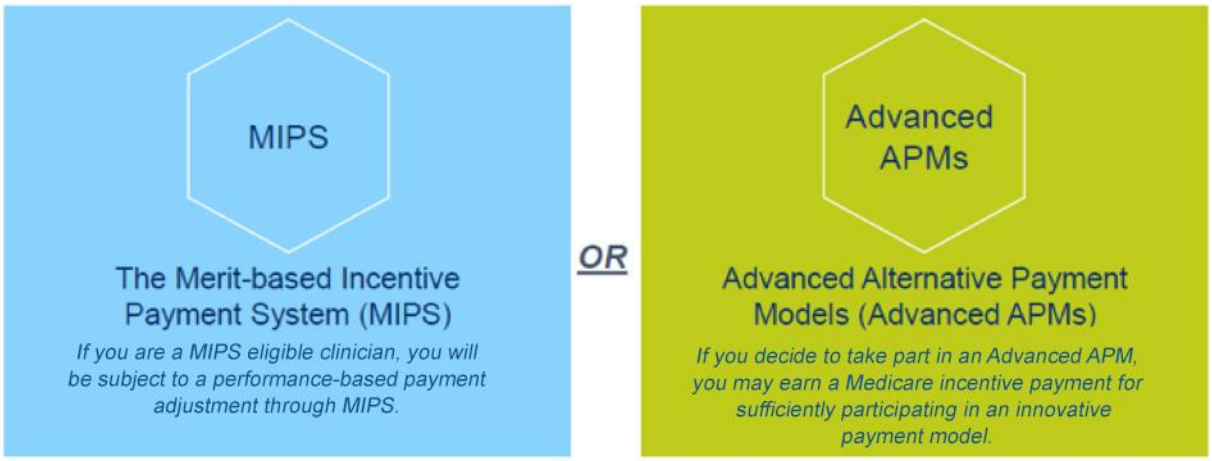
Quality Payment
PROGRAM

2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category Fact Sheet

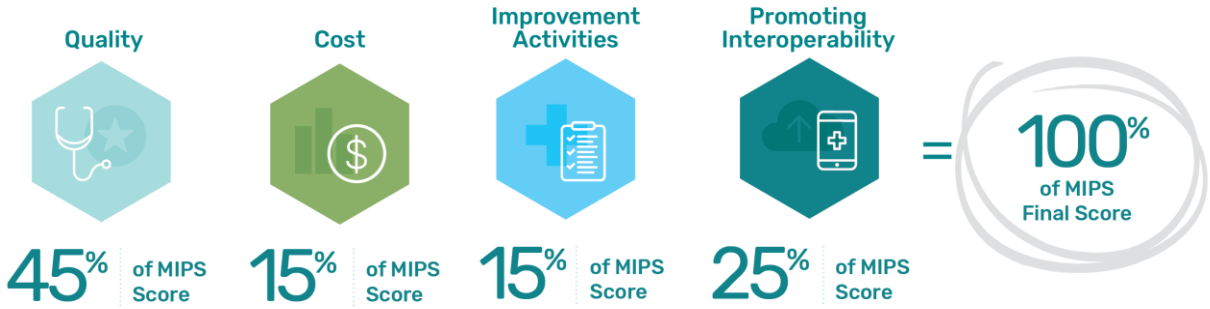
For Individual MIPS Eligible Clinicians, Groups, and Virtual Groups

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), which provides two participation tracks for clinicians:



Under MIPS there are four performance categories that could affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that is part of the MIPS Final Score. The payment adjustment determined for each MIPS eligible clinician is based on the MIPS Final Score. These are the performance category weights for the 2019 performance period:



These performance category weights are different for APM participants in MIPS who are scored according to the APM scoring standard. Please review the Quality Performance Category Scoring for Alternative Payment Models for more information on the APM scoring standard and for information specific to your APM.

Just like in 2018, MIPS eligible clinicians, who are not APM participants scored under the APM scoring standard, may participate in MIPS individually, as a group, or as a virtual group in Year 3 of the program (2019).

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

Please note that some clinicians participate in MIPS through a MIPS APM, which has separate requirements and scoring standards, and may receive a payment adjustment based on those standards. A comprehensive list of APMs is available as well as an array of resources in the

Quality Payment Program resource library. Additionally, if you are a part of a MIPS APM, we encourage you to work with your APM on program requirements.

New MIPS Terms

You'll notice the use of new language that more accurately reflects how clinicians and vendors interact with MIPS (i.e. Collection types, Submitter types, etc.). We've solicited and listened to your feedback and finalized these new terms in order to implement the program in a way that is understandable to participants and beneficiaries alike. The new terms include:

- **Collection Type** - a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS clinical quality measures (MIPS CQMs) (*formerly referred to as "Registry measures*"); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures (only small practices); CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.
- **Submitter Type** - the MIPS eligible clinician, group, or third-party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.
- **Submission Type** - the way the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment. purposes.

Why Focus on Quality?

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

- Effectiveness
- Safety
- Efficiency
- Patient-Centered
- Equitable
- Timely

There are over **250 MIPS quality measures** available for reporting in the 2019 performance period of MIPS. This includes measures available through most MIPS collection types such as eCQMs, MIPS CQMs, Medicare Part B claims measures (small practices only), CMS Web Interface measures (registered groups of 25+), and the CAHPS for MIPS survey measure.

If you're a MIPS eligible clinician reporting through a QCDR, you can also report on approved QCDR measures developed by the QCDRs. These additional measures are outside the 250+ MIPS quality measures finalized through rulemaking and provide quality measurement options that may be more applicable to your practice and/or specialty.

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

The QPP has seven types of quality measures:

1. Process,
2. Structure,
3. Intermediate outcome,
4. Outcome,
5. Patient Reported Outcome,
6. Efficiency, or
7. Patient engagement & patient experience.

These seven types apply to all of the quality measures submitted for MIPS across any of the 7 collection types. More information on each measure type along with examples, are listed in the chart below.

Quality Measures by Measure Type		
Process measures Process measures show what doctors and other clinicians do to maintain or improve the health of healthy people or those diagnosed with a given condition or disease. These measures usually show generally accepted recommendations for clinical practice. For example: • The percentage of people getting preventive services (such as mammograms or immunizations). Process measures can tell consumers about the medical	**Outcome measures** Outcome measures show how a health care service or intervention affects patients' health status. For example: • The percentage of patients who died because of surgery (surgical mortality rates). • The rate of surgical complications or hospital-acquired infections. Outcome measures may seem to be the "gold standard" in measuring quality, but outcomes happen for many reasons, some of	**Structure measures** Structural measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care. For example: • Utilizing electronic support systems such as a continuity of care recall system or a reminder system for mammogram screenings. • Checking for the availability of diagnostics for patient follow up and comparisons.

care they should get for a given condition or disease.	which clinicians don't have control over.	
Patient Engagement and Patient Experience measures Patient engagement and patient experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys. For example: • Administering the CAHPS for MIPS Survey.	**Intermediate Outcome measures** Intermediate outcome measures assess a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level. Over time, low cholesterol helps protect against heart disease. Under MIPS, intermediate outcome measures meet the outcome measure criteria. For example: • Reducing blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.	**Efficiency measures** Efficiency measures can be used to assess the variability of the cost of healthcare and to direct efforts to make healthcare more affordable. For example: • Ordering cardiac imaging when it does not meet the appropriate use criteria. • Overusing neuroimaging in a target patient population (such as patients with headaches and a normal neurological exam).
Patient-Reported Outcome measures These measures are derived from outcomes reported by patients and can include any report of a patient's health condition, health behavior, or experience with healthcare that comes directly from the patient without interpretation of the patient's response by a clinician. These are related to health-related quality of life, symptoms and symptom burden, etc. For example: • The average change in back pain following a Lumbar discectomy or Laminotomy is measure based on the patient's reported level of their back pain.		
High priority measures		
MIPS scoring policies emphasize and focus on high priority measures that impact beneficiaries. High priority measures are measures that fall within these measure categories: • Outcome (includes intermediate-outcome and patient-reported outcome measures) • Patient experience • Patient safety • Efficiency measures		

- Appropriate use
- **Opioid-related quality measures**
- Care coordination

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

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

New in 2019: We are implementing an approach to incrementally remove process measures. For this approach, prior to removal, consideration will be given, but not limited to:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the measure addresses a priority area highlighted in the Measure Development Plan
- Whether the measure promotes positive outcomes in patients.
- Considerations and evaluation of the measure's performance data.
- Whether the measure is designated as high priority or not.
- Whether the measure has reached an extremely topped out status, within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.

What Do I Have to Do for the Quality Performance Category in Year 3 (2019)?

Just like in 2018, the Quality performance category will continue to have a 12-month performance period (January 1 – December 31, 2019). When you report a full year of quality data, we get a more complete picture of your performance and you have a greater chance to earn a higher MIPS Final Score.

You will also have the chance to increase your 2019 Quality performance category score based on your rate of improvement from your Quality performance category score from Year 2 (2018) of the program.

To meet the Quality performance category requirements a clinician, group, or virtual group has to submit one of the following:

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

Select your measures from a defined specialty measure set. One of the measures must be an outcome measure or another high-priority measure in the absence of an applicable outcome measure. If the specialty measure set has fewer than 6 measures, you need to submit all measures within that specialty set.

Submit all quality measures included in the CMS Web Interface, a collection type available to registered groups and Virtual Groups with 25 or more eligible clinicians.

Review *Appendix A* for a summary of the 2018 and 2019 MIPS performance years Quality data submission criteria for Individual Clinicians and Groups.

What Are the Ways I Can Collect Quality Data?

We urge eligible clinicians, groups, and virtual groups to review each data collection type carefully and to choose what works best for them. Many collection types use third party intermediaries which you need to establish agreements with and/or register for before the performance period begins in order to utilize them.

New in 2019: We will aggregate quality measures collected through multiple collection types for the 2019 performance period. If the same measure is collected via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring. However, CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures. Please review *Appendix B* for a scoring example of how this policy will be applied for the 2019 performance period.

Collection Type	How does it work?
Qualified Clinical Data Registry (QCDR) Measures Can be used by individual MIPS eligible clinicians, groups, and virtual groups.	CMS-approved, QCDRs collect medical and/or clinical data to track patients and disease. Each QCDR usually gives customized instructions about how to submit data. For MIPS, eligible clinicians who choose this option have to participate with a QCDR that we've approved. You can find approved QCDRs in the 2019 QCDR Qualified Posting document in the Quality Payment Program resource library. You can also find a list of the 2019 QCDR Measure Specifications in the Quality Payment Program resource library. **Note:** Beginning with the 2020 MIPS performance period, a QCDR will be defined as an entity with clinical expertise in medicine and 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. This requires action on the part of the QCDR, not the MIPS

Collection Type	How does it work?
	participant. You will want to continue to monitor if your QCDR maintains their approved status for the MIPS program annually.
MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "Registry measures") Can be used by individual MIPS eligible clinicians, groups, and virtual groups.	MIPS CQMs are collected by Qualified Registries and QCDRs and are submitted (via the Direct, or Log-in and Upload submission types) on behalf of MIPS eligible clinicians. Eligible clinicians who choose this collection type will have to participate with a Qualified Registry or QCDR that we've approved. You will want to continue to monitor if your Qualified Registry and/or QCDR maintains their approval status for the MIPS program annually. You can find: Approved Qualified Registries in the 2019 Qualified Registries Qualified Posting document in the Quality Payment Program resource library, and Approved QCDRs in the 2019 QCDR Qualified Posting document in the Quality Payment Program resource library.
Electronic Clinical Quality Measures (eCQMs) Can be used by individual MIPS eligible clinicians, groups, and virtual groups.	Clinicians submit data they've collected through their certified EHR technology (CEHRT). Clinicians can do this themselves (via the Log-in and Upload submission type) or by working with a certified Health IT vendor, Qualified Registry or QCDR who will submit the data for them (via the Log-in and Upload, or Direct submission types). Groups and virtual groups that collect data using multiple EHR systems will need to aggregate their data before it's submitted. **Note for 2019:** If you submit eCQMs, you'll need to use CEHRT to collect the eCQM data. You must have 2015 Edition CEHRT in place by December 31, 2019 and the 2015 CEHRT must be used to generate your eCQM data for reporting.
Medicare Part B Claims Measures **New in 2019:** Can only be used by small practices participating in MIPS as individual MIPS eligible clinicians or as a group.	**New for 2019:** This collection type is only available for small practices who participate in MIPS as either individual MIPS eligible clinicians, groups, or virtual groups. Small practices pick measures and report through their routine billing processes. If they choose this option, they'll need to add certain billing codes to claims filed for denominator eligible patient encounters to show that the required quality action occurred or that the denominator exclusion was met.

Collection Type	How does it work?
	For the 2019 performance period, Medicare Part B claims must be submitted and processed no later than 60 days following the close of the performance period to be analyzed for the Quality performance category. Please refer to the 2019 Claims Data Submission Fact Sheet for additional information. .
CMS Web Interface Measures Can only be used by groups and virtual groups with 25 or more clinicians and Medicare Shared Savings Program (SSP) ACOs reporting on behalf of MIPS eligible clinicians.	This is a secure internet-based application that pre-registered groups and virtual groups with 25 or more clinicians can use. A sample of beneficiaries are identified for reporting and we partially pre-populate the CMS Web Interface with claims data from the group's Medicare Part A and Part B beneficiaries who've been assigned to the group. Then, the group adds the rest of the clinical data for the pre-populated Medicare patients. Reporting via the Web Interface requires that you submit data for all measures in the application. If you don't have any beneficiaries that qualify for the sample, CMS will direct you to select another collection type and submission type option for submitting quality data. Groups and virtual groups interested in reporting through the CMS Web Interface need to register at qpp.cms.gov between **April 1, 2019 and July 1, 2019**. ACOs participating in the Medicare Shared Savings Program (Shared Savings Program) or Next Generation program do not need to register for CMS Web Interface quality reporting because it is a requirement of these programs. See *Appendix G* for a list of the 2019 CMS Web Interface measures. **Note:** The bonus for submitting additional high-priority measures via the CMS Web Interface is discontinued beginning with the 2019 performance period. Also, when scoring measures across collection types, CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures.
CAHPS for MIPS Survey Measures Can only be used by groups and virtual groups.	Groups and virtual groups interested in administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey need to register via qpp.cms.gov between **April 1, 2019 and July 1, 2019**.

Collection Type	How does it work?
	Groups that choose to report their patient experience data via the CAHPS for MIPS survey have to pick another collection type and submission type to collect and submit their remaining quality measures. Groups must meet minimum sample sizes to administer the CAHPS for MIPS survey. We'll let groups know if they meet minimum sample sizes after group registration closes and assignment sampling finishes. Certain specialties such as surgeons, anesthesiologists, pathologists and radiologists that do not provide primary care services may not have patients to whom the CAHPS for MIPS survey could be issued and may therefore not be able to receive any bonus points for patient experience. Groups are responsible for the costs incurred by administering the survey and have to contract with a CMS-approved survey vendor to conduct the survey. A list of approved vendors will be posted on the Quality Payment Program resource library. The conditional list of 2019 CMS-Approved CAHPS for MIPS survey vendors will be made publicly available. **New in 2019:** A group that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measure must use a survey vendor that is approved by CMS for the applicable performance period to transmit survey measure data to us.
Administrative Claims Measure	The Quality performance category has 1 measure, the All-Cause Hospital Readmission measure, that's evaluated by administrative claims. Groups and virtual groups, with 16 or more clinicians, are automatically subject to the All-Cause Hospital Readmission measure if they meet the case minimum of 200 patients for the measure. If the group or virtual group falls below the case minimum, the All-Cause Hospital Readmission measure won't be calculated, and clinicians will only be scored on the reported measures. Please note that no data submission action is required for administrative claims evaluation and that the All-Cause Hospital Readmission measure is not a part of the APM Scoring Standard and won't be calculated for groups participating in a Shared Savings Program ACO.

Getting Started

Here are 5 steps to help you get started:

1. See if you're a MIPS eligible clinician

You're a MIPS eligible clinician or group if you're 1 of the following clinician types who bills more than $90,000 in Medicare Part B allowed charges for covered professional services, provides covered professional services to more than 200 Part B-enrolled Medicare beneficiaries **and** provides more than 200 covered professional services under the Physician Fee Schedule (PFS)[1]:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists
- Certified registered nurse anesthetists
- **Physical therapist**
- **Occupational therapist**
- **Qualified speech-language pathologist**
- **Qualified audiologist**
- **Clinical psychologist**
- **Registered dietitian or nutrition professionals**
- In any clinician group that includes 1 of the professionals listed above

Clinician types in **bold** are newly added to the program beginning in 2019.

For the 2019 performance period, if you would like to find out if you are a MIPS eligible clinician (either at the individual or group level), you can use the Participation Status Look-up tool on qpp.cms.gov.

2. Choose your measures

There are more than 250 quality measures in MIPS; additionally, if you chose to work with a QCDR, additional QCDR measures may be available for your choosing. You can start looking at the measures to find what works best for you, your group, or virtual group. If you're a group, virtual group, or MIPS APM reporting via the CMS Web Interface, you are required to report on the measures in the Web Interface application.

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

In addition to the quality measures you submit, there is one administrative claims measure, the All-Cause Hospital Readmissions Measure, that is automatically calculated by CMS based on

[1] This third element is new for 2019. For more information on it please review the 2019 MIPS Eligibility Overview Fact Sheet.

Medicare claims that are submitted. This measure will be calculated for groups of 16 or more clinicians if the case minimum of 200 patients is met.

New for 2019:

- We revised the definition of a high priority measure to include opioid-related quality measures.
- You can choose to submit the same measure across different collection types to optimize your achievement score for the measure.
- You can also choose measures across all of the collection types available to you in order to find the measures most meaningful to your practice (for example, you can submit two eCQMs and four Medicare Part B claims measures (if you're a small practice) and the data across both collection types can count towards your Quality performance category score)

3. Understand your quality measures

Once you've found the measures that work for you, you'll need to review each of your selected measure's specifications. Measure specifications describe each measure and outline their elements, reporting frequency, corresponding codes, and more.

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

4. Collect your data

You should start data collection on **January 1, 2019** to meet data completeness requirements and to increase your opportunity to receive a higher Quality performance category score**.** For the Quality Performance Category, you'll need to report on 12 months of quality data for the 2019 performance period (January 1, 2019 – December 31, 2019).

2019 Collection Types Available According to Reporting Level

Individuals	Groups
•eCQMs •MIPS CQMs •QCDR Measures •Medicare Part B Claims Measures (small practices only)	•eCQMs •MIPS CQMs •QCDR Measures •Medicare Part B Claims Measures (small practices only) •CMS Web Interface Measures •CAHPS for MIPS Survey Measure •Administrative Claims Measure

If you're participating in a MIPS APM, you should work with your APM entity on timelines and required activities for the 2019 performance period.

5. Submit your 2019 data

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

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

For the Direct, Log-in and Upload, and CMS Web Interface submission types, the data submission period will begin on **January 2, 2020, and will end no later than March 31, 2020.**

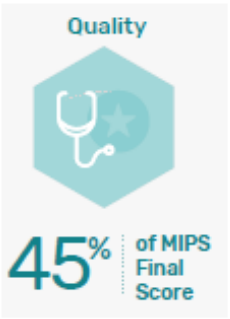
You'll be able to find a submission timeline, that includes due dates, on qpp.cms.gov. You can also review your performance feedback on quality data submitted via claims by logging into qpp.cms.gov. This feedback will be updated on a monthly basis.

Wondering which submission types include QCDRs, Qualified Registries, and EHRs? The below chart outlines the submission types and how they work.

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

What is Quality Scoring?

For the 2019 performance period:



The weight of the Quality performance category is 45% of your MIPS final score.

Quality measures submitted for the 2019 performance period will receive between 1 and 10 points as measure achievement points. Quality measures fall into one of three categories for scoring:

- The measure meets the data completeness criteria, has a benchmark, and the volume of cases is sufficient (> 20 cases for most measures).
    - These measures continue to receive between 3 to 10 points based on performance compared to the benchmark.
- The measure meets the data completeness criteria but either (1) doesn't have a benchmark and/or (2) the volume of cases you've submitted is insufficient (≤20 cases for most measures).
    - These measures continue to receive 3 measure achievement points.*
- The measure doesn't meet the data completeness criteria, which varies by collection type (see *Appendix C* for a summary of the data completeness requirements by Collection Type).
    - These measures receive 1 point, **except** for small practices which would continue to receive 3 measure achievement points.*

Note: Beginning with the 2020 MIPS performance period, MIPS eligible clinicians other than small practices will receive **zero** measure achievement points for measures that don't meet data completeness criteria. Small practices will continue to receive 3 points.

*These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims based measures.

Are there any other exceptions to these scoring policies?

We are continuing the topped-out measure cycle where we specify topped-out measures for each performance period. These measures are capped at 7 points each, and in 2019, they include, but are not limited to:

1. Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
2. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
3. Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
4. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy. (Quality Measure ID: 52)

To identify if a measure is topped out, visit the 2019 Quality Benchmarks file, which can be found in the Quality Payment Program resource library.

Note: QCDR measures are excluded from the topped-out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped-out during the self-nomination process, it may not be approved for the applicable performance period.

New in 2019: *Extremely Topped-Out Measures*. A measure is extremely topped out when the average mean performance is within the 98th to 100th percentile range. These measures can be proposed for removal in the next rule-making cycle and are not subject to the 4-year lifecycle that applies to other topped-out measures. To identify if a measure is extremely topped out, visit the 2019 Quality Benchmarks file, which can be found in the Quality Payment Program resource library.

You can also earn bonus points based on improvement at the Quality performance category level from one year to the next.

National Benchmarks

What are benchmarks?

When you submit measures for the QPP, each measure is assessed against its benchmark to determine how many points the measure earns. We establish Quality performance benchmarks either (1) prior to the reporting period for which they apply (these *historical benchmarks* are based off of data from two years prior) or (2) from data submitted for that performance period (these *performance period* benchmarks for the 2019 performance period will be calculated from 2019 data submitted during the data submission period, that is why they're not available before the start of the performance period).

Quality benchmarks for the MIPS CQMs, QCDR Measures, Medicare Part B claims measures, and eCQMs collection types are established using historical data that's collected 2 years before the performance period. The 2019 Quality benchmarks were established using 2017 MIPS performance data.

The CAHPS for MIPS benchmarks for Performance Year 2019 have not been established yet because a revised survey was used for Performance Year 2018 and therefore sufficient historical data are not available. However, benchmarks for Performance Year 2019 will be calculated in the Spring of 2020 using performance period data for each summary survey measure (SSM).

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

How do benchmarks convert to points?

When you submit measures for the MIPS Quality performance category, each measure is assessed against its collection type-specific benchmark to see how many points are earned based on your quality performance. Each quality measure is converted into a 10-point scoring system, except for:

- The topped-out measures finalized with a 7-point scale,
- Measures that don't meet data completeness criteria, and
- Measures that either don't have a benchmark and/or the volume of cases you've submitted is insufficient.

Performance on quality measures is broken down into "deciles," with each decile having a value between 3 and 10 points. There is a 3-point floor for measures that can be reliably scored based on performance for the 2019 MIPS performance period as a result measures in the lowest deciles cannot get less than 3 measure achievement points. The deciles will be based on stratified levels of national performance (benchmarks) within that baseline period. We'll compare your performance on a quality measure to the performance levels in the national deciles. The points you earn are based on the decile range that matches your performance level. For measures with inverse performance rates, such as Measure #1 Diabetes: Hemoglobin A1c Poor Control where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

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

Reliably scored means that:

- A national benchmark exists.
- The sufficient case volume has been met (>20 cases for most measures; >200 cases for readmissions).
- The data completeness criteria has been met (meaning at least 60% of possible data is submitted).

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

Quality measures that can't be reliably scored against a benchmark, or quality measures without a benchmark, will receive 3 points (assuming the measure meets data completeness) unless a benchmark can be established with performance period data. If the measure does not also meet data completeness it will receive 1 point (except for small practices which would receive 3 measure achievement points). This applies to measures across all collection types except for CMS Web Interface measures and administrative claims measures.

Maximum Number of Achievement Points by Collection Type

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



There are 80 available points if you submit your data via the CMS Web Interface, administer the CAHPS for MIPS survey, and the readmission measure can be calculated for your group or virtual group.

What if measures are impacted by clinical guideline changes?

Clinical guidelines and protocols developed by clinical experts and specialty medical societies often underpin quality measures. At times, measure stewards must amend quality measures to reflect new research and changed clinical guidelines. Sometimes, in rare cases, as a result of the change in these guidelines that occur during a performance period, adherence to guidelines in the existing measures could result in patient harm or otherwise provide misleading results as to good quality care.

If this were to occur for one or more measures, where a measure is impacted by clinical guideline changes, we will identify the measures on the CMS website.

Clinicians who are following the revised clinical guidelines may still report and submit data on the impacted measure. However, we will suppress scoring on this measure for the particular performance period. This is done by not scoring the measure and reducing the total available measure achievement points in the denominator for the Quality performance category by 10 points for the clinician reporting the measure. In this way, the clinician is held harmless for reporting this measure until the measure specifications can be updated by the measure steward.

How do we determine applicable quality measures?

If you're collecting quality data via Medicare Part B claims (small practices only) or MIPS CQMs and during the data submission period you submit less than 6 measures or no outcome or high priority measure, we'll use the Eligibility Measure Applicability (EMA) process to see if you could have submitted more clinically related measures within the same collection type.

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

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

Eligibility Measure Applicability (EMA) is:

- Based on evaluation of submitted measures and determination of clinically related measures aligned with specialty measure sets.
- Specific to the collection type (i.e., EMA won't determine that a Medicare Part B claims submitter had a MIPS CQM available).
- Not applicable for eCQMs, QCDR measures, and CMS Web Interface collection types. Clinicians, groups and virtual groups who use these collection types in conjunction with Medicare Part B claims measures or MIPS CQMs will not be eligible for EMA.

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

Measure Bonus Points

What is the end-to-end reporting bonus?

You'll receive 1 bonus point per measure for reporting your quality data directly from your CEHRT without any manual manipulation. (Your EHR must be certified to the 2015 Edition by the last day of the performance period.) This bonus is available to measures reported through the Direct, Log-in and Upload, and CMS Web Interface submission types. Those bonus points will be added to your or your group's or virtual group's Quality performance category achievement points (those earned based on performance). End-to-end bonus points will be added to your Quality performance category achievement points (those earned based on performance) and are capped at 10% of your Quality performance category denominator.

Note for 2019: If you submit eCQMs, you'll need to use CEHRT to collect the eCQM data. The CEHRT used to collect the eCQM data will need to be certified to the 2015 Edition by the last day of the Quality performance period (December 31, 2019). Therefore, in order for practices to earn the end-to-end bonus for reporting eCQMs for the 2019 performance period, they will need to report the latest version of the eCQM extracted from 2015 Edition CEHRT.

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

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

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

Beginning in 2019, high priority measure bonus points will **not** be applied to measures submitted via the CMS Web Interface.

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

How is the small practice bonus applied in 2019?

The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation. Beginning in Year 3 (2019), six (6) bonus points will be added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.

Improvement Scoring

For the 2019 performance period we are continuing to provide an opportunity to earn improvement points. Here, you can earn up to 10 percentage points based on the rate of your improvement in the Quality performance category from the year before. Bonus points will be incorporated into your or your group's/virtual group's overall Quality performance category score.

How do we evaluate eligibility for improvement scoring?

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

- Participate fully in the Quality performance category for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure OR submit as many measures as were available and applicable OR report all measures in the CMS Web Interface; all measures must meet data completeness requirements); AND
- Have a Quality performance category achievement percent score based on reported measures for the previous performance period (Year 2, 2018); AND
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

Please review *Appendix E* for details on how we'll compare data across identifiers.

How is improvement scoring calculated?

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



Example:

In 2018, a MIPS eligible clinician earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.

For the 2019 performance period, the same MIPS eligible clinician earned 33 measure achievement points and 6 measure bonus points for end-to-end electronic reporting.

- 2018 Quality performance category achievement percent score = 42%
  - (25/60)
  - Excludes the 2 bonus points
- 2019 Quality performance category achievement percent score = 55%
  - (33/60)
  - Excludes the 6 bonus points
- The increase in Quality performance category achievement percent score from prior performance period to current performance period = 13%
  - (55% - 42%)
- The improvement percent score is 3.1% which will be added to the percent score earned for reported measures.
  - (13%/42%)*10% = 3.1%

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

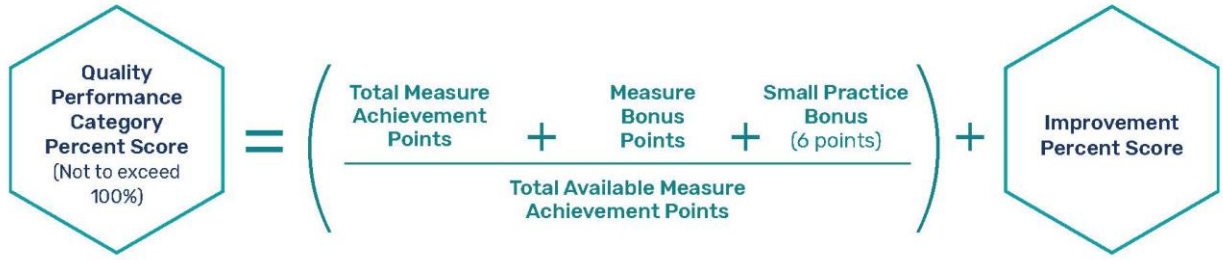
Calculating the Quality Performance Category Percent Score

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



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

The small practice bonus has been moved from a bonus added to the MIPS final score to a Quality Performance Category Score bonus for 2019. The Quality Performance Category Percent Score equation for small practices is a product of the following equation:



Facility-Based Measurement Scoring

Beginning with the 2019 performance period, we will identify clinicians and groups eligible for facility-based scoring. These clinicians and groups may have the option to use facility-based measurement scores for their Quality and Cost performance category scores.

Facility-based measurement scoring will be used for your Quality and Cost performance category scores when:

- You are identified as facility-based; and
- You are attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2019 performance period; and
- The Hospital VBP score results in a higher score than MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

Please review *Appendix F* for a list of the FY 2020 Hospital VBP Program Measures that will be used for facility-based measurement scoring for the MIPS 2019 performance period.

Data Accuracy

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

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

Shaping the Future of Quality

Quality measure development and inclusion

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

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

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

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

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

Annual Call for Quality Measures

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

Technical Assistance

We provide no cost technical assistance based on your practice size and location to help you successfully participate in the Quality Payment Program. To learn more about this support, or to connect with your local technical assistance organization, we encourage you to visit our Help and Support page on the Quality Payment Program website.

Resources

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

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

Version Control Table

Date	Version Notes
02/13/2019	**p. 8, 19:** Clarified CEHRT requirements **p. 17:** Corrected error about inverse measures benchmarks; Decile 10 has the lowest performance rates **p. 20:** Added CMS Web Interface reporting to list of “full participation” options for Improvement Scoring
12/27/2018	Original posting

Appendix A - Summary of Quality Data Submission Criteria for MIPS Payment Year 2020 and 2021 for Individual Clinicians and Groups

Clinician Type	Submission Criteria*	Measure Collection Types (or Measure Sets) Available
Individual Clinicians	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable.	Individual MIPS eligible clinicians select their measures from the following collection types: Medicare Part B claims measures (individual clinicians in small practices only), MIPS CQMs, QCDR measures, eCQMs, or reports on one of the specialty measure sets if applicable.
Groups and Virtual Groups (non- CMS Web Interface)	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable.	Groups and virtual groups select their measures from the following collection types: Medicare Part B claims measures (small practices only), MIPS CQMs, QCDR measures, eCQMs, or the CAHPS for MIPS survey - or reports on one of the specialty measure sets if applicable. Groups of 16 or more clinicians who meet the case minimum of 200 will also be automatically scored on the administrative claims based all-cause hospital readmission measure.
Groups (CMS Web Interface for group of at least 25 clinicians)	Report on all measures includes in the CMS Web Interface collection type and optionally the CAHPS for MIPS survey.	Groups report on all measures included in the CMS Web Interface measures collection type and optionally the CAHPS for MIPS survey. Groups of 16 or more clinicians who meet the case minimum of 200 will also be automatically scored on the administrative claims based all-cause hospital readmission measure.

* Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.

Appendix B - Example Assigning Total Measure Achievement and Bonus Points for an Individual MIPS Eligible Clinician Who Submits Measures Collected Across Multiple Collection Types

In the example below, a single clinician (associated with a practice that has 15 or fewer clinicians so they meet the definition of a small practice) reported a total of 12 quality measures through multiple collection types:

- 3 MIPS CQMs
- 4 Medicare Part B claims measures
- 5 eCQMs

This table explains which of these measures will contribute to the clinician's quality performance category score, and why (or why not).

	Measure Achievement Points	Six Scored Measures	High-Priority Measure Bonus Points	Incentive for CEHRT Measure Bonus Points
MIPS CQMs				
Measure A (Outcome)	7.1	7.1 (Outcome measure with highest achievement points)	(required outcome measure does not receive bonus points)	
Measure B	6.2 (points not considered because it is lower than the 8.2 points for the same claims measure)			
Measure C (high priority patient safety measure that meets requirements for additional bonus points)	5.1 (points not considered because it is lower than the 6.0 points for the same claims measure)		1	
Medicare Part B Claims				
Measure A (Outcome)	4.1 (points not considered because it is lower than the		No bonus points because the MIPS CQM of the same	

	7.1 points for the same MIPS CQM)		measure satisfies requirement for outcome measure	
Measure B	8.2	8.2		
Measure C (High priority patient safety measure that meets requirements for additional bonus points)	6.0	6.0	No bonus (Bonus applied to the MIPS CQMs)	
Measure D (outcome measure <50% of data submitted)	1.0		(no high priority bonus points because below data completeness)	
EHR (direct submission using end-to-end)				**Reporting that meets CEHRT /bonus point criteria**
Measure E	5.1	5.1		1
Measure F	5.0	5.0		1
Measure G	4.1			1
Measure H	4.2	4.2		1
Measure I (high priority patient safety measure that is below case minimum)	3.0		(no high priority bonus points because below case minimum)	1
		35.6	1 (below 10% cap)	5 (below 10% cap)
Quality Performance Category Score Prior to Improvement Scoring		**(35.6+1+5) / 60 =** **69.33%**		

Appendix C - Summary of Data Completeness Requirements and Performance Period by Collection Type for the 2020 and 2021 MIPS Payment Years

Collection Type	Performance Period	Data Completeness
Medicare Part B claims measures	Jan 1- Dec 31	60 percent of individual MIPS eligible clinician's, or group's Medicare Part B patients for the performance period.
Administrative claims measures	Jan 1- Dec 31	100 percent of individual MIPS eligible clinician's Medicare Part B patients for the performance period.
QCDR measures, MIPS CQMs, and eCQMs	Jan 1- Dec 31	60 percent of individual MIPS eligible clinician's, or group's patients across all payers for the performance period.
CMS Web Interface measures	Jan 1- Dec 31	Sampling requirements for the group's Medicare Part B patients: populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.
CAHPS for MIPS survey measure	Jan 1- Dec 31	Sampling requirements for the group's Medicare Part B patients.

Appendix D: Quality Performance Category: Scoring Measures

Measure Type	Description	Scoring Rules
Class 1	For the 2018 and 2019 MIPS performance period: • Measures that can be scored based on performance. • Measures that were submitted or calculated that met the following criteria: • (1) Has a benchmark; • (2) Has at least 20 cases; and • (3) Meets the data completeness standard (generally 60 percent.)	For the 2018 and 2019 MIPS performance period: • 3 to 10 points based on performance compared to the benchmark.
Class 2*	For the 2018 and 2019 MIPS performance period: • Measures that were submitted and meet data completeness, but do not have both of the following: • (1) a benchmark • (2) at least 20 cases.	For the 2018 and 2019 MIPS performance period: • 3 points * This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims based measures
Class 3**	For the 2018 and 2019 MIPS performance period: • Measures that were submitted, but do not meet data completeness criteria, regardless of whether they have a benchmark or meet the case minimum.	For the 2018 and 2019 MIPS performance period: • 1 point except for small practices, which would receive • 3 measure achievement points. 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. **This Class 3 measure policy would not apply to CMS Web Interface measures and administrative claims based measures

Appendix E – Identifiers Used for Comparing Quality Data in Order to Measure Improvement Scoring

The table below outlines how we'll compare data across identifiers for the purposes of Quality improvement scoring.

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

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

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

Appendix F - FY 2020 Hospital VBP Program Measures

The table below identifies the FY 2020 Hospital VBP Program quality measures that can be used for facility-based measurement scoring for MIPS beginning in 2019.

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, 2018 – December 31, 2018
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, 2015 – June 30, 2018
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229	July 1, 2015 – June 30, 2018
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0468	July 1, 2015 – June 30, 2018
THA/TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550	July 1, 2015 – June 30, 2018
Safety Domain			
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	0138	January 1, 2018 – December 31, 2018
CLABSI	National Healthcare Safety Network (NHSN) Central Line- Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	January 1, 2018 – December 31, 2018
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, 2018 – December 31, 2018
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716	January 1, 2018 – December 31, 2018

CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717	January 1, 2018 – December 31, 2018
PC-01	Elective Delivery	0469	January 1, 2018 – December 31, 2018
Efficiency and Cost Reduction Domain			
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158	January 1, 2018 – December 31, 2018

Appendix G - CMS Web Interface Collection Type Measures for 2019

CMS Web Interface Measure ID	Measure Name	Quality ID	Measure Type
HTN-2	Controlling High Blood Pressure	236	Intermediate Outcome
MH-1	Depression Remission at Twelve Months	370	Outcome
DM-2	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	Intermediate Outcome
CARE-2	Falls: Screening for Future Fall Risk	318	Process
PREV-5	Breast Cancer Screening	112	Process
PREV-6	Colorectal Cancer Screening	113	Process
PREV-7	Preventive Care and Screening: Influenza Immunization	110	Process
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Process
PREV-12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	134	Process
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	438	Process