Quality Payment PROGRAM

2020 Quality Payment Program Proposed Rule Overview Factsheet with Request for Information for 2021

History and Future Direction of the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment, and established a quality payment incentive program -- the Quality Payment Program. This program provides clinicians with two ways to participate: through Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). At its core, the Quality Payment Program is about improving the quality of patient care and outcomes. It rewards clinicians for implementing innovative approaches to patient care, and the program helps to drive the fundamental movement toward value in our healthcare system.

Since the Quality Payment Program launched in 2017, we have taken incremental steps to update both the MIPS and APM tracks to acknowledge the unique variation in clinician practices, further refine program requirements, respond to stakeholder feedback, reduce reporting burden, encourage meaningful participation, and improve patient outcomes. In 2017, MIPS eligible clinicians had flexible participation options under the “pick your pace” approach to help ease their transition into the program and encourage robust participation. “Pick your pace” also allowed for MIPS eligible clinicians to reach the MIPS performance threshold (i.e., the minimum number of points needed to avoid a negative payment adjustment, which, in 2017, was 3 points) in various ways. This measured approach allowed more clinicians to successfully participate, which led to many clinicians exceeding the performance threshold and a wider distribution of positive payment adjustments. In 2018, we increased the performance threshold to 15 points, and in 2019, we raised it to 30 points.

The flexibilities that we have created for the program, especially within MIPS, resulted in overall participation rates by MIPS eligible clinicians of 95 and 98 percent for the 2017 and 2018 performance years, respectively. Additionally, over 99,000 clinicians became Qualifying APM Participants (QPs) based on participation in Advanced APMs in 2017, and the number of QPs has nearly doubled to over 183,000 in 2018.

While we are proud of this success, our goal has always been to develop a meaningful program for every clinician, regardless of practice size or specialty, and we recognize that additional long-term improvements are needed. We have heard from clinicians and stakeholders that the program, specifically MIPS, remains overly complex. The feedback we have received included:

- The overall MIPS performance requirements are still confusing
- There is too much choice and complexity when it comes to selecting and reporting on MIPS measures
- The MIPS performance categories should be more aligned
- The need for better performance comparability across all clinicians
- The importance of including the patient experience

We have attempted to address some of these concerns over the last few years by leveraging our Patients over Paperwork initiative to review MIPS and remove unnecessary elements to help streamline program requirements and reduce clinician burden. We have also reduced the number of MIPS quality measures through our Meaningful Measures framework to remove low-bar, standard of care, process measures and focus on outcome and high-priority measures that will improve care for patients. We believe that these were strong initial solutions, and we are now focused on taking the next step in improving MIPS.

We are proposing our MIPS Value Pathways (MVPs), a conceptual participation framework that would apply to future proposals beginning with the 2021 performance year. The goal is to move away from siloed activities and measures and move towards an aligned set of measure options more relevant to a clinician's scope of practice that is meaningful to patient care. The MVP framework would aim to align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS for different specialties or conditions. A clinician or group would be in one MVP associated with their specialty or with a condition, reporting on the same measures and activities as other clinicians and groups in that MVP.

In addition, the MVP framework would incorporate a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities, and reduce reporting burden by limiting the number of required specialty or condition specific measures so all clinicians or groups reporting on a clinical area would be reporting the same measure set(s). We believe this combination of administrative claims-based measures and specialty/condition specific measures would streamline MIPS reporting, reduce complexity and burden, and improve measurement.

Another key component of the MVP framework proposal is that we would provide enhanced data and feedback to clinicians. We also intend to analyze existing Medicare information so that we can provide clinicians and patients with more information to improve health outcomes. We believe the MVP framework would help to simplify MIPS, create a more cohesive and meaningful participation experience, improve value, reduce clinician burden, and better align with APMs to help ease the transition between the two tracks. Additionally, we believe that implementing the MVP framework honors our commitment to keeping the patient at the center of our work. In addition to achieving better health outcomes and lowering costs for patients, we anticipate that these MVPs would result in comparable performance data that helps patients make more informed health care decisions.

We recognize that this would be a significant shift in the way clinicians may potentially participate in MIPS, therefore we want to work closely with clinicians, patients, specialty societies, stakeholders, third parties and others to establish this new framework. We encourage each of these groups to review our Transforming MIPS: MIPS Value Pathways Request for Information (RFI) as well as our illustrative diagram and submit comments on all areas of interest. We want to develop the future state of MIPS together with each of you to ensure that we are reducing burden, driving value through meaningful participation, and, most importantly, improving outcomes for patients.

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In order to help us get to the future state of MIPS and the new participation framework in the 2021 Performance Year, we need to continue laying the groundwork during the 2020 Performance Year. Our approach for the 2020 Performance Year is to maintain many of the requirements from the 2019 Performance Year, while providing some needed updates to both the MIPS and Advanced APM tracks to continue reducing burden, respond to feedback that we have heard from clinicians and stakeholders, and align with statutory requirements.

Quality Payment Program CY 2020 Proposals: MIPS Highlights

For MIPS, we are proposing to increase the performance threshold (which is the minimum number of points to avoid a negative payment adjustment) from 30 points in 2019 to 45 points in 2020 and 60 points in 2021. We are also proposing to increase the additional performance threshold for exceptional performance to 80 points in 2020 and to 85 points in 2021. Our goal is to continue incrementally increasing the performance threshold to meet the requirements established by Congress that beginning with the sixth year of the program (2022 Performance Year) the performance threshold needs to be set at the mean or median of the final scores for all MIPS eligible clinicians for a prior period. These increases are also a response to the strong performance of clinicians during the 2017 and 2018 Performance Years.

For the MIPS performance categories, we are proposing to:

- Reduce the Quality performance category weight to 40 percent in 2020, 35 percent in 2021, and 30 percent in 2022
- Increase the Cost performance category weight to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022

We are proposing these changes to continue aligning the Quality and Cost performance categories to create better value and to gradually work toward equal weighting which is required by law beginning with the sixth year of the program (2022 performance year). Within the same categories we are also refining the measures.

For the Quality performance category, we propose continuing to remove low-bar, standard of care, process measures, focus on high-priority outcome measures, and add new specialty sets (Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology). For the Cost performance category, we are proposing to add 10 new episode-based measures and revise the current measures – Medicare Spending Per Beneficiary Clinician measure and Total Per Capita Cost measure. These proposed changes:

- Assign responsibility for services to a larger number of clinicians
- Improve risk adjustment timelines
- Avoid assigning costs that are incurred before a clinician begins providing services to a patient

For the Improvement Activities performance category, we are proposing the following changes:

- Modification of the definition of a rural area;
- Removal of criteria for patient-centered medical home designation that a practice must have received accreditation from one of four accreditation organizations that are nationally recognized or comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition;
- Increasing the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice;
- Updating the Improvement Activity Inventory and establishing criteria for removal in the future; and
- Concluding the CMS Study on Factors Associated with Reporting Quality Measures.

We did not propose significant changes to the Promoting Interoperability performance category. However, we are seeking comment on several key areas:

- Potential opioid measures for future inclusion in the Promoting Interoperability performance category
- Development of potential measures that are based on existing NQF and CDC efforts that measure the clinical and process improvements specifically related to the opioid epidemic
- A metric to improve efficiency of providers within EHRs
- Issues related to the standards-based API criterion in the ONC 21st Century Cures Act proposed rule with the goal of establishing an alternative measure under the Provider to Patient Exchange that would require providers to give patients their complete data contained within an EHR
- Integration of patient-generated health data (PGHD) into EHRs using CEHRT
- Engaging in activities that promote the safety of the EHR

Aside from the MIPS performance categories, we are focused on improving partnerships with third parties. To help reduce clinician reporting burden, we are proposing updates in policies for third party vendors, such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries. We are proposing to establish new requirements for MIPS performance categories that must be supported by QCDRs, qualified registries and Health IT vendors. We are proposing to modify the criteria for approval as a third party intermediary by establishing new requirements to promote continuity of service to clinicians and groups that use third party intermediaries for their MIPS submissions. We are also clarifying the remedial action and termination provisions applicable to all third party intermediaries.

- With respect to QCDRs, we are proposing requirements to engage in activities that foster improvement in the quality of care, and to enhance performance feedback requirements. We are also proposing to update considerations for QCDR measures, including that QCDR measures would be required to be fully developed with completed testing results at the clinician level and must be ready for implementation at the time of self-nomination for the 2021 performance period.
- With respect to qualified registries, we are proposing to require enhance performance feedback requirements.

Finally, recognizing the importance of providing patients with valuable information to help empower their decision-making, we are proposing updates for the public reporting of MIPS. We propose to publicly report aggregate MIPS data beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible.

The Table beginning on page 8 describes the proposed changes to existing policies. Policies without proposed changes (such as eligible clinician types and the low-volume threshold) are included in Appendix A.

Quality Payment Program CY 2020 Proposals: APM Highlights

For APMs, we also have several proposed updates. For the APM Scoring Standard, we are proposing quality reporting options for APM participants. We have, in previous rules, attempted to streamline APM participation in MIPS. However, quality measures based on an APM's measures are not always available for MIPS scoring. In order to offer flexibility and improve meaningful measurement, we propose allowing APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS Quality performance category. APM Entities would receive a calculated score based on individual, TIN, or APM Entity reporting, similar to our approach for the MIPS Promoting Interoperability performance category.

We are also proposing a MIPS APM Quality Reporting Credit for APM participants in Other MIPS APMs where quality scoring through the APM is not technically feasible. For these APM participants, we are proposing a credit equal to 50 percent of the MIPS Quality performance category weight. APM participants will have the opportunity to submit quality measures and their score will be added to the credit. Additionally, with regard to the quality performance category, we propose to apply the existing extreme and uncontrollable circumstances policies to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standard and would report on MIPS quality measures. Finally, we are requesting comment on APM scoring in future years of the Quality Payment Program.

The Table beginning on page 24 describes the proposed changes to existing policies.

We Want to Hear from You

We welcome your feedback on the proposed policies for the 2020 performance period of the Quality Payment Program. Please note that the official method for commenting is outlined below.

How Do I Comment on the CY 2020 Proposed Rule?

The proposed rule includes directions for submitting comments. Comments must be received within the 60-day comment period, which closes on September 27, 2019. When commenting refer to file code: CMS-1715-P

FAX transmissions won't be accepted. Use one of the following ways to officially submit your comments:

- Electronically through Regulations.gov
- Regular mail
- Express or overnight mail
- Hand or courier

The proposed rule can be accessed through "Regulatory Resources" section of the QPP Resource Library.

Contact Us

We will continue to provide support to clinicians who need assistance. While our support offerings will reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance in order to help them successfully participate. We will continue offering direct, customized technical assistance to clinicians in small practices through our Small, Underserved, and Rural Support initiative. We also encourage clinicians to contact our Quality Payment Program Service Center for immediate support at 1-866-288-8292 (TTY) 1-877-715-6222 Monday through Friday, 8:00 AM-8:00 PM Eastern Time or via email at QPP@cms.hhs.gov, as well as visit the Quality Payment Program website for educational resources, information, upcoming webinars, and an unparalleled user experience.

Proposed changes to QPP Policies for CY 2020

Quality Payment Program CY 2020 Proposals: MIPS Overview

Policy Area	CY 2019 Policy	CY 2020 Proposed Policy
Performance Category Weights	• Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	*For the 2020 performance period:* • Quality: **40%** • Cost: **20%** • Promoting Interoperability: 25% • Improvement Activities: 15% *For the 2021 performance period:* • Quality: **35%** • Cost: **25%** • Promoting Interoperability: 25% • Improvement Activities: 15% *For the 2022 performance period:* • Quality: **30%** • Cost: **30%** • Promoting Interoperability: 25% • Improvement Activities: 15%
Quality Performance Category	**Data Completeness Requirements:** • Medicare Part B Claims measures: 60% of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, and eCQMs: 60% of clinician's or group's patients across all payers for the performance period	**Data Completeness Requirements:** • Medicare Part B Claims measures: **70%** sample of Medicare Part B patients for the performance period. • QCDR measures, MIPS CQMs, and eCQMs: **70%** sample of clinician's or group's patients across all payers for the performance period • Note: If quality data is submitted selectively such that the data are unrepresentative of a MIPS eligible clinician or group's performance, any such data

		would not be true, accurate, or complete.
	Call for Measures CMS seeks measures that are: • Applicable • Feasible • Reliable • Valid at the individual clinician level • Different from existing measures For complete information on current policy, review the 2019 Call for Measures and Activities.	**Call for Measures** In addition to current requirements: • Measures submitted in response to Call for Measures would be required to demonstrate a link to existing and related cost measures and improvement activities as appropriate and feasible.
	Measure Removal • A quality measure may be considered for removal if the measure is no longer meaningful, such as measures that are topped out. • A measure would be considered for removal if a measure steward is no longer able to maintain the quality measure.	**Measure Removal** In addition to current measure removal criteria: • MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking for 2 consecutive years would be removed. • We may consider a MIPS quality measure for removal if we determine it is not available for MIPS Quality reporting by or on behalf of all MIPS eligible clinicians (including via third party intermediaries).
	Modified Benchmarks to Avoid Potential Patient Risk: No special benchmarking policy. The general benchmarking policy for	**Modified Benchmarks to Avoid Potential Patient Risk**: *Beginning in the 2022 MIPS payment year:* • Establish **flat percentage benchmarks*** in limited cases where CMS determines that the

	quality measures applies, where: • Performance on quality measures is broken down into 10 “deciles.” • Each decile has a value of between one and 10 points based on stratified levels of national performance (benchmarks) within that baseline period. • A clinician’s performance on a quality measure will be compared to the performance levels in the national deciles. The points received are based on the decile range that matches their performance level. • For inverse measures (like the diabetic HgA1c measure), the order is reversed—decile one starts with the highest value and decile 10 has the lowest value.	measure’s otherwise applicable benchmark could potentially incentivize treatment that could be inappropriate for particular patients. • As proposed, the modified benchmarks would be applied to all collection types where the top decile for a historical benchmark is higher than 90% for the following measures: ○ MIPS #1 ((NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) ○ MIPS #236 (NQF 0018): Controlling High Blood Pressure *In flat percentage benchmarks, any performance rate at or above 90% would be in the top decile, any performance rate between 80% and 89.99%% would be in the second highest decile, and so on.
QCDRs, Qualified Registries and other Health IT vendors	• QCDRs and Qualified Registries not required to support multiple performance categories.	*Beginning in 2021 performance period*: • QCDRs and Qualified Registries would be required to submit data for each category: ○ Quality; ○ Improvement Activities; and ○ Promoting Interoperability performance categories.

		• Health IT vendors would be required to submit data for at least one category. • With respect to QCDRs, we are also proposing requirements to engage in activities that will foster improvement in the quality of care. • Certain third party intermediaries would be excepted from the requirement of reporting the Promoting Interoperability performance category in instances where the third party intermediary is specialty specific and that specific specialty is exempt from reporting under Promoting Interoperability under the Promoting Interoperability exclusion.
	Performance Feedback: • Qualified Registries and QCDRs must provide timely performance feedback at least 4 times a year on all of the MIPS performance categories that the Qualified Registry or QCDR reports to CMS.	**Performance Feedback:** *Beginning in 2021 performance period*: • This feedback (still required 4 times per year) would be required to include **information on how participants compare to other clinicians within the Qualified Registry or QCDR cohort** who have submitted data on a given measure (MIPS quality measure and/or QCDR measure). • QCDRs and Qualified Registries will be required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year. In instances where the

		QCDR/Qualified Registry does not receive data from their clinician until the end of the performance period, the QCDR/Qualified Registry could be excepted from this requirement. The QCDR/Qualified Registry must submit a request to CMS within the reporting period promptly within the month of realization of the impending deficiency in order to be considered for this exception.
	QCDR Measure Requirements: • QCDR measures must be beyond the measure concept phase of development. • CMS will show a preference for QCDR measures that are outcome-based rather than clinical process measures. • Measures should address significant variation in performance. • QCDR measures are approved for use in MIPS for a single performance period.	**QCDR Measure Requirements** *Beginning in performance period 2020, we propose that:* • In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. Duplicative QCDR measures would not be approved if QCDRs do not elect to harmonize identified measures as requested by CMS within the allotted timeframe. *Beginning in performance period 2021, we propose that*: • QCDRs must identify a linkage between their QCDR measures to the following, at the time of

		self-nomination: (a) cost measure; (b) Improvement Activity; or (c) CMS developed MVPs. • QCDR Measures would be required to be **fully developed** with **completed testing** results at the clinician level and must be **ready for implementation at the time of self-nomination**. • QCDRs would be required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. • CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. • We propose a QCDR measure that does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance may not continue to be approved in the future. • At CMS discretion, QCDR measures may be approved for

		two years, contingent on additional factors.
	QCDR Measure Rejections • There is no formal policy for measure removal, as QCDR measures must be submitted for CMS approval on an annual basis as part of the self-nomination process.	**QCDR Measure Rejections** CMS is proposing the following guidelines to help QCDRs understand when a QCDR measure would likely be rejected during the annual self-nomination process: • QCDR measures that are duplicative of an existing measure or one that has been removed from MIPS or legacy programs • Existing QCDR measures that are “topped out” (though these may be resubmitted in future years) • QCDR measures that are process-based (consideration given to the impact on the number of measures available for a specific specialty) or have no actionable quality action • Considerations and evaluation of the measure’s performance data, to determine whether performance variance exists • QCDR measures that don’t address a priority area highlighted in the Measure Development Plan • QCDR measures that have the potential for unintended consequences

		• QCDR measures that split a single clinical practice/action into several measures or that focus on rare events • QCDR measures that are “check-box” with no actionable quality action • Existing QCDR measures that have been in MIPS for two years and have failed to reach benchmarking thresholds due to low adoption (unless a plan to improve adoption is submitted and approved) • Whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality action, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization • QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician. (that is, the quality aspect being measured cannot be attributed to the clinician or is not under the direct control of the reporting clinician) • QCDR measures that focus on rare events or “never events” in the measurement period
Improvement Activities	**Definition of Rural Area:** Rural area means a ZIP code designated as rural,	**Definition of Rural Area**: Rural area is proposed to mean a ZIP code designated as rural by

Performance Category	using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available.	the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP Code file available.
	Patient-Centered Medical Home Criteria To be eligible for Patient-Centered Medical Home designation, the practice must meet one of the following criteria: • The practice has received accreditation from one of four accreditation organizations that are nationally recognized: ○ The Accreditation Association for Ambulatory Healthcare; ○ The National Committee for Quality Assurance (NCQA); ○ The Joint Commission; or ○ The Utilization Review Accreditation Commission (URAC); OR • The practice is participating in a Medicaid Medical Home Model or Medical Home Model; OR • The practice is a comparable specialty practice that has received the NCQA Patient-	**Patient-Centered Medical Home Criteria** To be eligible for Patient-Centered Medical Home designation, the practice would need to meet one of the following criteria: • The practice has received accreditation from an accreditation organization that is nationally recognized; • The practice is participating in a Medicaid Medical Home Model or Medical Home Model; • The practice is a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; OR The practice has received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following: (1) Have a personal physician/clinician in a team-based practice.

	Centered Specialty Recognition.	(2) Have a whole-person orientation. (3) Provide coordination or integrated care. (4) Focus on quality and safety. (5) Provide enhanced access.
	Improvement Activities Inventory: • Added 1 new criterion, "Include a public health emergency as determined by the Secretary." • Removed "Activities that may be considered for a Promoting Interoperability bonus."	**Improvement Activities Inventory:** • Addition of 2 new Improvement Activities • Modification of 7 existing Improvement Activities • Removal of 15 existing Improvement Activities Please review Appendix 2 in the CY 2020 NPRM for a comprehensive look at the changes proposed to the inventory.
	CMS Study on Factors Associated with Reporting Quality Measures: • MIPS eligible clinicians who successfully participate in the study receive full credit in the Improvement Activities performance category.	**CMS Study on Factors Associated with Reporting Quality Measures:** • Study year 2019 (CY 2019) is the **last year** of the 3-year study, as stated in CY 2019 PFS final rule (83 FR 59776). CMS will not continue the study during the 2020 performance period. Final study results will be shared at a later date.
	Removal of Improvement Activities • No formal policy but invited public comments on what criteria should be used to identify improvement activities for	**Removal of Improvement Activities:** Establish factors to consider for removal of improvement activities from the Inventory. An activity would be considered for removal if:

	removal from the Inventory.	• It is duplicative of another activity • An alternative activity exists with stronger relationship to quality care or improvements in clinical practice • The activity does not align with current clinical guidelines or practice • The activity does not align with at least one meaningful measures area • The activity does not align with Quality, Cost, or Promoting Interoperability performance categories • There have been no attestations of the activity for 3 consecutive years • The activity is obsolete
	Requirement for Improvement Activity Credit for Groups • Group or virtual group can attest to an improvement activity if at least one clinician in the TIN participates.	**Requirement for Improvement Activity Credit for Groups** • Group or virtual group would be able to attest to an improvement activity when **at least 50%** of MIPS eligible clinicians (in the group or virtual group) participate in or perform the activity. • At least 50% of a group's NPIs must perform the same activity for the same continuous 90 days in the performance period.
Promoting Interoperability Performance Category - Hospital-Based MIPS Eligible	A group is identified as hospital-based and eligible for reweighting when 100% of the MIPS eligible clinicians in the group meet the	A group would be identified as hospital-based and eligible for reweighting if more than **75%** of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician.

Clinicians in Groups	definition of a hospital-based MIPS eligible clinician.	For **non-patient facing groups** (more than 75% of the MIPS-eligible clinicians in the group are classified as non-patient facing) we would **automatically reweight** the Promoting Interoperability performance category. No change to definition of an individual hospital-based MIPS eligible clinician.
Promoting Interoperability Performance Category	**Objectives and Measures** • One set of objectives and measures based on the 2015 Edition CEHRT • Four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed. • Two new measures for the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement as optional with bonus points available	**Objectives and Measures** *Beginning with the 2019 performance period* • CMS would require a yes/no response for the Query of PDMP measure. • CMS would redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Access to Their Health Information measure if an exclusion is claimed. *Beginning with the 2020 performance period* • Remove Verify Opioid Treatment Agreement Measure • Keep Query of PDMP measure as optional
Cost Performance Category	**Measures:** • Total Per Capita Cost (TPCC)	**Measures:** • TPCC measure (**Revised**)

	• Medicare Spending Per Beneficiary (MSPB) • 8 episode-based measures **Case minimums:** • 10 for procedural episodes • 20 for acute inpatient medical condition episodes	• MSPB-C (MSPB Clinician) measure (**Name and specification Revised**) • 8 existing episode-based measures • **10 new episode-based measures** 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair 4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation 6. Lower Gastrointestinal Hemorrhage 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment No changes to case minimums
	Measure Attribution: • All measures are attributed at the TIN/NPI level for both individuals and groups.	**Measure Attribution:** • Measure attribution would be different for individuals and groups and would be defined in the measure specifications.

	• Plurality of primary care services rendered by the clinician to determine attribution for the total per capita cost measure. • Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure. • For procedural episodes, we attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes). • For acute inpatient medical condition episodes, we attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization.	• TPCC attribution would require E&M services to have an associated primary care service or a follow up E&M service from the same clinician group. • TPCC attribution would exclude certain clinicians who primarily deliver certain non-primary care services (e.g. general surgery). • MSPB clinician attribution changes would have a different methodology for surgical and medical patients. • No changes proposed for attribution in episode-based measures (existing and new). • Proposed specifications are available for public comment and can be found at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-feedback.html
Final Score Calculation: Performance Category Reweighting due to Data Integrity Issues	• No policy to account for data integrity concerns. • Several scenarios for reweighting have previously been finalized, including extreme and uncontrollable events (all performance categories) and hardship exemptions	• We would reweight performance categories in rare events due to compromised data outside the control of the MIPS eligible clinician. MIPS eligible clinicians or third party intermediaries can inform CMS that they believe they are impacted by a relevant event by providing information on the event (CMS may also

	specific to the Promoting Interoperability performance category.	independently learn of qualifying events). • If we determine that reweighting for compromised data is appropriate, we would generally redistribute to the Promoting Interoperability performance category as well as the Quality performance category. • In rare cases, we would redistribute to the Cost performance category.
Performance Threshold / Additional Performance Threshold / Payment Adjustment	• Performance Threshold is set at **30 points**. • Additional performance threshold set at 75 points for exceptional performance. • As required by statute, the maximum negative payment adjustment is -7%. • Positive payment adjustments can be up to 7% (not including additional positive payment adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 7%.	*For the 2020 performance period:* • Performance Threshold would be set at **45 points**. • Additional performance threshold would be set at **80 points** for exceptional performance. • As required by statute, the maximum negative payment adjustment is **-9%**. • Positive payment adjustments can be **up to 9%** (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9%. *For the 2021 performance period:* • Performance Threshold would be set at **60 points**. • Additional performance threshold would be set at **85**

		points for exceptional performance.
Targeted Review	MIPS eligible clinicians and groups may submit a targeted review request **by September 30** following the release of the MIPS payment adjustment factor(s) with performance feedback.	*Beginning with the 2019 performance period:* All requests for targeted review would be required to be submitted **within 60 days** of the release of the MIPS payment adjustment factor(s) with performance feedback.

Quality Payment Program CY 2020 Proposals: APM Overview

Policy Area	CY 2019 Policy	CY 2020 Proposed Policy
APMs: Medical Home Models	Medical Home Models and Medicaid Medical Home Models have a primary care focus with participants that provide primary care, empanelment of each patient to a primary clinician and at least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; Risk-stratified care management; Coordination of care across the medical neighborhood; Patient and caregiver engagement; Shared decision-making; and/or Payment arrangements in addition to, or substituting for, fee-for-service payments.	In addition to existing definitions, we propose to create a new Aligned Other Payer Multi-Payer Medical Home Model definition, which would mean an aligned other payer arrangement (not including Medicaid arrangements) operated by another payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation with CMS, such as a memorandum of understanding (MOU), and is determined by CMS to have the following characteristics: • The other payer arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine;

		11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant; • Empanelment of each patient to a primary clinician; and • At least four of the following: planned coordination of chronic and preventive care; Patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood; patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments). • The Medicaid Medical Home Model financial risk and nominal amount standards would also apply to Aligned Other Payer Medical Home Models.
APMs: Partial QPs	**Partial QP status** An eligible clinician who is a Partial QP is excluded from MIPS. This exclusion is applied at the NPI level across all of the clinician's TIN/NPI combinations.	**Partial QP status** Beginning in the 2020 QP Performance Period, Partial QP status would only apply to the TIN/NPI combination(s) through which an eligible clinician attains QP status.
APMs: Other Payer	**Marginal Risk**	**Marginal Risk**

Advanced APM	Currently, when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we use the lowest marginal risk rate across all possible levels of actual expenditures that would be used for comparison to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30%, with exceptions for large losses and small losses as provided in CMS regulations.	We propose that when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we will use the average marginal risk rate across all possible levels of actual expenditures that would be used for comparison to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30%, with exceptions for large losses and small losses as provided in CMS regulations.
APM Scoring Standard: Quality performance category	MIPS APMs receive quality scores based on their participation in the model. If no data is available for scoring the category is reweighted to: 75% Promoting Interoperability and 25% Improvement Activities. Exception: we will use data submitted by the Participant TIN in a Shared Saving Program ACO in the rare event that no data is submitted by the Entity.	We propose that for APMs where quality is unavailable through the model MIPS eligible clinicians will be scored under the APM scoring standard receive a score in the Quality performance category based on Quality data submitted by the APM Entity, individual, or TIN. We propose a 50% credit be applied to the quality category for MIPS APMs that are unable to receive a quality score through the model.

Quality Payment Program CY 2020 Proposals: Public Reporting via Physician Compare Overview

Policy Area	CY 2019 Policy	CY 2020 Proposed Policy
Public Reporting under Physician Compare	**Release of aggregate performance data** No established schedule for release of aggregate MIPS data on Physician Compare.	**Release of aggregate performance data** Aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores, will be available on Physician Compare beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible.

Appendix A: MIPS Policies Without Proposed Changes in CY 2020

MIPS Eligibility • Low-Volume Threshold (LVT) • Eligible Clinician Types • Opt-in Policy • MIPS Determination Period	No change
Data Collection and Submission • MIPS Performance Period • Collection Types • Submitter Types • Submission Types • CEHRT Requirements	No change
Quality Measures • Topped-Out Measures • Measures Impacted by Clinical Guideline Changes	No change

MIPS Scoring
• Measure, Activity and Performance Category Scoring Methodologies
• 3 Point Floor for Scored Measures
• Improvement Scoring
• Bonus Points:
  ○ Small Practice Bonus
  ○ High-Priority Measures
  ○ End-to-End Electronic Reporting
	No change

Facility-Based Clinicians • Definition and Determination • Scoring Methodology and Policies	No change