Proposed Rule for the Quality Payment Program Year 3

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, which is 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).

The first two years of the Quality Payment Program were implemented gradually to reduce burden, provide flexible participation options, and allow clinicians to spend less time on regulatory requirements and more time with patients. As a result, we were pleased to announce on May 31st that 91 percent of all clinicians eligible for MIPS participated in the 2017 performance period. We strive to implement the program as Congress intended while focusing on simplification and burden reduction, drawing on the flexibilities offered by the recent enactment of the Bipartisan Budget Act of 2018, smoothing the transition where possible, and offering targeted educational resources for program participants. We've also never lost sight of supporting a pathway to participation in Advanced APMs, and Year 3 is a reflection of that effort.

As an agency priority announced during the 2018 Healthcare Information and Management Systems Society (HIMSS) Annual Conference by CMS Administrator, Seema Verma, we also address furthering clinicians' access to all health information on their patients via interoperability. We are continuing to support all clinician practices with a focus on those that are small, independent, and/or rural, and most importantly, the beneficiaries are always at the heart of our proposals. We will continue proposing policies that protect the safety of our beneficiaries and strengthen the quality of the healthcare they receive.

The Year 3 policies are reflective of the feedback we received from many stakeholders and, we will continue offering our free, hands-on technical assistance to help individual clinicians and group practices participate in the Quality Payment Program.

A high-level overview of the Year 3 proposals is listed below along with information on how to submit comments. Please note that these are proposals and subject to change in the 2019 Physician Fee Schedule (PFS) Final Rule.

Quality Payment Program Year 3 Proposals: MIPS

For Year 3, we continue building on what is working and using your feedback to improve program policies. We will continue to identify low-value or low-priority process measures, which will be recommended for removal, and focus on meaningful quality outcomes for patients and streamlining reporting for clinicians. We believe that the Meaningful Measures initiative and the MACRA funding opportunity to develop measures for the Quality Payment Program will improve our quality measures over time.

Some prominent proposals include expanding the definition of MIPS eligible clinicians to include new clinician types (physical therapists, occupational therapists, clinical social workers, and clinical psychologists), adding a third element to the low-volume threshold determination, and giving eligible clinicians who meet one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy). We also propose adding new episode-based measures to the Cost performance category, restructuring the Promoting Interoperability (formerly Advancing Care Information) performance category, and creating an option to use facility-based Quality and Cost performance measures for certain facility-based clinicians.

We propose to continue to reduce burden and offer flexibilities to help clinicians successfully participate by:

- Overhauling the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record interoperability and patient access while aligning with the proposed new Promoting Interoperability Program requirements for hospitals.
- Moving clinicians to a smaller set of Objectives and Measures with scoring based on performance for the Promoting Interoperability performance category.
- Allowing the use of a combination of collection types for the Quality performance category.
- Retaining bonus points in the scoring methodology for:
    - The care of complex patients;
    - End-to-End Electronic Reporting;
    - Small practices (which we propose to include as a bonus under the Quality performance category); and
- Providing the option to use facility-based scoring for facility-based clinicians that doesn't require data submission.

Opt-in to participate in MIPS

Starting in Year 3, clinicians or groups would be able to **opt-in to MIPS** if they meet or exceed one or two, but not all, of the low-volume threshold criteria.

Proposed Low-Volume Threshold Criteria for Year 3

- Dollar Amount ($90,000)
- Number of Beneficiaries (200)
- Number of Covered Professional Services (200)

We're also proposing the following flexibilities for clinicians in small practices, including:

- Continuing the small practice bonus, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus.
- Awarding small practices 3 points for quality measures that don't meet the data completeness requirements.
- Consolidating the low-volume threshold determination periods with the determination period for identifying a small practice.

Lastly, you'll notice the use of new language that more accurately reflects how clinicians and vendors interact with MIPS (i.e. Collection types, Submitter types, etc.). We look forward to your feedback on the changes.

Newly Proposed MIPS Terms

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

Bipartisan Budget Act of 2018

Enacted earlier this year, the Bipartisan Budget Act of 2018 provides additional authority to continue the gradual transition in MIPS for three more years. Although the Bipartisan Budget Act of 2018 was enacted after the publication of the Calendar Year (CY) 2018 Quality Payment Program final rule, we've already implemented adjustments to the low-volume threshold calculations for Year 2 of the program. In the CY 2019 Physician Fee Schedule proposed rule, we're proposing to continue using this authority to help further reduce clinician burden.

Key Changes to Implement the Bipartisan Budget Act of 2018 include:

- Changing the application of MIPS payment adjustments, so that the adjustments will not apply to all items and services under Medicare Part B, but will now apply only to covered professional services paid under or based on the Physician Fee Schedule beginning with 2019, which is the first payment year of the program.
- Changing the way MIPS eligibility is determined with respect to the low-volume threshold. The low-volume threshold calculations had been based on all Medicare Part B allowed charges and Part B services furnished to patients. Beginning with performance periods in 2018, this calculation will now be based on allowed charges for covered professional services and the number of covered professional services furnished to patients.
- Providing flexibility in the weighting of the Cost performance category in the final score for three additional years. Instead of requiring this performance category to have a weight of 30% in Year 3 of the program (performance period 2019) the weight is required to be not less than

10 percent and not more than 30 percent for the third, fourth and fifth years of the Quality Payment Program.

- Allowing flexibility in establishing the performance threshold for three additional years (program years 3, 4, and 5) to ensure a gradual and incremental transition to the estimated performance threshold for the sixth year of the program based on the mean or median of final scores from a prior period. For 2019, the proposed performance threshold is 30 points.

Quality Payment Program Year 3 Proposals: APMs

We are building off of many of the policies we finalized for Year 2 of the program, and we are proposing changes and updates, including:

- Updating the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75 percent of eligible clinicians in each APM Entity use CEHRT.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024.
- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.
    - Establishing a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement. We propose this streamlined process to reduce the burden on payers and eligible clinicians.
    - Allowing QP determinations at the TIN level, in addition to the current options for determinations at the APM entity level and the individual level, in instances when all clinicians who bill under the TIN participate as a single APM Entity. This will provide additional flexibility for eligible clinicians under the All-Payer Combination Option.
    - Moving forward with allowing all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period.
- Streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM criteria to reduce confusion and burden among payers and eligible clinicians submitting payment arrangement information to CMS.
- Clarifying the requirement for MIPS APMs to assess performance on quality measures and cost/utilization.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.

Comment Period

We want to hear from you on our proposed policies for Year 3 of the Quality Payment Program. Please note that the official method for commenting is outlined below.

How Do I Comment on the Proposed Rule?

Please see the proposed rule for how to submit comments by the close of the 60-day comment period on September 10, 2018.

You can find the instructions for submitting comments in the proposed rule; FAX transmissions won't be accepted. Use 1 of the following ways to officially submit your comments:

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

For more information, go to: qpp.cms.gov

Contact Us

The Quality Payment Program can be reached at 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern time or by email at QPP@cms.hhs.gov.

MIPS Policies		
Policy Area	**Current Year 2 (Final Rule CY 2018)**	**Year 3 (Proposed Rule CY 2019)**
MIPS Eligibility	**Eligible clinician types include:** • Physician • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • A group that includes such professionals (required by statute)	**Eligible clinician types include:** Eligible clinician types remain the same as Year 2 with the following additions: • Physical therapist • Occupational therapist • Clinical social worker • Clinical psychologist
Low-Volume Threshold (LVT)	• To be excluded from MIPS, clinicians and groups must meet one of the following two criterion: have ≤ $90K in Part B allowed charges for covered professional services OR provide care to ≤ 200 beneficiaries	• The low-volume threshold would include a third criterion for determining MIPS eligibility • To be excluded from MIPS, clinicians or groups would need to meet one of the following three criterion: have ≤ $90K in Part B allowed charges for covered professional services, provide care to ≤ 200 beneficiaries, OR provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)
Opt-in	• Not Applicable	• Starting in Year 3, clinicians or groups would be able to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion
MIPS Determination Period	**Low Volume Threshold Determination Period:** • First 12-month segment: Sept. 1, 2016 to Aug. 31, 2017 (including a 30-day claims run out) • Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)	**Now referred to as MIPS Determination Period:** • Created a streamlined and consistent “MIPS determination period” for different categories of clinicians, which will be used to determine the low-volume threshold and the following special statuses: non-patient facing, small practice, hospital-based, and ASC-based

	• Note: If a clinician or group is identified as not exceeding the LVT during this time, they will be excluded regardless of the results of the second 12-month analysis
	Hospital-Based MIPS eligible clinician:
	• MIPS eligible clinician furnishing 75% or more of covered professional services in POS 19, POS 21, POS 22, or POS 23 based on claims for a period prior to the performance period
	  ○ Claims will be used from September 1 of the calendar year, 2 years preceding the performance period through August 31 of the calendar year preceding the performance period; if not feasible, claims from a 12-month period close to this period will be used
	
	ASC-Based MIPS eligible clinician:
	• MIPS eligible clinician furnishing 75% or more of covered professional services in POS 24 based on claims for a period prior to the performance period
	  ○ Claims will be used from September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period; if not feasible,
		○ First 12-month segment: Oct. 1, 2017 to Sept. 30, 2018 (including a 30-day claims run out)
		○ Second 12-month segment: Oct. 1, 2018 to Sept. 30, 2019 (does not include a 30-day claims run out)
		
		• Hospital-based MIPS eligible clinician determinations would be based on claims from the MIPS determination period
		
		• ASC-based MIPS eligible clinician determinations would be based on claims from the MIPS determination period

	claims from a 12-month period close to this period will be used	
Virtual Groups	**In general, group policies apply to virtual groups, except:** • A virtual group will be considered a small practice if it contains 15 or fewer clinicians • A virtual group will be designated as rural or HPSA practice if more that 75% of the NPIs billing under the virtual group's TINs are designated in a ZIP code as a rural area or HPSA • A virtual group will be considered non-patient facing if more than 75% of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period	**Virtual group policies remain the same as Year 2, with the following change:** • Beginning with 2019 the virtual group eligibility determination period aligns with the first segment of data analysis under the MIPS eligibility determination period. ○ For example: Oct. 1, 2017 to Sept. 30, 2018 (including a 30-day claims run out)
	Virtual group election: • Must be made by December 31 of the calendar year preceding the applicable performance period, and cannot be changed during the performance period • The election process can be broken into two stages: Stage 1 (which is optional) pertains to virtual group eligibility determinations, and stage 2 pertains to virtual group formation	**Virtual Group election is the same as Year 2, with the following change:** • As part of the virtual group eligibility determination period, TINs would be able to inquire about their TIN size prior to making an election during a 5-month timeframe, which would begin on August 1 and end on December 31 of a calendar year prior to the applicable performance period. TIN size inquiries would be made through the Quality Payment Program Service Center. Technical assistance resources already available to stakeholders would continue to be available

	To meet the **eligibility requirements**, each member of a virtual group must establish a formal written agreement prior to an election • A designated virtual group representative must e-mail a virtual group election to MIPS_VirtualGroups@cms.hhs.gov by December 31 of the calendar year prior to the start of the applicable performance period	The requirement for virtual groups to have a formal written agreement between each member of a virtual group remains the same for Year 3 • For 2019, a designated virtual group representative must e-mail a virtual group election to MIPS_VirtualGroups@cms.hhs.gov by December 31 of the calendar year prior to the start of the applicable performance period
MIPS Performance Period	Minimum Performance Period for each Performance Category: • Quality: 12-months • Cost: 12-months • Improvement Activities: 90-days • Promoting Interoperability: 90-days	Minimum Performance Period for each Performance Category: • Same performance periods as in Year 2

Quality Performance Category	**Weight to final score:**
	• 50% in Year 2
	• The Quality performance category may be reweighted:
	  ○ If a score cannot be calculated due to no applicable and available measures
	  ○ Due to extreme and uncontrollable circumstances
		Weight to final score:
		• 45% in Year 3
		• Maintain the same reweighting criteria for the Quality performance category

	For individual eligible clinicians, one submission mechanism[1] must be selected: • Claims • QCDR • Qualified registry	In Year 3, individual eligible clinicians would be able to submit a single measure via multiple collection types (e.g. MIPS CQM, eCQM, QCDR measures and Medicare Part B claims measures)

[1] Note that the terminology for submission mechanisms has been updated to more accurately reflect how clinicians and vendors interact with MIPS. Instead of submission mechanisms, collection type will be used to refer to a set of quality measures with comparable specifications and data completeness criteria including, as applicable: eCQMs; MIPS CQMs; QCDR measures; Medicare Part B claims measures; the CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.

	• EHR	and be scored on the data submission with the greatest number of measure achievement points
	Groups and Virtual Groups must use one submission mechanism: • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25+) • CMS-Approved Survey Vendor for CAHPS for MIPS	**Groups and Virtual Groups would be able to use multiple collection types.** • The Quality performance category would be scored if groups submit data using multiple collection types (e.g. MIPS CQM, eCQM, QCDR measures, and Medicare Part B claims measures) • CMS Web Interface cannot be scored with other collection types other than the CMS approved survey vendor measure and/or administrative claims measures
	Data Completeness Requirements: • Claims: 60% of Medicare Part B patients for the performance period • QCDR/Registry/EHR: 60% of clinician's or group's patients across all payers for the performance period • CMS Web Interface: Sampling requirements for Medicare Part B patients • CAHPS for MIPS Survey: Sampling requirements for Medicare part B patients	**Data Completeness Requirements:** • The same data completeness requirements as Year 2, with the following change: • For groups registered to report the CAHPS for MIPS survey, there is an additional policy. If the sample size was not sufficient, the total available measure achievement points (the denominator) would be reduced by 10 points and the measure would receive zero points
	Topped-Out Measures: Definition: if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. QCDR measures would not go through the comment and rulemaking process to remove	**Topped-Out Measures:** • The definition and lifecycle for topped out measures remain the same for Year 3, although additional factors may affect the time a topped-out measure remains as such

	topped out measures. Polices include: • Finalized 4-year lifecycle for identification and removal of topped out measures • Scoring cap of 7 points for topped out measures • Policies to identify, remove and cap scoring for topped out measures do not apply to CMS Web Interface measures • Policy does not apply to CAHPS for MIPS Summary Survey Measures (SSMs). • 6 measures identified for scoring cap for topped out measures	
	Measures Impacted by Clinical Guideline Changes: • No requirements	**Measures Impacted by Clinical Guideline Changes:** • In response to clinical guideline or other changes, impacted measures will be given a score of 0 and the Quality performance category denominator would be reduced by 10. If this situation occurs the clinician would be required to submit data for one less measure (i.e. 5 measures instead of 6)
	Bonus Points: High-Priority Measures (after first required measure) • 2 points for outcome, patient experience • 1 point for other high priority measures which need to meet data completeness, case minimum, and have performance greater than 0 • Capped bonus points at 10% of the denominator of total Quality performance category	**Bonus Points: High-Priority Measures (after first required measure)** • Same as Year 2, with the following change: • Discontinue high priority measure bonus points for CMS Web Interface Reporters

	Bonus Points: End-to-End Electronic Reporting: • 1 point for each measure submitted using electronic end-to-end • Capped at 10% of the denominator of total Quality performance category points	**Bonus Points: End-to-End Electronic Reporting:** • Same as Year 2.
	Improvement Scoring- Full Participation: • Eligible clinicians must fully participate (i.e., submit all required measures and have met data completeness criteria, and for performance year • The quality improvement percent score is 0 if the eligible clinician did not fully participate in the quality category for the current performance period • If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we would compare 2018 performance to an assumed 2017 Quality category score of 30%	**Improvement Scoring – Full Participation:** • Same as Year 2
Cost Performance Category	**Weight to final score:** • 10% in Year 2	**Weight to final score:** • 15% in Year 3
	Measures: • Two measures: Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB) • Derived from Medicare claims • Reliability threshold of 0.4 established • Case minimum of 20 for total per capita cost and 35 for MSPB	**Measures:** The Total Per Capita Cost and MSPB measures will be the same as in Year 2, with the following changes: • 8 episode-based measures will be added to the list of Cost measures • Case minimum of 10 for procedural episodes and 20 for

		acute inpatient medical condition episodes
	Measure Attribution: • 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 • Added two CPT codes (99487 and 99489 describing complex chronic care management) to list of primary care services used to determine attribution under the total per capita cost measure	**Measure Attribution:** Same as Year 2 with the following changes: • For procedural episodes, we will attribute episodes to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes • For acute inpatient medical condition episodes, we will 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 percent of the inpatient E&M claim lines in that hospitalization
	Scoring Improvement: • Improvement scoring added to the Cost performance category scoring methodology with a maximum cost improvement score of 1 percent; • However, the Bipartisan Budget Act of 2018 delayed consideration of improvement in the Cost performance category until the 2024 payment year (based on the 2022 performance year). As a result, there will be no improvement scoring in Year 2 MIPS payment year.	**Scoring Improvement:** • Cost performance category percent score will not take into account improvement until the 2024 MIPS payment year
	Calculating the Cost Score: • Cost Achievement Points/Available = Cost Performance Category Percent Score	**Calculating the Cost Score:** • Same as Year 2

	• The percent score cannot not exceed 100% • The Bipartisan Budget Act of 2018 delayed consideration of improvement in cost until the 2024 MIPS payment year (based on the 2022 performance year) • We will not calculate a Cost performance category score if the eligible clinician is not attributed any Cost measures, because of case minimum requirements or the lack of a benchmark	
Facility-Based Quality and Cost Performance Categories	**Measurement**: • Not Applicable	**Measurement:** • For facility-based scoring, the measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians
	Applicability – Individual: • Not Applicable	**Applicability – Individual:** • MIPS eligible clinician furnishes 75 percent or more of their covered professional services in inpatient hospital, on-campus outpatient hospital, as identified by POS code 22, or an emergency room, based on claims for a period prior to the performance period • Clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room
	Applicability – Group: • Not Applicable	**Applicability – Group:** • Facility-based group is one in which 75 percent or more of the MIPS eligible clinician NPIs billing

		under the group's TIN are eligible for facility-based measurement as individuals
	Attribution: • Not Applicable	**Attribution:** • A facility-based clinician is attributed to the hospital at which they provide services to the most Medicare patients • A facility-based group is attributed to the hospital at which a plurality of its facility-based clinicians are attributed • If unable to identify a facility with a VBP score to attribute a clinician's performance, that clinician is not eligible for facility-based measurement and will have to participate in MIPS via other methods
	Election: • Not Applicable	**Election:** • Automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score • No submission requirements for individual clinicians in facility-based measurement but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a group under facility-based measurement
	Benchmarks: • Not Applicable	**Benchmarks:** • Benchmarks for facility-based measurement are those that are adopted under the Hospital VBP

		program of the facility for the year specified
	Assigning MIPS Category Scores: • Not Applicable	**Assigning MIPS Category Scores:** • Both the Quality performance category score and Cost performance category score for facility-based measurement are reached by determining the percentile performance of the facility determined in the VBP program for the specified year and awarding a score associated with that same percentile performance in the MIPS Quality and Cost performance category scores for those clinicians who are not scored using facility-based measurement
	Scoring Improvement: • Not Applicable	**Scoring Improvement:** • Given that improvement is already captured in the distribution of the MIPS performance scores that is used to translate a Hospital VBP Program Total Performance Score into a MIPS Quality performance category score, there is no additional improvement scoring for facility-based measurement for either the Quality or Cost performance category
	Scoring - Special Rules: • Not Applicable	**Scoring - Special Rules:** • Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital IQR Program, or other reasons. In these cases,

		we would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method
Improvement Activities Performance Category	**Weight to final score:** • 15% in Year 2	**Weight to final score**: • 15% in Year 3
	Improvement Activities Inventory: • Initial inventory established based on research, environmental scan and priorities • In Year 2, the Annual Call for submitting Improvement Activities, was established	**Improvement Activities Inventory:** • In Year 3, the timeframe for the Annual Call for Activities and the improvement activities inventory would be modified • Modifications include the addition of one new criteria in this category, "Include a public health emergency as determined by the Secretary," and the removal of, "Activities that may be considered for a Promoting Interoperability bonus" • Adding 6 new Improvement Activities • Modification of 5 existing Improvement Activities • Removal of 1 existing Improvement Activity
	Improvement Activities Inventory Submission Timeline: • Submissions at any time during the performance period to create an Improvement Activities Under Review (IAUR) list; submissions received by March 1st will be considered for inclusion in the following calendar year	**Improvement Activities Inventory Submission Timeline:** • Improvement activity nominations received in Year 3 will be reviewed and considered for possible implementation in Year 5 of the program • The submission timeframe/due dates for nominations would be from February 1st through June 30th, providing approximately 4 additional months to submit nominations
	CMS Study on Burdens: • Study purpose, participation credit and requirements and	**CMS Study on Burdens:** • The CMS study title would be changed to, "CMS Study on

	study procedures updated from Year 1 establishment	Factors Associated with Reporting Quality Measures" ○ The sample size would be increased to 200 MIPS eligible clinicians with focus group requirements for only a subset of study participants • We are also proposing to limit the focus group requirement to a subset of the 200 participants, and require that at least one of the minimum of three required measures be either an outcome or a high priority measure
	Scoring: PI Bonus • Certain improvement activities will qualify for a bonus under the PI performance category	**Scoring: PI Bonus** • In Year 3, the Promoting Interoperability bonus will be removed
Promoting Interoperability (PI) Performance Category	**Weight to final score:** • 25% in Year 2 **Note: Performance category name changed to Promoting Interoperability.**	**Weight to final score:** • 25% in Year 3
	Reweighting: • Reasons to reweight the PI category to 0% include:[2] • Nurse practitioner, physician assistant, clinical nurse specialist, or certified registered nurse anesthetist • Significant hardship (e.g. lack of internet, extreme and uncontrollable circumstances, small practice) • 50% or more of patient encounters occurred in practice locations where no control over the availability of CEHRT	**Reweighting:** • Reweighting of the Promoting Interoperability performance category remains the same as Year 2 and extends to additional clinician types (physical therapists, occupational therapists, clinical social workers, and clinical psychologists)

[2] Automatic extreme and uncontrollable circumstances policy has been proposed for Year 2.

	• Non-patient facing • Hospital-based[3] • ASC-based[4] • Automatic reweighting for extreme and uncontrollable circumstances • even if the category could be reweighted • MIPS eligible clinicians using decertified EHR Technology, exception available for no more than 5 years • For any of the above reasons, if a MIPS eligible clinician reports PI (formerly ACI) measures and objectives, they will be scored like other MIPS eligible clinicians and the PI performance category will not be reweighted to 0%	
	Certification Requirements: • Eligible clinicians may use either the 2014 or 2015 Edition CEHRT or a combination of the two; one-time bonus of 10 percentage points in if using only 2015 Edition CEHRT	**Certification Requirements**: • Eligible clinicians must use 2015 Edition CEHRT in Year 3
	Scoring: • Performance category score is comprised of the base, performance, and bonus score • Clinicians must complete the base score requirements in order to receive a score in the category	**Scoring:** • Eliminating base, performance, and bonus scores • Proposing a new scoring methodology • Performance-based scoring at the individual measure-level. Each measure would be scored based on the MIPS eligible clinician's performance for that

[3] For Hospital-based definition, refer to "Other Special Status Definitions" in *Eligibility and Participation Options* on page 6.
[4] For ASC-based definition, refer to "Other Special Status Definitions" in *Eligibility and Participation Options* on page 6.

		measure based on the submission of a numerator or denominator, or a “yes or no” submission, where applicable • The scores for each of the individual measures would be added together to calculate the score of up to 100 possible points. If exclusions are claimed the points for measures will be reallocated to other measures
	Objectives and Measures • Two measure set options for reporting based on the clinician’s CEHRT edition (either 2014 or 2015).	**Objectives and Measures** • One objectives and measure set 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 • Proposing to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement
Final Score	**General Performance Category Weights in Year 2:** • Quality: 50% • Cost: 10% • PI: 25% • IA: 15% If a MIPS eligible clinician is scored on fewer than two performance categories, a final	**General Performance Category Weights in Year 3:** • Quality: 45% • Cost: 15% • PI: 25% • IA: 15% If a MIPS eligible clinician is scored on fewer than two performance categories, a final score equal to the

	score equal to the performance threshold will be assigned and the MIPS eligible clinician will receive an adjustment of 0%	performance threshold will be assigned and the MIPS eligible clinician will receive a payment adjustment of 0%
	Small Practice Bonus: • A bonus of 5 points is added to the final score for MIPS eligible clinicians, groups, virtual groups and APM Entities that meet the definition of small practice and submit data on at least one performance category in the 2018 performance period	**Small Practice Bonus:** • The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation • Add 3 points in the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure
MIPS Payment Adjustments	**Application of Payment Adjustment to Medicare Paid Amount:** • Finalized that for each MIPS payment year, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician during the year • However, the Balanced Budget Act of 2018 changed this so that the MIPS adjustment factors will apply to 'covered professional services' under the physician fee schedule beginning with the 2019 payment year • Finalized application of the payment adjustment to the Medicare paid amount	**Application of Payment Adjustment to Medicare Paid Amount:** • Same as Year 2

	Final Score/2020 payment adjustment:
	• For individual eligible clinicians, we will use the final score associated with the TIN/NPI used during the performance period
	• For groups submitting data using the TIN identifier, we will apply the group final score to all the TIN/NPI combinations that bill under the TIN during the performance period
	• For eligible clinicians in a MIPS APM, we will assign the APM Entity group's final score to all APM Entity Participant National Provider Identifiers associated with the APM Entity
	• For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, we will determine a final score using either the individual or group data submissions
	• If a MIPS eligible clinician is not in an APM Entity and is in a virtual group, the MIPS eligible clinician would receive the virtual group final score over any other final score
		Final Score/2021 payment adjustment:
		• Remains the same as Year 2, with one change. MIPS eligible clinicians in a group practice who qualify for a group final score will have a modified determination period to include:
		  ○ 15-month window that starts with the second 12-month determination period (October 1 prior to the MIPS performance period through September of the current MIPS performance period)
		• Proposed policy to assign a weight of 0% to each of the four performance categories and a final score equal to the performance threshold when:
		  ○ MIPS eligible clinician joins an existing practice (TIN) in the final three months of the performance period year and the practice is not participating in MIPS as a group
		  ○ MIPS eligible clinician joins a practice that is a newly formed TIN in the final three months of the performance period year

Performance Threshold / Payment Adjustment	• Performance Threshold is set at 15 points • Additional performance threshold set at 70 points for exceptional performance • MIPS eligible clinicians receive a payment adjustment and, if applicable, an additional payment adjustment, determined by comparing final	• Performance Threshold is set at 30 points • Additional performance threshold set at 80 points for exceptional performance • As required by statute, the maximum negative payment adjustment is -7 percent. Positive payment adjustments can be up to 7% (but they are multiplied by

	score to performance threshold and additional performance threshold • A final score at or above the performance threshold receive a zero or positive payment adjustment and a score below the performance threshold receive a negative adjustment • As required by statute, the maximum negative payment adjustment is -5 percent positive payment adjustments can be up to 5% (but they are multiplied by a scaling factor to achieve budget neutrality). • The additional payment adjustments for exceptional performance starts at 0.5% and goes up to 10% x scaling factor not to exceed 1	a scaling factor to achieve budget neutrality) • The additional payment adjustment for exceptional performance shall be applied in the same way as in 2018 for scores at or above the additional performance threshold
Public Reporting via Physician Compare		
Policy Area	**Current Year 2 (Final Rule CY 2018)**	**Year 3 (Proposed Rule CY 2019)**
Public Reporting on Physician Compare	• All measures under the MIPS Quality performance category are available for public reporting if they meet the public reporting standards and prove meaningful to users in testing • Codified that no first year quality measures are available for public reporting	Remains the same in Year 3 with the following change: • First year quality measures would not be publicly reported for the first 2 years in use in the Quality performance category, starting with performance year 2
	Public Reporting of Cost Measures: • A subset of Cost measures is available for public reporting.	**Public Reporting of Cost Measures:** • Remains the same in Year 3 except that first year Cost measures would not be publicly reported for the first 2 years a measure is in use in the Cost performance category

	Indicator for Promoting Interoperability: • Include an indicator on Physician Compare for any eligible clinician or group with "high" or "successful" performance under the Promoting Interoperability performance category • Include additional information, such as objectives, activities, or measures • Make first year objectives, activities, and measures available for public reporting, as appropriate • No longer include an indicator for "low" performance starting in Year 2	**Indicator for Promoting Interoperability:** Remains the same in Year 3 with the following change: • Propose to include only an indicator for "successful" performance starting with Year 3
	Benchmark Methodology: • Use the Achievable Benchmark of Care (ABC™) methodology to determine a benchmark for the Quality, Cost, Improvement Activities, and Promoting Interoperability data, as feasible and appropriate, by measure and by collection type • Use this benchmark as the basis of a 5-star rating for each available measure, as feasible and appropriate	**Benchmark Methodology:** Remains the same in Year 3 with the following changes: • Use the ABC™ methodology to determine benchmarks based on historical data by measure and collection type using a baseline period of the 12-month calendar year that is 2 years prior to the applicable performance period, or, if such data is not available, performance data from the performance period, beginning with Year 3 • Extend use of the ABC™ methodology and equal ranges method to determine, by measure and collection type, a benchmark and 5-star rating for Qualified Clinician Data Registry (QCDR) measures using the current performance period data

		in Year 2 of the Quality Payment Program, and use historical benchmark data when possible, beginning with Year 3
APM Policies		
Policy Area	**Current Year 2 (Final Rule CY 2018)**	**Year 3 (Proposed Rule CY 2019)**
APMs: Advanced APMs Minimum CEHRT Use Threshold	• In general, to qualify as an Advanced APM (across both Medicare and other payers), a payment arrangement must satisfy the criterion of requiring that at least 50 percent of the eligible clinicians in each APM entity use CEHRT	• We are increasing the CEHRT use criterion threshold for Advanced APMs so that an Advanced APM must require at least 75 percent of eligible clinicians in each APM Entity use CEHRT document and communicate clinical care with patients and other health care professionals
APMs: MIPS Comparable Measures	• We previously established in the Advanced APM criteria that the quality measures upon which an Advanced APM bases payment must be reliable, evidence-based, and valid. We indicated that a determination as to whether a measure is reliable, evidence-based, and valid could be made based on several criteria: whether the measure is (1) on the MIPS final list, (2) endorsed by a consensus-based entity (NQF), (3) submitted in the annual call for quality measures, (4) developed using QPP Measure Development funds, or (5) otherwise determined by CMS to be reliable, evidence-based, and valid	• We are amending the Advanced APM quality criteria to state that at least one of the quality measures upon which an Advanced APM bases payment must be (1) on the MIPS final list, (2) endorsed by a consensus-based entity, or (3) otherwise determined to be evidence-based, reliable, and valid by CMS to be considered MIPS comparable, beginning in 2020 for both Advanced APMs and Other Payer Advanced APMs
APMs: Outcome Measures	• In 2017 Rule, we established that the quality measures upon which an Advanced APM	• We are amending the Advanced APM quality criterion to require that the outcome measure used

	bases payment must include at least one outcome measure unless CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APM's QP Performance Period	must be (1) on the MIPS final list, (2) endorsed by a consensus-based entity, or (3) otherwise determined to be evidence-based, reliable, and valid by CMS effective in 2020 for both Advanced APMs Other Payer Advanced APMs.
APMs: Revenue-Based Nominal Amount Standard	• For performance years 2019 and 2020, we maintained the revenue-based nominal amount standard at 8% of the average estimated Parts A and B revenue of providers in participating APM Entities	• We are maintaining the revenue-based nominal amount standard for Advanced APMs at 8 percent through performance year 2024
APMs: Payer-Initiated Process for Remaining Other Payers	• We established a process to allow select payers – including Medicaid, Medicare Advantage plans, and participants in multi-payer CMMI models – to submit payment arrangements for consideration as Other Payer Advanced APMs, starting in 2018 (for the 2019 All-Payer QP Performance Period). In the 2018 rule, we also finalized our intent to allow remaining other payers (i.e., those not incorporated in the process for 2019), including commercial and other private payers, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 (for the 2020 All-Payer QP Performance Period) and annually each year thereafter	• We are implementing the previously finalized policy and allowing all payer types to be included in the 2019 Payer Initiated Process for the 2020 QP Performance Period. Moving forward with the policy in the current rule will offer additional flexibilities for payers and reduce burdens for eligible clinicians
APMs: Addition of TIN Level All-Payer QP	• We previously finalized to conduct All-Payer QP determinations at the individual eligible clinician level	• Beginning in 2019, we will allow for QP determinations under the All-Payer Option to be requested at the TIN level in addition to the APM Entity and individual eligible

determinations		clinician levels. This was a change made as a result of public comment and subsequent listening sessions with the payer community about how contracting is executed in the commercial, non-Medicare space
APMs: Multi-Year Other Payer Advanced APM Determinations	• We previously finalized that payers and eligible clinicians with payment arrangements determined to be Other Payer Advanced APM to re-submit all information for CMS review and redetermination on an annual basis	• We are maintaining annual submissions, but streamlining the process for multi-year arrangements such that when initial submissions are made, the payer and/or eligible clinician would provide information on the length of the agreement, and attest at the outset that they would submit for redetermination if they payment arrangement underwent any changes during its duration. In subsequent years, if there were no changes to the payment arrangement, the payer and/or eligible clinician would not have to annually attest there were no changes to the payment arrangement
APMs: Addition of a Revenue-Based Nominal Amount Standard	• We established a revenue-based nominal amount standard for Other Payer Advanced APMs parallel to the revenue-based nominal amount standard for Advanced APMs. Specifically, we finalized that another payer arrangement would meet the revenue-based nominal amount standard for performance years 2019 and 2020 if risk is: at least 8% of the total combined revenues from the payer of providers and suppliers in participating APM Entities	• We are maintaining the revenue-based nominal amount standard for Other Payer Advanced APMs at 8 percent through performance year 2024

APMs: Other Payer Advanced APMs Minimum CEHRT Use Threshold	• In general, to qualify as an Advanced APM (across both Medicare and other payers), a payment arrangement must satisfy the criterion of requiring that at least 50 percent of the eligible clinicians in each APM entity use CEHRT	• We are increasing the CEHRT use criterion threshold for Other Payer Advanced APMs so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75 percent
APMs: Use of CEHRT criterion for Other Payer Advanced APMs	• We previously finalized that we would presume that another payer arrangement would satisfy the 50 percent CEHRT use criterion if we receive information and documentation from the eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinician information	• We are modifying the CEHRT use criterion for Other Payer Advanced APMs to allow either payers or eligible clinicians to submit evidence that demonstrates CEHRT is actually used at the required threshold level rather than it be a requirement of Other Payer Advanced APMs
APMs: Revising the MIPS APM criteria	• Currently, one of the MIPS APM criteria is that an APM "bases payment on cost/utilization and quality measures." We did not intend to limit an APM's ability to meet the cost/utilization part of this criterion solely by having a cost/utilization measure.	• We are reordering the wording of this criterion to state that the APM "bases payment on quality measures and cost/utilization." This would clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure.