Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2024 Measures and Activities for Cardiology

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Table of Contents

How To Use This Guide 3

Overview 5

Performance Categories 9

- Quality Performance Category 10
- Promoting Interoperability Performance Category 14
- Improvement Activities Performance Category 17
- Cost Performance Category 18

Help, Resources, and Version History 20

- Where Can You Go for Help? 21
- Version History 23

How to Use This Guide

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

The Table of Contents is interactive. Click on a Chapter in the Table of Contents to read that section. You can also click on the icon on the bottom left to go back to the Table of Contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

What is the Merit-based Incentive Payment System?

If you're eligible for MIPS in 2024:

- You have to report measure and activity data for the quality (PDF, 271KB), improvement activities (PDF, 298KB), and Promoting Interoperability (PDF, 244KB) performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances (EUC) or hardship exception. Detailed information will be available in the forthcoming 2024 Traditional MIPS Scoring Guide, 2024 APP Scoring Guide and 2024 MIPS Value Pathways Implementation Guide. These will be posted to the QPP Resource Library.
- We collect and calculate data for the cost (PDF, 348KB) performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances and whether or not you meet the case minimum for any cost measures. Detailed information will be available in the forthcoming 2024 MIPS Cost User Guide, which will be posted on the QPP Resource Library.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - Positive payment adjustment for clinicians with a 2024 final score above 75.
  - Neutral payment adjustment for clinicians with a 2024 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2024 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

What is the Merit-based Incentive Payment System (Continued)

There are **3 reporting options** available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Traditional MIPS Overview webpage to learn more.	• The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM)**. • Visit the APM Performance Pathway webpage to learn more.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

MIPS Value Pathways (MVPs)

MVPs are the newest way that you can meet reporting requirements, offering a more meaningful way to participate in MIPS.

- Each MVP includes a subset of measures and activities related to a specialty or medical condition.
- While some MVPs are considered most applicable to certain specialties, you aren't limited to only those identified MVPs. Clinicians may select the MVP that aligns best with their scope of care and for which they're able to meet the reporting requirements.

There are 16 MVPs finalized for the 2024 performance year.

You can review each MVP in detail by clicking the links below.

MVPs that are most applicable to the cardiology specialty:

- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP
- Advancing Cancer Care MVP

Additional MIPS MVPs available for 2024:

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP
- Advancing Rheumatology Patient Care MVP
- Improving Care for Lower Extremity Joint Repair MVP
- Patient Safety and Support of Positive Experiences with Anesthesia MVP
- Optimal Care for Kidney Health MVP
- Optimal Care for Patients with Episodic Neurological Conditions MVP
- Supportive Care for Neurodegenerative Conditions MVP
- Advancing Care for Heart Disease MVP
- Value in Primary Care MVP
- Focusing on Women's Health MVP
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP
- Quality Care in Mental Health and Substance Use Disorders MVP
- Rehabilitative Support for Musculoskeletal Care MVP

Performance Categories

Quality Performance Category – Traditional MIPS

Getting Started with Quality

1. Understand Your Reporting Requirements
   - To meet the quality performance category requirements, you must report:

6 quality measures Including at least 1 outcome measure or high-priority measure in absence of an applicable outcome measure.	**OR**	**A defined specialty measure set or sub-specialty measure set** If the measure set has fewer than 6 measures, you need to submit all applicable measures within that set.

2. Choose Your Quality Measures
   - Use the 2024 Quality Measures List (XLSX, 999KB) to identify:
     - The available collection type(s) for each measure
     - Measure type (outcome, patient experience, etc.)
     - Specialty sets associated with each measure

Did you know?
- **Collection Type** refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specifications (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.
- **For example:** You're looking for a quality measure to report on the Use of High-Risk Medications in Older Adults (ID: 238). The measure is available as 2 distinct collections types with 2 distinct specifications: MIPS CQM (clinical quality measure) and eCQM (electronic clinical quality measure). You would use the measure specification that corresponds with how you choose to collect your data.
- You can report measures from multiple collection types to meet quality reporting requirements.

Quality Performance Category – Traditional MIPS (Continued)

3. Collect Your Data
   - You should **start data collection on January 1, 2024,** to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive zero points for the measure unless you're a small practice (15 or fewer clinicians), who will still receive 3 points.
   - You must collect data for a 12-month performance period (January 1 to December 31, 2024).
   - The **data completeness requirement increased to 75% beginning with the 2024 performance period**, which means that you need to report performance data (met, not met, or exclusion/exceptions) for at least 75% of denominator-eligible encounters.
   - If you're working with a third party intermediary to collect and submit data, make sure you work with them throughout the year on data collection.
4. Submit Your Data
   - The data submission period will begin on **January 2, 2025**, and end no later than **April 1, 2025**. If reporting Medicare Part B claims measures, submission will be continuous throughout the performance period.
5. Review Performance Feedback
   - Measure and activity-level scoring information will be available beginning **January 2, 2025**, once data has been submitted.
   - We anticipate final scores will be available in **summer 2025**.
   - You can review your performance feedback by signing in to the Quality Payment Program website.

Did you know?

The level at which you participate in MIPS (individual, group, or virtual group) applies to all performance categories. We won't combine data submitted at the individual, group, and/or virtual group level into a single final score.

For example:

- If you submit any data as an individual, you'll be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you'll be evaluated for all performance categories as a group.
- If a clinician has multiple final scores, CMS will use the following hierarchy to assign the final score and determine the payment adjustment:
  - Virtual group final score
  - Highest available final score from the group or individual participation

*** Note:** Subgroups are only available within MVP reporting. Refer to the MIPS Value Pathways (MVPs) webpage for additional information.

Quality Performance Category – Traditional MIPS (Continued)

The Cardiology Specialty Measure Set contains quality measures relevant to the cardiology specialty and includes the measures below.

- Heart failure (HF): angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) or angiotensin receptor-neprilysin inhibitor (ARNI) therapy for left ventricular systolic dysfunction (LVSD) **(Identifier [ID]: 005)**
- Coronary artery disease (CAD): antiplatelet therapy **(ID: 006)**
- Coronary artery disease (CAD): beta-blocker therapy – prior myocardial infarction (MI) or left ventricular systolic dysfunction (LVEF ≤ 40%) **(ID: 007)**
- Heart failure (HF): beta-blocker therapy for left ventricular systolic dysfunction (LVSD): **(ID: 008)**
- Advance care plan **(ID: 047)**
- Coronary artery disease (CAD): angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy - diabetes or left ventricular systolic dysfunction (LVEF ≤ 40%) **(ID: 118)**
- Documentation of current medications in the medical record **(ID: 130)**
- Stroke and stroke rehabilitation: thrombolytic therapy **(ID: 187)**
- Preventive care and screening: tobacco use: screening and cessation intervention **(ID: 226)**
- Controlling high blood pressure **(ID: 236)**
- Use of high-risk medications in older adults **(ID: 238)**
- Cardiac rehabilitation patient referral from an outpatient setting **(ID: 243)**
- Preventive care and screening: screening for high blood pressure and follow-up documented **(ID: 317)**

30% of final score for most MIPS eligible clinicians, groups, and virtual groups.

Please refer to Help, Resources, and Version History for more information.

Quality Performance Category – Traditional MIPS (Continued)

- Cardiac stress imaging not meeting appropriate use criteria: preoperative evaluation in low-risk surgery patients **(ID: 322)**
- Atrial fibrillation and atrial flutter: chronic anticoagulation therapy **(ID: 326)**
- Rate of carotid artery stenting (CAS) for asymptomatic patients, without major complications (discharged to home by post-operative day #2) **(ID: 344)**
- Closing the referral loop: receipt of specialist report **(ID: 374)**
- Preventive care and screening: unhealthy alcohol use: screening & brief counseling **(ID: 431)**
- Statin therapy for the prevention and treatment of cardiovascular disease **(ID: 438)**
- Ischemic vascular disease (IVD) all or none outcome measure (optimal control) **(ID: 441)**
- Screening for social drivers of health **(ID: 487)**
- Adult immunization status **(ID: 493)**
- Connection to community service provider **(ID: 498)**
- Gains in patient activation measure (PAM®) scores at 12 months **(ID: 503)**

In addition, MIPS eligible clinicians, groups, and virtual groups may want to consider applicable cardiology-specific Qualified Clinical Data Registry (QCDR) measures that are available via the QCDR collection type only. Review the 2024 QCDR measure specifications (XLSX, 627KB) on the QPP Resource Library.

CMS solicits recommendations from interested parties for potential consideration of new specialty measure sets and/or revisions to existing specialty measure sets on an annual basis. All feedback and submissions are considered for the next performance year's rulemaking and are made evident through publications of the Physician Fee Schedule proposed and final rules. CMS encourages interested parties to work with their specialty society to provide applicable measure recommendations during the specialty measure set solicitation process. Feedback/recommendations for a particular specialty set should be submitted during the Call for Specialty Sets at the beginning of the calendar year.

Quality Payment PROGRAM

Promoting Interoperability Performance Category – Traditional MIPS

Promote patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT)

In order to earn a score greater than zero for the Promoting Interoperability performance category, MIPS eligible clinicians, groups, and virtual groups must:

- ☑ Collect your data using technology certified to the Office of the National Coordinator for Health Information Technology (ONC) Certification Criteria for Health IT necessary to meet the CEHRT definition (certified by the last day of the performance period) for a minimum of any continuous 180-day period in 2024;
- ☑ Submit a "yes" to the Actions to Limit or Restrict Interoperability of CEHRT Attestation (formerly named Prevention of Information Blocking);
- ☑ Submit a "yes" to the SAFER Guides attestation measure;
- ☑ Submit a "yes" or "no" to the ONC Direct Review Attestation;
- ☑ Submit a "yes" that you have completed the Security Risk Analysis measure in 2024;
- ☑ Report the 6 to 7 required measures or claim their exclusion(s); and
  - For measures that require a numerator and denominator (as defined in the measure specifications), you must submit at least a '1' in the numerator;
- ☑ Submit your level of active engagement for the Public Health and Clinical Data Exchange measures you're reporting;
- ☑ Provide your EHR's CMS identification code from the Certified Health IT Product List (CHPL), available on HealthIT.gov.

Clinicians must use technology certified to the criterion at 45 CFR 170.315(b)(3) for the 2024 performance period. Functionality must be in place by the start of the performance period with certification obtained by the last day of the performance period. The 2024 Promoting Interoperability performance category scored objectives are:

- e-Prescribing*
- Health Information Exchange (HIE)*
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange*

25% of final score for most MIPS eligible clinicians, groups, and virtual groups.

*Measure exclusions may be applicable. Please review the individual measure specifications to see if you meet the exclusion criteria. You must claim an exclusion to have the measure points redistributed to another measure. The measure specifications are on the QPP Resource Library.

Promoting Interoperability Performance Category – Traditional MIPS (Continued)

Extend performance period to 180 days

- Performance period extended to a minimum of any continuous 180-day period within the 2024 calendar year.

Regulatory definition of CEHRT revised

- Regulatory definition of CEHRT to be more flexible in reflecting any changes ONC may make to certification criteria and standards for health information technology.

Self-Assessment of the High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)

- Requires the MIPS eligible clinicians to conduct this self-assessment annually and attest a "yes" response.

Updated the Query of Prescription Drug Monitoring Program (PDMP) under the e-Prescribing Objective

- Modified the second exclusion criterion to state that any MIPS eligible clinician who doesn't electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period can claim the second exclusion.

Reweighting the Promoting Interoperability Performance Category

- Continue to automatically reweight this performance category at 0% for clinical social workers for the calendar year 2024 performance period/2026 MIPS payment year.

Promoting Interoperability Performance Category – Traditional MIPS (Continued)

Qualifying hospital-based, Ambulatory Surgical Center (ASC)-based, small practice, and non-patient-facing MIPS eligible clinicians, groups, and virtual groups will automatically have their Promoting Interoperability performance category score reweighted to 0% of the final score. You can find additional information on the Special Statuses webpage.

Hospital-Based MIPS Eligible Clinicians	A **hospital-based MIPS eligible clinician** is defined as furnishing 75% or more of their covered professional services in either the off-campus outpatient hospital (Place of Service 19), inpatient hospital (Place of Service 21), on-campus outpatient hospital (Place of Service 22), or emergency department (Place of Service 23) setting. • A group or virtual group is considered hospital-based when more than 75% of the clinicians in the group or virtual group are hospital-based MIPS eligible clinicians.
Non-Patient-Facing MIPS Eligible Clinicians	A **non-patient-facing MIPS eligible clinician** is defined as an individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Social Security Act) during the MIPS determination period. • To qualify as a non-patient-facing group or virtual group, more than 75% of the clinicians in the group or virtual group must meet the definition of a non-patient-facing individual MIPS eligible clinician.

- In the case of reweighting to 0%, CMS will assign the 25% from the Promoting Interoperability performance category to another performance category or categories.
- MIPS eligible clinicians, groups, and virtual groups that qualify for reweighting of the Promoting Interoperability performance category can still choose to report if they would like, and if data is submitted, CMS will score their performance and weight their Promoting Interoperability performance accordingly.

See the 2024 Promoting Interoperability Quick Start Guide (PDF, 1MB) for more information on Promoting Interoperability performance category objectives and measures, reporting requirements, scoring, and reweighting. Comprehensive information about hardship exceptions for the 2024 Promoting Interoperability performance category will be available on the QPP Resource Library later in the year.

Improvement Activities Performance Category – Traditional MIPS

Participation in activities that improve clinical practice are encouraged, such as:

- Ongoing care coordination
- Clinician and patient shared decision making
- Using quality improvement best practices and validated tools
- Regularly using patient safety best practices
- Making progress in achieving health equity

15% of final score for most MIPS eligible clinicians, groups, and virtual groups.

During the 2024 performance year, MIPS eligible clinicians, groups, and virtual groups will be able to choose from 100+ activities. The activities listed below are suggestions, not requirements or preferences on the part of CMS. MIPS eligible clinicians, groups, and virtual groups can choose activities that are most appropriate for their practice/patient populations from the full 2024 improvement activities inventory (ZIP, 499KB). The MIPS data validation criteria (ZIP, 599KB) document provides supporting information and guidance on documentation requirements for improvement activities. The 2024 Improvement Activities Quick Start Guide (PDF, 928KB) contains additional information.

Clinicians may select activities from the posted inventory. Some recommendations for the cardiology specialty are included below:

- IA_AHE_6 – Provide education opportunities for new clinicians
- IA_BE_6 – Regularly assess patient experience of care and follow up on findings
- IA_CC_1 – Implementation of use of specialist reports back to referring clinician or group to close referral loop
- IA_EPA_1 – Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record
- IA_EPA_3 – Collection and use of patient experience and satisfaction data on access
- IA_PM_2 – Anticoagulant management improvements
- IA_PM_15 – Implementation of episodic care management practice improvements
- IA_PSPA_19 – Implementation of formal quality improvement methods, practice changes or other practice improvement processes
- IA_PSPA_27 – Invasive procedure or surgery anticoagulation medication management

Note: Attestation to IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation (or comparable specialty practice) improvement activity results in an improvement activities performance category score of 100% as finalized in the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (PFS) Final Rule.

Cost Performance Category – Traditional MIPS

Helps create efficiencies in Medicare spending

- The 2024 performance period includes 2 population-based cost measures:
  - Medicare Spending Per Beneficiary Clinician measure, which assesses costs surrounding a hospital stay.
  - Revised Total Per Capita Cost measure, which assesses overall cost of care.
- It also includes 27 episode-based cost measures across a range of procedures, acute inpatient medical conditions requiring a hospital stay, settings (i.e., emergency medicine), and chronic conditions.
- A full list of the MIPS cost measures is available in the 2024 MIPS Summary of Cost Measures (PDF, 505KB) document.
- Data for cost measurement are collected from Medicare Parts A and B claims submitted by MIPS eligible clinicians, groups, and virtual groups. Certain measures also incorporate Part D costs. Clinicians, groups, and virtual groups don't have to submit any additional data.
- For a cost measure to be scored, a MIPS eligible clinician, group, or virtual group must have enough attributed cases to meet or exceed the case minimum for that measure.
- For most MIPS eligible clinicians, groups, and virtual groups who don't have a cost performance category score assigned, the majority of the cost weight goes to the quality performance category. This is true if only the cost performance category is reweighted.
- Benchmarks based on data from the performance period will be established for each cost measure. Since the benchmark isn't based on a historical baseline period, CMS can't publish the numerical benchmarks for the cost measures before the start of each performance period.
  - A MIPS eligible clinician, group, or virtual group can compare their costs for each measure with the benchmark information provided in their performance feedback to better understand their performance relative to their peers.

30% of final score for most MIPS eligible clinicians, groups, and virtual groups.

Cost Performance Category – Traditional MIPS (Continued)

CMS will automatically reweight the cost performance category for MIPS eligible clinicians, groups, and virtual groups located in a CMS-designated region that has been affected by extreme and uncontrollable circumstances.

- For MIPS eligible clinicians, groups, and virtual groups that are designated in the extreme and uncontrollable circumstances policy, they won't receive a score for the cost performance category, regardless of whether they have applicable cost measures.

The 2024 Cost Quick Start Guide (PDF, 1MB) in the Quality Payment Program Resource Library contains additional information for the cost performance category.

Did you know?

If only 1 cost measure can be scored, that cost measure's score will serve as the performance category score. If 3 out of 25 cost measures are scored, the **cost performance category score is the equally-weighted average of the 3 scored measures**. If none of the 25 measures can be scored, the MIPS eligible clinician, group, or virtual group won't be scored on cost, and the weight of the cost performance category would be reweighted.

Help, Resources, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

Additional Resources

The following resources are available in the QPP Resource Library and other QPP and CMS webpages:

- 2024 MIPS Overview Quick Start Guide (PDF, 1MB)
- 2024 MIPS Quick Start Guide for Small Practices (PDF, 1MB)
- 2024 MIPS Data Validation Criteria (ZIP, 599KB)
- 2024 Quality Quick Start Guide (PDF, 981KB)
- 2024 MIPS Eligibility and Participation Quick Start Guide (PDF, 1MB)
- 2024 Part B Claims Reporting Quick Start Guide (PDF, 1MB)
- 2024 MIPS Quality Measures List (XLSX, 999KB)
- 2024 Clinical Quality Measure Specifications and Supporting Documents (ZIP, 58MB)
- 2024 Medicare Part B Claims Measure Specifications and Supporting Documents (ZIP, 10MB)
- 2024 eCQM Measure Specifications (Links)
- 2024 MIPS Promoting Interoperability Quick Start Guide (PDF, 1MB)
- 2024 MIPS Promoting Interoperability Measure Specifications (ZIP, 3MB)
- 2024 Improvement Activities Quick Start Guide (PDF, 924KB)
- 2024 Improvement Activities Inventory (ZIP, 499KB)
- 2024 Cost Quick Start Guide (PDF, 1MB)
- 2024 Summary of Cost Measures (PDF, 505KB)
- 2024 MIPS Cost Measure Codes Lists (ZIP, 14MB)
- 2024 Quality Payment Program Final Rule Resources (ZIP, 1MB)

Version History

If we need to update this document, changes will be identified here.

DATE	DESCRIPTION
04/10/2024	Original Posting.