Quality Payment
PROGRAM

2020 QUALITY PAYMENT PROGRAM PROPOSED RULE OVERVIEW

AUGUST 13, 2019

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Proposed Rule for Year 4

How to Comment on the 2020 Proposed Rule

- Proposed rule includes proposed changes not reviewed in this presentation so please refer to proposed rule for complete information.
- Feedback during presentation not considered as formal comments; please submit comments in writing using formal process.
- See proposed rule for information on submitting comments by close of 60-day comment period on **September 27** (When commenting **refer to file code CMS-1715-P**).
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted.
- You must officially submit your comments in one of following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: qpp.cms.gov.

Quality Payment Program

Topics

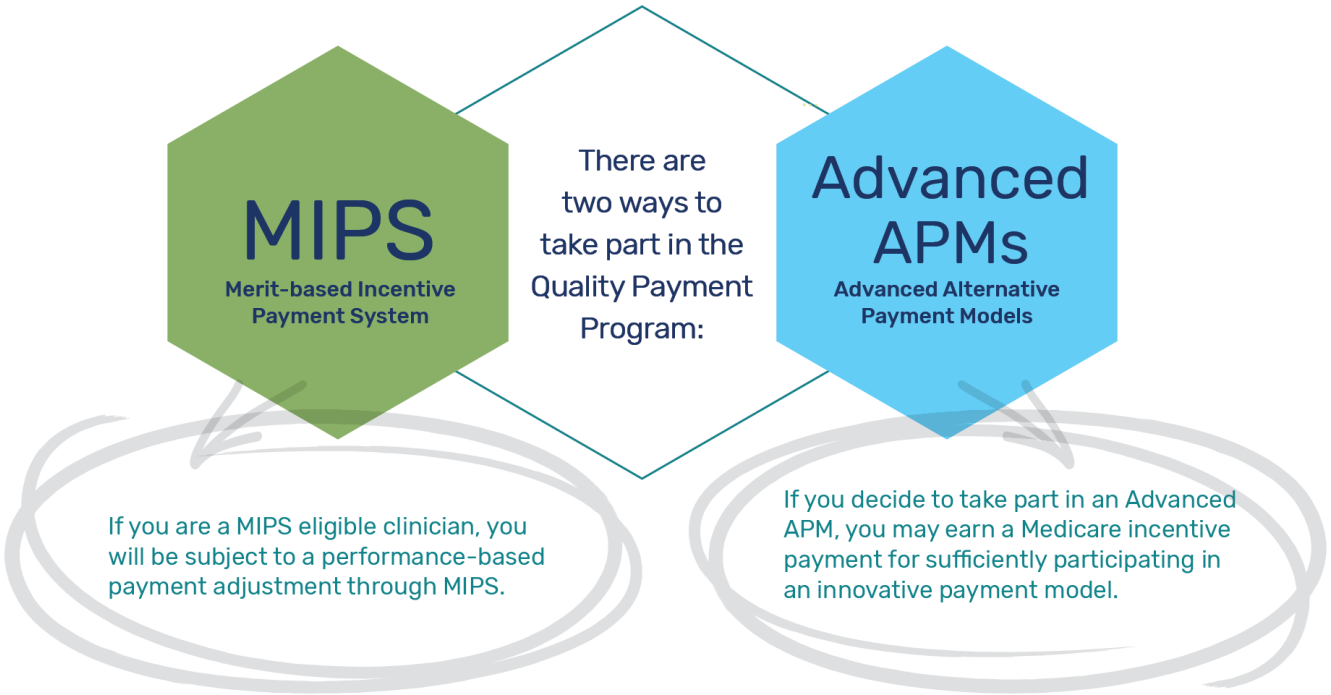
- Quality Payment Program Overview
- Merit-based Incentive Payment System (MIPS) Overview
- Proposed Rule for Year 4 – MIPS
- Advanced Alternative Payment Models (APMs) Overview
- Proposed Rule for Year 4 – Advanced APMs
- Proposed Rule: Public Reporting via Physician Compare Overview
- Help & Support
- Appendix

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides two participation tracks:



Quality Payment Program

Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

MIPS Value Pathways

Request for Information

While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS' goal to develop a meaningful program for every clinician, regardless of practice size or specialty.

CMS is proposing **MIPS Value Pathways (MVPs)** to create a new participation framework beginning with the 2021 performance year. This new framework would:

- Unite and connect measures and activities across the **Quality**, **Cost**, **Promoting Interoperability**, and **Improvement Activities** performance categories of MIPS
- Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities
- Streamline MIPS reporting by limiting the number of required specialty or condition specific measures

CMS encourages the health care community to review the MIPS Value Pathways Request for Information (RFI) and our illustrative diagram and submit formal comments. We look forward to working with you to establish this new framework.

MIPS Value Pathways

Current Structure of MIPS
(In 2020)

- Many Choices
- Not Meaningfully Aligned
- Higher Reporting Burden

New MIPS Value Pathways Framework
(In Next 1-2 Years)

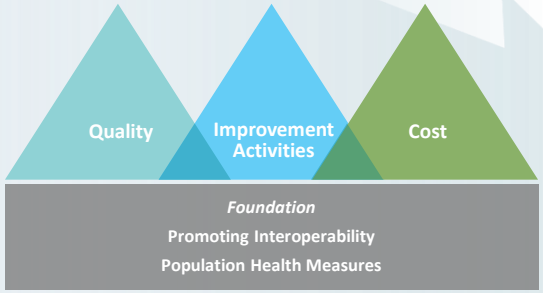
- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority

Building Pathways Framework

MIPS Value Pathways

Clinicians report on fewer measures and activities base on specialty and/or outcome within a MIPS Value Pathway

Moving to Value



Future State of MIPS
(In Next 3-5 Years)

- Simplified
- Increased Voice of the Patient
- Increased CMS Provided Data
- Facilitates Movement to Alternative Payment Models (APMs)

Fully Implemented Pathways

Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

Population Health Measures: *a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.*

Clinician/Group Reported Data CMS Provided Data

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

We Need Your Feedback on:

Pathways:
What should be the structure and focus of the Pathways? What criteria should we use to select measures and activities?

Participation:
What policies are needed for small practices and multi-specialty practices? Should there be a choice of measures and activities within Pathways?

Public Reporting:
How should information be reported to patients? Should we move toward reporting at the individual clinician level?

MIPS Value Pathways: Surgical Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track		
Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area	*Surgeon reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty*	*Surgeon reports on same foundation of measures with patient-reported outcomes also included*
Four performance categories feel like four different programs	*Surgeon reports on fewer measures overall in a pathway that is meaningful to their practice*	*Performance category measures in Surgical Pathway are more meaningful to the practice*
Reporting burden higher and population health not addressed	*CMS provides more data; reporting burden on surgeon reduced*	*CMS provides even more data (e.g. comparative analytics) using claims data and surgeon's reporting burden even further reduced*
Clinician/Group CMS	Clinician/Group CMS	Clinician/Group CMS

MIPS Value Pathways for Surgeons

QUALITY MEASURES

- Unplanned Reoperation within the 30-Day Postoperative Period **(Quality ID: 355)**
- Surgical Site Infection (SSI) **(Quality ID: 357)**
- Patient-Centered Surgical Risk Assessment and Communication **(Quality ID: 358)**

IMPROVEMENT ACTIVITIES

- Use of Patient Safety Tools **(IA_PSPA_8)**
- Implementing the Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop **(IA_CC_1)**

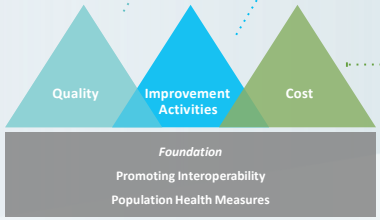
OR

- Completion of an Accredited Safety or Quality Improvement Program **(IA_PSPA_28)**

COST MEASURES

- Medicare Spending Per Beneficiary **(MSPB_1)**
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia **(COST_CCLI_1)**
- Knee Arthroplasty **(COST_KA_1)**

*Measures and activities selected for illustrative purposes and are subject to change.



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

MIPS Value Pathways: Diabetes Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)

MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area	*Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment*	*Endocrinologist reports on same foundation of measures with patient-reported outcomes also included*
Four performance categories feel like four different programs	*Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice*	*Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice*
Reporting burden higher and population health not addressed	*CMS provides more data; reporting burden on endocrinologist reduced*	*CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced*
Clinician/Group CMS	Clinician/Group CMS	Clinician/Group CMS

MIPS Value Pathways for Diabetes

QUALITY MEASURES

- Hemoglobin A1c (HbA1c) Poor Care Control (>9%) **(Quality ID: 001)**
- Diabetes: Medical Attention for Nephropathy **(Quality ID: 119)**
- Evaluation Controlling High Blood Pressure **(Quality ID: 236)**

IMPROVEMENT ACTIVITIES

- Glycemic Management Services **(IA_PM_4)**
- Chronic Care and Preventative Care Management for Empaneled Patients **(IA_PM_13)**

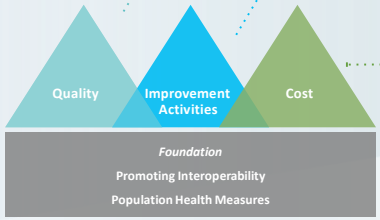
OR

- Electronic Submission of Patient Centered Medical Home Accreditation **(IA_PCMH)**

COST MEASURES

- Total Per Capita Cost **(TPCC_1)**
- Medicare Spending Per Beneficiary **(MSPB_1)**

*Measures and activities selected for illustrative purposes and are subject to change.



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

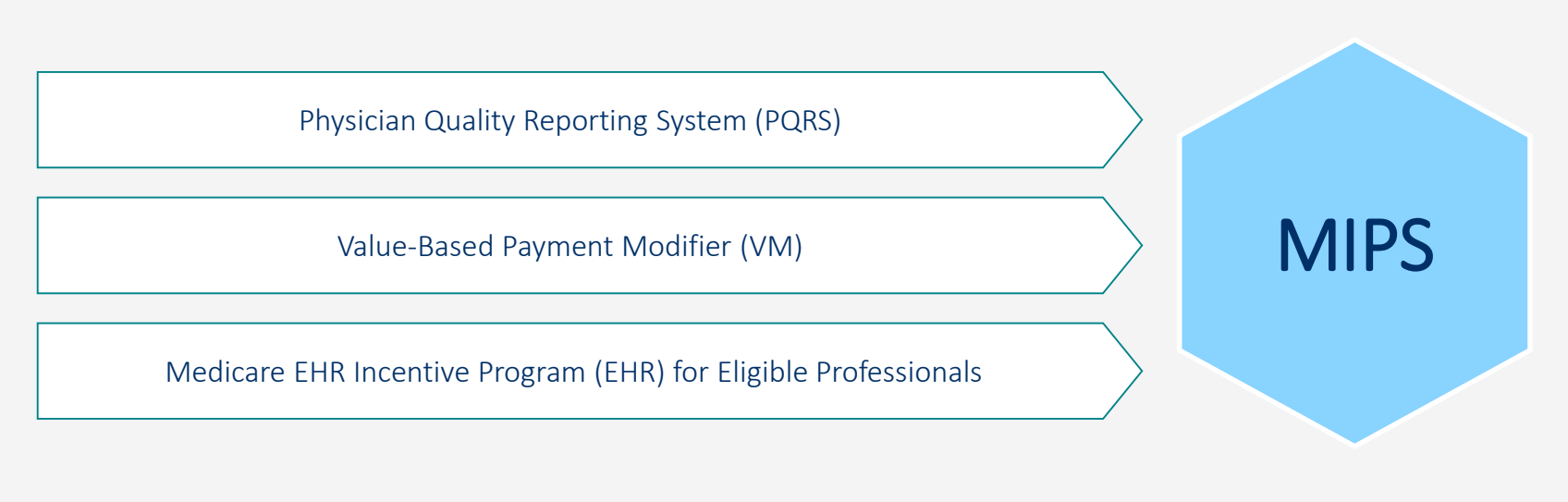
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

Quick Overview

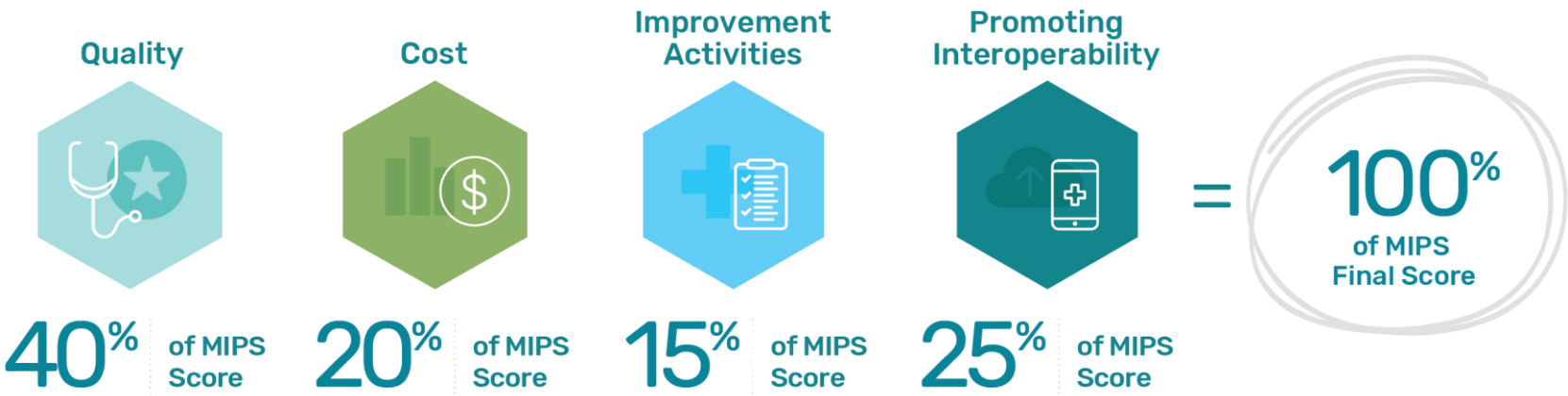
Combined legacy programs into a single, improved program.



Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories



**Revised weights according to the 2020 Proposed Rule*

- Comprised of **four** performance categories.
- So what? *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Merit-based Incentive Payment System (MIPS)

Terms and Timelines

As a refresher…

- TIN - Tax Identification Number
  - Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes
- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians
- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Performance Period	Also referred to as…	Corresponding Payment Year
2017	2017 “Transition” Year	2019
2018	“Year 2”	2020
2019	“Year 3”	2021
2020	“Year 4”	2022

Merit-based Incentive Payment System (MIPS)

Timelines

2020
Performance Year

- Performance period opens January 1, 2020
- Closes December 31, 2020
- Clinicians care for patients and record data during the year

March 31, 2021
Data Submission

- Deadline for submitting data is March 31, 2021
- Clinicians are encouraged to submit data early

Feedback

- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

January 1, 2022
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2022

PROPOSED RULE FOR YEAR 4 - MIPS

Eligibility

MIPS Year 4 (2020) Proposed Changes

MIPS Eligible Clinician Types

No proposed changes to the MIPS eligible clinician types in Year 4 (2020); they are the same as in Year 3 (2019):

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Audiologists
- Speech-language pathologists
- Registered dietitians and other nutrition professionals
- Groups of such clinicians

MIPS Year 4 (2020) Proposed Changes

Low-volume Threshold Determination

No proposed changes to low-volume threshold criteria in Year 4 (2020).

The low-volume threshold **includes** MIPS eligible clinicians who:

- Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

AND

- Furnish covered professional services to more than 200 Medicare beneficiaries

AND

- Provide more than 200 covered professional services under the PFS.

To be included in MIPS, a clinician **must exceed all three** criteria.

MIPS Year 4 (2020) Proposed Changes

Opt-in Policy

No proposed changes in Year 4 (2020) to the opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (New-proposed)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 4 (2020) Proposed Changes

MIPS Determination Period

No proposed changes to the MIPS determination period.

For Year 4 (2020), CMS will look at your Medicare claims from two 12-month segments aligned to the fiscal year:

- **First 12-month segment**: October 1, 2018 – September 30, 2019 (historical period)
- **Second 12-month segment:** October 1, 2019 – September 30, 2020 (performance period; does not include 30-day claims run out)

During the MIPS determination period, we will also identify MIPS eligible clinicians with the following special status:

- Non-Patient Facing
- Small Practice
- Hospital-based
- ASC-based

Quick Tip: MIPS eligible clinicians with a special status **are included in MIPS** and qualify for special rules. Having a special status **does not exempt** a clinician from MIPS.

MIPS Year 4 (2020) Proposed Changes

Definition of Hospital-based Clinician

Year 3 (2019) Final

Hospital-based clinicians

- A group is identified as hospital-based when 100% of the MIPS eligible clinicians in the group meet the definition of a hospital-based individual clinician.

Year 4 (2020) Proposed

Hospital-based clinicians

- A group would be identified as hospital-based if more than **75%** of the MIPS eligible clinicians in the group meet the definition of a hospital-based individual 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 PI performance category.

PROPOSED RULE FOR YEAR 4 – MIPS

Performance Categories Overview

MIPS Year 4 (2020) Proposed Changes

Performance Category Weights

Year 3 (2019) Final

Performance Category	Performance Category Weight
Quality	45%
Cost	15%
Improvement Activities	15%
Promoting Interoperability	25%

Year 4 (2020) Proposed

Performance Category	Performance Category Weight
Quality	**40%**
Cost	**20%**
Improvement Activities	15%
Promoting Interoperability	25%

MIPS Year 4 (2020) Proposed Changes

Performance Category Weights

Year 5 (2021) Proposed

Performance Category	Performance Category Weight
Quality	35%
Cost	25%
Improvement Activities	15%
Promoting Interoperability	25%

Year 6 (2022) Mandated

Performance Category	Performance Category Weight
Quality	30%
Cost	30%
Improvement Activities	15%
Promoting Interoperability	25%

PROPOSED RULE FOR YEAR 4 - MIPS

Quality Performance Category

MIPS Year 4 (2020) Proposed Changes

Quality Performance Category Measures

- **Quality Performance Category Measures – Year 4 (2020) Proposed**
  - Remove low-bar, standard of care, process measures
  - Focus on high-priority outcome measures
  - Add new specialty sets
    - Speech Language Pathology
    - Audiology, Clinical Social Work
    - Chiropractic Medicine, Pulmonology
    - Nutrition/Dietician
    - Endocrinology

MIPS Year 4 (2020) Proposed Changes

Quality Performance Category

Basics:

- ***Proposed:*** Increased data completeness requirements
- Additional measure removal criteria
- Alternative benchmarks established

Data Completeness Requirements:

Year 3 (2019) Final	Year 4 (2020) Proposed
• Medicare Part B Claims measures: 60% of Medicare Part B patients for the performance period.	• Medicare Part B Claims measures: 70% sample of Medicare Part B patients for the performance period.
• Qualified Clinical Data Registry (QCDR) measures, MIPS Clinical Quality Measures (CQMs), and electronic CQMs (eCQMs): 60% of clinician's or group's patients across all payers 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.

MIPS Year 4 (2020) Proposed Changes

Quality Performance Category

Basics:

- ***Proposed:*** Increased data completeness requirements
- Additional measure removal criteria
- Alternative benchmarks established

Modified Benchmarks to Avoid the Potential for Inappropriate Treatment

Year 3 (2019) Final	Year 4 (2020) Proposed
No special benchmarking policy. The general benchmarking policy for 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 measures 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.	Beginning in the 2022 MIPS payment year: For each measure that has a benchmark that CMS determines has the potential to result in inappropriate treatment, CMS will set benchmarks using a **flat percentage** for all collection types where the top decile is higher than 90% under the performance-based benchmarking methodology. 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 (National Quality Forum (NQF) 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) • MIPS #236 (NQF 0018): Controlling High Blood Pressure

PROPOSED RULE FOR YEAR 4 - MIPS

Cost Performance Category

MIPS Year 4 (2020) Proposed Changes

Cost Performance Category

Basics:

- ***Proposed:*** New episode-based measures and current global measures' attribution methodologies revised
- Different measure attribution for individuals and groups

Measures:

Year 3 (2019) Final	Year 4 (2020) Proposed
Measures: • Total Per Capita Cost (TPCC) • Medicare Spending Per Beneficiary (MSPB) • 8 episode-based measures Case minimums: • 10 for procedural episodes • 20 for acute inpatient medical condition episodes	Measures: • TPCC measure (**Revised**) • MSPB Clinician (MSPB-C) measure **(Name and specification Revised)** • 8 existing episode-based measures • **10 new episode-based measures** No changes to case minimums

MIPS Year 4 (2020) Proposed Changes

Cost Performance Category

Basics:

- ***Proposed:*** New episode-based measures and new measure revision
- Different measure attribution for individuals and groups

Measure Attribution:

Year 4 (2020) Proposed
• 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 (MSPB-C) attribution changes would have a different methodology for surgical and medical patients

PROPOSED RULE FOR YEAR 4 - MIPS

Improvement Activities
Performance Category

MIPS Year 4 (2020) Proposed Changes

Improvement Activities Performance Category

Basics:

- ***Proposed:*** Removal of improvement activities
- Modification and addition of nine more
- Conclusion of CMS study

Improvement Activities Inventory

Year 3 (2019) Final	Year 4 (2020) Proposed
• 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."	• Addition of 2 new Improvement Activities. • Modification of 7 existing Improvement Activities. • Removal of 15 existing Improvement Activities.

MIPS Year 4 (2020) Proposed Changes

Improvement Activities Performance Category

Basics:

- ***Proposed:*** Removal of improvement activities
- Modification and addition of nine more

Requirement for Improvement Activity Credit for Groups:

Year 3 (2019) Final	Year 4 (2020) Proposed
Group or virtual group can attest to an improvement activity if at least one clinician in the TIN participates.	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.

PROPOSED RULE FOR YEAR 4 - MIPS

Promoting Interoperability Performance Category

MIPS Year 4 (2020) Proposed Changes

Promoting Interoperability Performance Category

Basics:

- ***Proposed:*** New reweighting standards for groups
- Revised measures

Hospital-Based MIPS Eligible Clinicians in Groups

Year 3 (2019) Final	Year 4 (2020) Proposed
A group is identified as hospital-based and eligible for reweighting when **100%** of the MIPS eligible clinicians in the group meet the definition of a hospital-based MIPS eligible clinician.	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. 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.

MIPS Year 4 (2020) Proposed Changes

Promoting Interoperability Performance Category

Basics:

- ***Proposed:*** New reweighting standards for groups
- Revised measures

Objectives and Measures:

Year 3 (2019) Final	Year 4 (2020) Proposed
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.	<u>Beginning with the 2019 performance period:</u> • The Query of PDMP measure would require a yes/no response instead of a numerator/denominator. • 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. <u>Beginning with the 2020 performance period:</u> • Remove Verify Opioid Treatment Agreement Measure

PROPOSED RULE FOR YEAR 4 - MIPS

Third Party Intermediaries

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

- CMS is focused on improved partnerships with third parties to help reduce the clinician reporting burden.

- **Beginning with the 2021 Performance Period**, third party intermediaries, such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries, are encouraged to become a one-stop-shop for reporting. CMS is proposing that QCDRs and Qualified Registries must:

    - Support the **Quality**, **Improvement Activities**, and **Promoting Interoperability** performance categories;
    - Provide enhanced performance feedback; and
    - Deliver quality improvement services.

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

Year 3 (2019) Final

Performance Categories:

- QCDRs/Qualified Registries are not required to support multiple performance categories.

Year 4 (2020) Proposed

Performance Categories:

<u>Beginning in 2021 performance period:</u>

QCDRs and Qualified Registries would be required to support the reporting of measures and activities in the:

- 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.

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

Year 3 (2019) Final

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

Year 4 (2020) Proposed

Performance Feedback:

Beginning in 2021 performance period

- Feedback (still required 4x 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 4x a year.

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

Year 3 (2019) Final

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.

Year 4 (2020) Proposed

QCDR Measure Requirements:

<u>Beginning in performance period 2020:</u>

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 reporting through other QCDRs. CMS may not approve the measure.

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

QCDR Measure Requirements
Year 5 (2021) Proposed

Beginning in performance period 2021:

- 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
- 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.

MIPS Year 4 (2020) Proposed Changes

Third Party Intermediaries

QCDR Measure Removal

Year 4 (2020) Proposed:

CMS is proposing new guidelines to help QCDRs understand when a QCDR measure would likely be rejected during the annual self-nomination process, such as:

- 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 or have no actionable quality action;
- Considerations and evaluation of the measure's performance data to check for performance variance
- QCDR measures that don't address a priority area highlighted in the Measure Development Plan; and
- QCDR measures that have the potential for unintended consequences.

PROPOSED RULE FOR YEAR 4 - MIPS

Performance Threshold and Payment Adjustment

MIPS Year 4 (2020) Proposed Changes

Performance Threshold and Payment Adjustments

Year 3 (2019) Final

Performance Threshold/Payment Adjustment:

- 30 point performance threshold.
- Additional performance threshold for exceptional performance set at 75 points.
- Payment adjustment could be up to +7% or as low as -7%.

Year 4 (2020) Proposed

Performance Threshold/Payment Adjustment:

- 45 point performance threshold
- Additional performance threshold for exceptional performance set at 80 points.
- Payment adjustment could be up to **+9%** or as low as **-9%**.

*To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor." The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

MIPS Year 4 (2020) Proposed Changes

Performance Threshold and Payment Adjustments

Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

Year 4 (2020) Proposed

Final Score 2020	Payment Adjustment 2022
≥80 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
45.01-79.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
45 points	• Neutral payment adjustment
11.26-44.99	• Negative payment adjustment greater than -9% and less than 0%
0-11.25 points	• Negative payment adjustment of -9%

Year 5 (2021) Proposed:

- Performance Threshold = 60 points
- Additional Performance Threshold = 85 points

PROPOSED RULE FOR YEAR 4 - MIPS

Final Score Calculation and Targeted Reviews

MIPS Year 4 (2020) Proposed Changes

Final Score Calculation

Year 3 (2019) Final

Performance Category Reweighting due to Data Integrity Issues:

- No formal 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 specific to the Promoting Interoperability performance category.

Year 4 (2020) Proposed

Performance Category Reweighting due to Data Integrity Concerns:

- We would reweight performance categories in rare events due to compromised data outside the control of the MIPS eligible clinician. 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 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.

MIPS Year 4 (2020) Proposed Changes

Targeted Reviews

Year 3 (2019) Final

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.

Year 4 (2020) Proposed

Targeted Review:

Beginning with the 2019 performance period

- CMS is issuing a clarification that, 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.

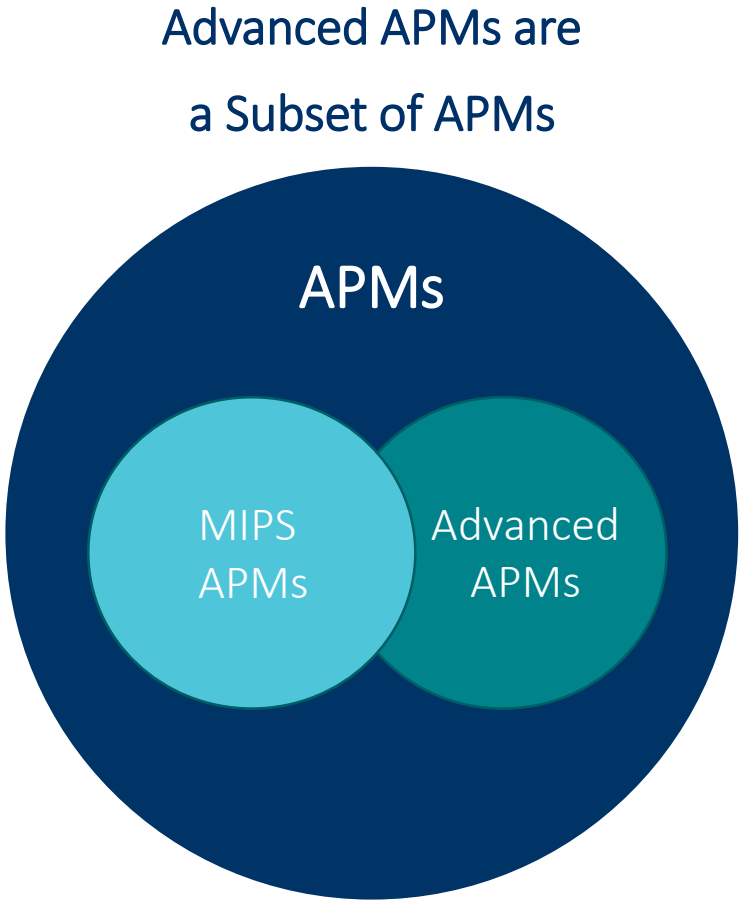
ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

Overview

Alternative Payment Models (APMs)

Overview

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care
- Can apply to a specific condition, care episode or population
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs



Advanced APMs

Benefits

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.

Advanced APMs

Advanced APM Criteria

To be an Advanced APM, the following three requirements must be met:

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Advanced APMs

Terms at a Glance

- **APM Entity** - An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

- **Advanced APM** – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- **Affiliated Practitioner** - An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.

- **Affiliated Practitioner List** - The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.

Advanced APMs

Terms at a Glance

- **MIPS APM –** Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.

- **Participation List** - The list of participants in an APM Entity that is compiled from a CMS-maintained list.

- **Qualifying APM Participant (QP)** - An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.

PROPOSED RULE FOR YEAR 4 - APMS

Overview

APMs Year 4 (2020) Proposed Changes

Overview

- For the APM Scoring Standard, CMS is proposing that MIPS eligible clinicians participating in APMS are allowed the option to **report for the MIPS Quality performance category** to offer flexibility and improve meaningful measurement.

- CMS is proposing a **MIPS APM Quality Reporting Credit** for MIPS APMs that do not require reporting through MIPS quality reporting mechanisms.

    - The credit would be equal to 50% percent of the MIPS Quality performance category weight

APMs Year 4 (2020) Proposed Changes

Partial QPs

Year 3 (2019) Final	Year 4 (2020) Proposed
Partial QP Status: A clinician who is a Partial QP is excluded from MIPS at the NPI level, including all TINs the clinician is associated with.	**Partial QP Status:** A clinician who is a Partial QP is only excluded from MIPS in the TIN through which the clinician received Partial QP status.

APMs Year 4 (2020) Proposed Changes

Other Payer Advanced APM

Year 3 (2019) Final

Marginal Risk:

In order to meet the nominal amount standard for an Other Payer Advanced APM, the specific level of marginal risk must be at least 30% of losses in excess of the expected expenditures and total potential risk must be at least 4% of the expected expenditures. A payment arrangement must require APM Entities to bear financial risk for at least 3% of the expected expenditures for which an APM Entity is responsible under the payment arrangement.

Year 4 (2020) Proposed

Marginal Risk:

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 for comparison to the 30% marginal risk requirement of the generally applicable nominal amount standard.

PROPOSED RULE: PUBLIC REPORTING VIA PHYSICIAN COMPARE OVERVIEW

Public Reporting via Physician Compare - Year 4 (2020) Proposed Changes

Year 3 (2019) Final	Year 4 (2020) Proposed
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 the 2018 performance period as technically feasible.

HELP & SUPPORT

Technical Assistance

Available Resources

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

Primary Care & Specialist Physicians

Transforming Clinical Practice Initiatives

- Supports more than 140,000 clinical practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PIN(s) and SAN(s) in your state

Small & Solo Practices

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or assistance getting connected, contact QPPSURS@IMPAQINT.com.

Technical Support

All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website: qpp.cms.gov** Serves as a starting point for information on the Quality Payment Program.
- **Quality Payment Program Sevice Center** Assists with all Quality Payment Program questions. 1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov
- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems** Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Comments due September 27

When and Where to Submit Comments

- See proposed rule for information on submitting comments by close of 60-day comment period on **September 27** (When commenting **refer to file code CMS-1715-P**)
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted
- You must officially submit your comments in one of following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

Q&A Session

- CMS must protect rulemaking process and comply with Administrative Procedure Act
- Participants are invited to share initial comments or questions, but only comments formally submitted through process outlined by Federal Register taken into consideration by CMS
- See proposed rule for information on how to submit a comment

Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: **1083278**

Press *1 to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.

APPENDIX

Appendix

Previously Finalized MIPS Policies Unchanged in PY 2020 Proposed Rule

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:
	  • Complex Patient Bonus
	  • 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

Note: There are several 2020 policies that were finalized in the CY 2019 PFS Final Rule.

Questions