

Physician Fee Schedule Proposed Rule for 2020

Summary Part II: Updates to the Quality Payment Program (Section III.K of CMS-1715-P)

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2020¹ and other revisions to Medicare Part B policies. The proposed rule is scheduled to be published in the August 14, 2019 issue of the *Federal Register*. If finalized, policies in the proposed rule generally would take effect on January 1, 2020. The addenda to the proposed rule along with other supporting documents are only available through the Internet at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>. **The 60-day comment period ends at close of business on September 27, 2019.²**

This summary is provided in two parts. Part II summarizes section III.K of the proposed rule: Updates to the Quality Payment Program. Previously covered in Part I were sections I through III.J. of the rule, including payment policies under the PFS; Medicare Shared Savings Program requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; establishment of an Ambulance Data Collection System; Medicare enrollment of Opioid Treatment Programs and enhancements to provider enrollment regulations concerning improper prescribing and patient harm; and amendments to Physician Self-Referral Law Advisory Opinion Regulations.

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¹ Henceforth in this document, a year is a calendar year unless otherwise indicated.

² CMS invites comments generally on all of the proposed changes to the Quality Payment Program including the alternatives considered. More specific comment requests are highlighted in the relevant sections of this summary.

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III. Other Provisions of the Proposed Rule

K. CY 2020 Updates to the Quality Payment Program

1. Introduction and Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for updates to the Physician Fee Schedule (PFS), and established the Quality Payment Program (QPP) as a pathway to move physicians from volume-driven to value-based care for Medicare beneficiaries. The evolution of Medicare's payments to physicians and the foundations of the QPP are described in the QPP Year 1 (2017) proposed rule (81 FR 28167-28169). Key features of the QPP are as follows:

- Two participant tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs);³
- Payment adjustments for MIPS-eligible clinicians based on their reported data for four performance categories: Quality, Cost, Improvement Activities (IA) and Promoting Interoperability (PI), adjustments increase in size over time per statute until stabilizing at ± 9 percent in 2022;
- Through 2024, lump sum (“bonus”) APM incentive payments to clinicians whose participation in Advanced APMs exceeds pre-set thresholds that increase over time per statute (“APM Qualifying Participants” or QPs)
 - Also per statute, the bonus is to be replaced in 2026 by a higher annual PFS update percentage for QPs than non-QPs (0.75 vs. 0.25 percent, respectively);
- Two-year lag between each *performance* year and corresponding *payment* year; and
- QPP annual updates that are implemented as part of the PFS rulemaking process.

³QPP participants currently include the following practitioner types: physician (as defined in section 1861(r) of the Act), physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), physical therapist, occupational therapist, clinical psychologist, qualified speech-language pathologists, qualified audiologists, and registered dieticians and nutrition professionals.

CY 2019 is the QPP's first payment year: MIPS payment adjustments are being applied, and APM incentive payments are being made to eligible clinicians based upon their QPP Year 1 (2017) performance period data. MIPS adjustments (based on 2017 data) range from -4 to +4 percent and are being applied to payments made for covered Part B professional services furnished during 2019. Some clinicians who met a separately-specified threshold also are receiving an additional positive adjustment in payment year 2019 for exceptional 2017 performances.⁴ The MIPS adjustment percentage will continue to increase annually, reaching -9 to +9 percent for payment year 2022, and the exceptional performance bonus will continue. The 2019 APM incentive payment is set at 5 percent of a QP's covered Part B professional services furnished during 2018, and will remain at percent through payment year 2024.

Based on 2020 performance, 2022 payments to clinicians participating in MIPS will be adjusted over a range of -5 to +5 percent MIPS-eligible clinicians during the 2020 performance period, and another 385,000 clinicians will be potentially MIPS-eligible but not required to participate. CMS further estimates that about 280,000 clinicians will be excluded from MIPS participation because they meet all 3 low-volume threshold criteria or for other reasons (e.g., newly-enrolled in Medicare, having reached QP status).

Budget neutrality is required within the QPP by statute. CMS estimates that positive and negative payment adjustments distributed in payment year 2022 will each total \$584 million. As in prior QPP years, an additional \$500 million will be available for distribution for exceptional performance. CMS estimates that the maximum possible positive payment adjustment attainable for payment year 2022 will be 5.8 percent combined from the MIPS base adjustment and the adjustment for exceptional performance. Finally, CMS estimates that between 175,000 and 225,000 clinicians will meet thresholds to become QPs, resulting in total lump sum APM incentive payments of \$500-600 million for the 2022 QPP payment year. The APM bonus remains at 5 percent and will be applied to a QP's covered Part B professional services furnished during 2021.

2. Key Proposals for QPP Year 4

Changes to the QPP for 2020 are proposed in Section III.K of the PFS rule. CMS identifies the following as major proposals, all of which are discussed further in subsequent sections of this summary:

- Applying a new MIPS Value Pathways framework to the QPP beginning with the 2021 performance year (QPP Year 5);
- For the MIPS Quality performance category, strengthening the Qualified Clinical Data Registry (QCDR) measure standards beginning with 2020 by requiring measure testing, harmonization, and clinician feedback;
- For the MIPS Cost performance category, adding eight new evidence-based cost measures and retaining but revising the Total Per Capita Cost of Care (TPCC) and Medicare Spending Per Beneficiary measures (MSPB);

⁴ The “exceptional” threshold is determined annually. The adjustment starts at 0.5 percent, increases on a linear sliding scale to a maximum of 10 percent, and is subject to a scaling factor to maintain budget neutrality.

- Under the All Payer APM Combination Option of the APM incentive pathway, newly defining an Aligned Other Payer Medical Home Model, to which the Medicaid medical home model financial risk and nominal amount standards would be applied when making Other Payer Advanced APM status determinations; and
- Under the All Payer APM Combination Option of the APM incentive pathway, modifying the definition of marginal risk rate so that the average marginal risk rate would be used when making Other Payer Advanced APM status determinations.

The MIPS category weights reflect parameters set in statute, within which the Secretary may make certain adjustments. The category weights finalized for QPP Year 3 and proposed for Year 4 are shown below.

Performance Category	2019 MIPS Performance Year QPP Year 3	2020 MIPS Performance Year QPP Year 4
Quality	45%	40%
Cost	15%	20%
Improvement Activities (IA)	15%	15%
Promoting Interoperability (PI)	25%	25%

3. MIPS Program Details

a. MIPS Value Pathways

(1) Overview

CMS proposes to apply a new MIPS Value Pathways (MVP) framework to future QPP proposals beginning with those for the 2021 MIPS performance period. CMS notes that having previously emphasized flexibility in MIPS has inadvertently produced a complex program that is failing to yield the robust practitioner performance information needed to move more quickly towards value-based care. CMS states that standardization gained through applying the MVP framework would enhance accountability across the wide range of existing clinical practice sizes, specialties, and composition.

CMS proposes to define a MIPS Value Pathway (§414.1305) as a subset of measures and activities specified by CMS. CMS notes that all pathways would share key features:

- Connecting measures and activities across the 4 MIPS performance categories and aligning them to specific clinical conditions and/or the practitioners who treat them;
- Incorporating an administrative claims-based quality measure set focusing on population health as a base requirement for each pathway;
- Providing actionable data and feedback to clinicians (e.g., outlier analysis); and
- Enhancing information provided to patients including at the individual clinician level (e.g., patient reported outcome measures or PROMs, experience of care survey scores).⁵

⁵ Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program in which a suite of

(2) Request for Information MIPS Value Pathways

CMS requests public input on all aspects of the MVP framework, and particularly encourages commenters, when formulating their input, to include their reactions to the examples of potential MVPs provided in Table 34 of the rule. Illustrative portions of the table are reproduced below. The two draft MVPs in the modified table are also presented in graphic form, as the Diabetes and Major Surgery MVP Examples, in a zip file available at <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/587/MIPS%20Value%20Pathways%20Diagrams.zip>.

In sections III.K.3.a.(3) through (6) of the rule, CMS poses numerous conceptual and operational questions about the MVP framework. The questions may be grouped into several major areas, listed below.

- Constructing MVPs: approaches, definitions, development, and specifications (e.g., how best to engage stakeholders in MVP development);
- Selecting measures and activities for MVPs (e.g., criteria for measure and activity inclusion, limiting the number of available quality measures per pathway);
- Determining MVP assignment to clinicians and groups (e.g., by specialty as listed in PECOS);
- Transitioning to MVPs (e.g., proposing a timeline consistent with practice-level operational considerations);
- Adjusting MVPs for Practice Characteristics (e.g., small, rural, multispecialty);
- Incorporating QCDR measures into MVPs (e.g., reliability);
- Adjusting current scoring policies to account for MVP adoption (elimination bonuses);
- Identifying appropriate administrative-based claims measures to address population-health (e.g., unplanned readmissions for patients with multiple chronic conditions); and
- Determining MVP performance information for public reporting (e.g., value indicator)

Of particular note, CMS indicates that stakeholders continue to request a group option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed and scored based on the subgroup's performance. CMS has not developed a MIPS subgroup option thus far due to operational challenges and concern about providing potential gaming opportunities by creating subgroups comprised of only the group's high- performing clinicians. CMS invites comment about whether the MVP approach could provide an alternative to subgroup reporting. CMS suggests that multispecialty groups potentially would report at the group level on multiple MVPs that would be assigned or selected as directed by future rulemaking. Subgroups of clinicians might choose to participate under one or more of the group's MVPs. Depending on how the MVPs then are combined and scored at the group level, the need for groups to create sub-TIN-level identifiers and apply eligibility criteria at the sub-TIN level might be eliminated.

surveys, usually defined by type of care or site of service, focus on aspects of quality that consumers are best qualified to assess (e.g., provider communication skills).

TABLE 34: Examples of Possible MIPS Value Pathways

MVP Example	Quality Measures	Cost Measures	Improvement Activities	PI Measures
Diabetes Prevention and Treatment	Hemoglobin A1c (HbA1c) Poor Care Control (>9%) (ID: 001) Diabetes Medical Attention for Nephropathy (ID: 119) Evaluation Controlling High Blood Pressure (ID: 236) PLUS Population health administrative claims quality measures	Total Per Capita Cost (TPCC_1) Medicare Spending Per Beneficiary (MSPB_1)	Glycemic Management Services (IA_PM_4) Chronic Care and Preventive Care Management for Empaneled Patients (IA_PM_13)	All measures in Promoting Interoperability
Major Surgery	Unplanned Reoperation within the 30-day postoperative period Surgical Site Infections (SSI) (ID: 357) Patient-Centered Surgical Risk Assessment and Communication (ID: 358) PLUS Population health administrative claims quality measures	Medicare Spending Per Beneficiary (MSPB_1) Revascularization for Lower Extremity Critical Chronic Limb Ischemia (COST_CCLI_1) Knee Arthroplasty (COST_KA_1)	Use of patient safety tools Implementing use of specialist reports back to referring physician or group to close referral loop (IA_CC_) or Completion accredited Safety or Quality Improvement Program (IA_PSPA_28)	All measures in Promoting Interoperability

b. Group Reporting

Both the MIPS and APM Incentive pathways of the QPP have specific provisions governing reporting of performance data by clinicians aggregated to various levels, including individual practitioner, group practice, or APM model participant entity. CMS proposes two technical changes to the regulations applicable to group reporting. The first change would delete duplicative language by removing §414.1310(e)(3) through (5) and retaining §414.1310(e)(2)(ii) through (iv). Both sets of requirements provide that in order to report as a group under MIPS, the group's clinicians must aggregate their performance data across the TIN, be assessed as a group across all four MIPS performance categories, and adhere to any established CMS process for electing to report as a group. The second change would align existing regulations for group and virtual group reporting under MIPS in general with PI performance category reporting requirements. CMS proposes to do so by revising §414.1310(e)(2)(ii) and §414.1315(d)(2) to each state that groups or virtual groups, respectively, would be required for PI category scoring to aggregate the PI data of all of the clinicians in the group's TIN for whom the group has data in CEHRT.

c. MIPS Performance Category Measures and Activities

(1) Quality Performance Category (§414.1330 through §414.1340)

(a) Measure Selection and Changes to Measures for the 2020 Performance Period

CMS calls attention to Appendix 1 of the rule that contains the groups of MIPS measures with proposed changes for performance year 2020 (unless otherwise noted) and future years:

- The 4 new quality measures proposed for inclusion are found in Table Group A.
 - International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
 - Multimodal Pain Management
 - Adult Immunization Status
 - Functional Status Change for Patients with Neck Impairments.
- One new quality measure proposed for addition for the 2021 MIPS performance year and future years is found in Table Group AA.
 - All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions.
- The modifications to numerous existing specialty sets and 7 new specialty sets are found in Table Group B.
- The 55 previously finalized quality measures now proposed for removal are found in Table Group C.
- The 78 previously finalized quality measures with substantive changes now proposed are found in Table Group D.
- One previously finalized quality measure with substantive changes proposed for the 2019 MIPS payment year and future years is found in Table Group DD.
 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

CMS makes observations about selected measures from the Tables in the preamble, highlighted below.

Measure Addition for 2021 Performance Period

CMS proposes to add the claims-based measure titled All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions beginning with the 2021 performance period. CMS considers this a population-health measure that if finalized would be available for use in the MVPs planned for implementation in 2021. Delaying adoption of this measure for a year would allow time for its consideration by the MAP as well as further development by CMS of the global/population health measure set envisioned for the MVPs.

Measure Changes for Web Interface Reporters

CMS proposes to add one measure (Adult Immunization Status) and to remove one (Influenza Immunization) from the CMS Web Interface inventory MIPS-eligible clinicians who report quality data through the CMS Web Interface. If finalized, the new measure would be pay-for-reporting for all ACOs for years (2020 and 2021) and phase into pay-for-performance beginning in performance year 2022. (Details of Web Interface reporting for MSSP ACOs are addressed previously in the rule in section III.E. and in Part I of this summary.)

Specialty Measure Set Changes

Seven new specialty measure sets are proposed for addition: Endocrinology, Nutrition/Dietician, Pulmonology, Chiropractic Medicine, Clinical Social Work, Audiology, and Speech Language Pathology. Several sets recognize the expansion of MIPS-eligible practitioner types for the 2019 performance period (e.g., Speech-Language Pathology). **Clinical social workers have not yet been added as MIPS-eligible clinicians and CMS specifically invites comments on this set.**

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

CMS heard from stakeholders that the 2018 CMS Web Interface measure numerator guidance for this measure is inconsistent with the intent of the CMS Web Interface version of this measure as modified for the 2018 performance year (82 FR 54164) and is unduly burdensome. CMS notes that the numerator discordance precludes historical benchmarking for the measure. CMS will exclude the Web Interface version of this measure from MIPS eligible clinicians' quality scores for the 2018 performance period (i.e., it will be treated as pay-for-reporting). For performance year 2019, CMS proposes to update the numerator guidance as shown in Table Group DD. While this is a scoring change made after the start of the performance period, CMS believes that not to make the change would be contrary to the public interest. CMS expects being able to benchmark and score the CMS Web Interface version of this measure (pay-for-performance) for the 2019 MIPS performance period and subsequent years if the new numerator is finalized.

(b) Other Quality Performance Category Issues

Final Score Contribution

The Bipartisan Budget Act of 2018 provided that corresponding adjustments be made to the Quality and Cost performance categories for payment years 2022-2024 so that their combined

total scoring weight equals 60 percent. Accordingly, CMS proposes to weight the Quality category at 40, 35, and 30 percent for payment years 2022, 2023, and 2024, respectively.

Data Completeness Criteria

CMS previously has stated plans for continuing to raise the data completion threshold for satisfactory quality measure submission. The threshold was increased from 50 percent in 2018 to 60 percent for performance period 2019. CMS analyzed data completeness rates for MIPS-eligible individual clinicians, groups, and small practices during performance period 2017 and found the rates to range from 75 percent for small practices to 85 percent for groups, shown below in Table 35, reproduced below from the rule. CMS uses this analysis in support of proposing to further increase the data completeness threshold to 70 percent for the 2020 performance period. The increased threshold would apply to claims-based measures, QCDR measures, MIPS clinical quality measures (CQMs), and electronic CQMs. **CMS also considered raising the threshold to 80 percent for 2020 and invites comment on this alternative.**

TABLE 35: CY 2017 Data Completeness Rates for MIPS Individual Eligible Clinicians, Groups, and Small Practices

Average data completeness rate- Individual Eligible Clinician	Average data completeness rate- Groups	Average data completeness rate- Small Practices
76.14	85.27	74.76

Selective Data Submission

Using selection criteria to present clinician performance data in a more favorable light than complete data reporting would support is referred to as “cherry picking”. CMS has concluded based upon queries received that misunderstanding may exist about data reporting obligations for clinicians. CMS emphasizes that all MIPS data submitted by or on behalf of a MIPS eligible clinician, group, or virtual group must be certified as true, accurate and complete (see §§414.1390(b) and 414.1400(a)(5)). CMS proposes to enhance the clarity of complete, accurate data submission by adding §414.1340(d), which would state that unrepresentative data would not meet the true, accurate and complete data requirement.

Preparation for MVPs

CMS has previously outlined criteria to guide anyone interested in submitting new quality measures for potential inclusion in MIPS: for example, measures that have completed reliability, feasibility, and validity testing and that are outcomes-based ((82 FR 53636). CMS continues to encourage new measure submitters to electronically specify their measures as eCQMs. As part of preparing for MVP implementation in 2921, CMS proposes that MIPS quality measure stewards would be required to link their MIPS quality measures to existing and related cost measures and Improvement Activities (IAs) whenever feasible and applicable. **CMS invites comment on this new requirement that would take effect with the 2020 Call for Measures.**

Measure removal criteria

CMS has previously established criteria for MIPS quality measure removal (83 FR 59763) and proposes to add 2 more for 2020. First, CMS proposes to remove measures that have not met case minimum and reporting volumes required for benchmarking after having been in the measure inventory for 2 consecutive CY performance periods. CMS states its belief that low reporting may be a marker for failure to provide meaningful measurement to clinicians. CMS would reserve the ability to retain a low-reported measure if review identified a suitable rationale. CMS also proposes to remove any MIPS quality measure if it is not available for reporting, such as when a measure steward restricts access to the measure by QCDRs. Measures that are not universally available are less likely to achieve sufficient usage volumes to allow for robust benchmarking. Relatedly, **CMS invites comment on a 1-year delay of removal of any of the measures proposed for removal for 2020.**

Topped out measures

CMS previously established a 4-year timeline for topped out measure identification that may end with proposed measure removal from the MIPS inventory (82 FR 53637 through 53640). The MIPS Quality Benchmarks file contains measures that have advanced along the 4-year timeline.⁶ While extremely topped out measures are eligible for removal in the next rulemaking cycle, CMS instead may choose to retain them for compelling reasons, such as limited availability of other measures for a particular specialty, a situation that now exists for 4 of 5 measures in the Pathology specialty measure set. **CMS invites comment about raising the data completeness threshold for retained extremely topped out measures and about alternative approaches to manage such measures.** CMS notes that selective data submission (described above) could incorrectly cause measures to appear to be topped out or extremely topped out.

Measure update process alignment

Currently, the update cycle for MIPS quality measures and the eCQM annual update process are separate, and CMS discusses but does not propose alignment. Alignment would require that CMS collect measure specifications earlier in the year for its annual measure review, potentially prior to NQF endorsement decisions being made and/or the release of new clinical guideline versions. **CMS invites comment about whether to pursue alignment of the two updates.**

CAHPS for MIPS survey modifications

CMS invites comment about adding narrative reviews by patients of clinicians to the survey at both the group and individual clinical levels. CMS states that the Physician Compare website's user testing group has repeatedly requested that CMS collect this type of information and make it publicly available. CMS also explores whether the 7 domains for measuring federal government customer experience could be applicable to measuring patient experience of care: overall satisfaction, confidence/trust, quality of service, ease and simplicity of processes, efficiency/speed, equity/transparency, and employee helpfulness.⁷ CMS asks whether adding a narrative about a recent encounter with an individual clinician would be helpful to patients in choosing a clinician and, if so, how such information would best be

⁶ Available at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>.

⁷ The domains are fully described in Office of Management and Budget Circular No. A-11, available at <https://www.whitehouse.gov/wp-content/uploads/2018/06/s280.pdf>.

collected. CMS envisions building upon the Narrative Elicitation Protocol work done by AHRQ and would develop additional items and test implementation processes at CMS.⁸

RFI Potential Opioid Overuse Measure

CMS has developed and field tested an eCQM titled Potential Opioid Overuse to capture the extent of long-term, high-dose opioid prescribing. Testing supported the feasibility, reliability, validity, and usability of the measure, but EHR vendors have raised implementation concerns for reasons including that some of the measure's data elements are inconsistently captured during typical clinical workflows. To salvage this potentially important measure, **CMS invites comment from technical implementers on multiple questions about the measure, detailed in section III.K.3.c.(1) of the rule, such as how best to manage the embedded dosing calculations.**

(2) Cost Performance Category (§414.1350)

(a) Final Score Contribution

As noted above, the Bipartisan Budget Act of 2018 provided that corresponding adjustments be made to the Quality and Cost performance categories for payment years 2022-2024 so that their combined total scoring weight equals 60 percent. Accordingly, CMS proposes to weight the Cost category at 20, 25, and 30 percent for payment years 2022, 2023, and 2024 (and subsequent years), respectively. CMS states its belief that this steady but gradual and predictable series of increases would allow clinicians to adequately prepare for the final 30 percent weight while gaining experience with new and revised cost measures. CMS considered maintaining the current 15 percent weight for payment years 2022-2023 but expresses concern about the more abrupt increase to 30 percent that then would be required for 2024 to be statutorily compliant. **CMS invites comments concerning alternative Cost performance category weights.**

(b) Attribution: General Aspects

CMS considers attribution is a fundamental element of cost-based measures. Attribution helps to ensure that all costs are in fact captured as defined by the measure, but also that assignments of costs are made only to those clinicians who can meaningfully influence those costs and thereby should be held accountable. During past rulemaking, CMS has both reviewed attribution methodology in the preamble and included it in the regulatory text for each measure. Beginning with the current rulemaking cycle (for the 2020 performance period), CMS proposes instead to include the attribution methodology with the measure specifications.⁹ CMS considers advantages of this approach to be: 1) reducing complexity since all specifications would be in a single place; 2) facilitate making non-substantive changes (e.g., updated diagnosis codes) outside of rulemaking;¹⁰ and 3) align with the approach used for Quality performance category measures.

⁸ More information is available at <https://www.ahrq.gov/cahps/surveysguidance/cg/index.html>.

⁹ Specifications are publicly available at <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-basedprograms/macra-mips-and-apms/macra-feedback.html> during the public comment period for the proposed rule, and become available in final form at <https://qpp.cms.gov/about/resource-library> after the final rule is published.

¹⁰ CMS follows the standard pre-rulemaking process for new measures when proposing substantive changes to measures owned and developed by CMS, including resubmission to the Measures Under Consideration (MUC) list

CMS further notes that identifying the level of attribution (i.e., TIN/NPI or TIN) is most appropriately included in each cost measure's specifications, and proposes a policy similar to that proposed for attribution methodology. Beginning with the current rulemaking cycle, CMS proposes to include the level of attribution in measure specifications; information about attribution level would thereby be publicly available along with attribution methodology. CMS states that by so doing, the attribution methodology and level would more clearly align with whether the reporting clinicians are submitting as groups or individuals.

(c) Evidence-Based Cost Measures

An episode is a specific instance of an episode group for a specific patient and clinician. An episode group represents a clinically cohesive set of medical services rendered to treat a given medical condition; aggregates all items and services provided for a defined patient cohort to assess the total cost of care; and are defined around treatment for a condition (acute or chronic) or performance of a procedure. The episode group includes diagnostic and treatment-related items and services used acutely and may include after-care, such as items and services used to treat complications. Specific items and services are assigned to each episode group. CMS applies payment standardization rules and risk adjustment when determining the costs of the included items and services.

CMS reprises key elements of the episode-based cost measure development process as implemented by the Agency's contractor.¹¹ These include:

- Identification of priority areas for measure development by CMS, the contractor, and the public;
- A Technical Expert Panel (TEP) that provides process and methodologic guidance;
- Clinical subcommittees that work with the contractor to develop the specifications of the measures;
- A Person and Family Committee composed of patients, family members, and caregivers that provides input on prioritizing measures to be developed and on specifications;
- Field-testing of potential measures and analysis of results by the contractor with opportunities for public comment during and after field-testing;
- Measure refinement by the clinical subcommittees based on field-test results; and
- Final review and refinement of new measures by the TEP and formulation of recommendations to CMS about measure implementation.

For performance period 2020 and subsequent years, CMS proposes to add 10 new episode-based cost measures that were successfully field-tested in 2018 and reviewed by the MAP, listed in Table 37, reproduced below from the rule. Detailed measure specifications (e.g., assigned items and services, episode triggers) are available at

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-revised-ebcm-measure-specs.zip>.

and reconsideration by the MAP. Non-substantive changes are addressed by CMS on a case-by-case basis.

¹¹ Details of the process are available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-measure-development-process.pdf>.

TABLE 37: Episode-Based Measures Proposed for the 2020 Performance Period and Future Performance Periods

Measure Topic	Episode Measure Type
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Elective Primary Hip Arthroplasty	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition
Lower Gastrointestinal Hemorrhage*	Acute inpatient medical condition
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural

*Proposed for group use only in section III.K.3.c.(2)(b)(vi)(B) of the rule

(d) Operational List Revisions

The Act requires the Secretary to develop and maintain an operational list of care episode and patient condition groups, and classification codes for such groups, with a target that over time the episodes and groups will account for increasing amounts of Parts A and B expenditures. In January 2018, after extensive stakeholder input, CMS posted its first operational list, consisting of 8 care episode groups and patient condition groups, along with the codes and logic used to define the episode groups. These initial episode and condition groups served as the foundation for CMS' 8 new episode-based cost measures, finalized for use in performance year 2019.

CMS reviews the list annually and no revisions were required during the 2019 rulemaking cycle. CMS proposes to revise the operational list beginning in 2020, adding 10 new care episode and patient condition groups that serve as the basis for the 10 new episode-based cost measures proposed for performance year 2020 and subsequent years. Details are available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html>.

(e) Measure Revision: Total Per Capita Cost of Care (TPCC)

TPCC is an administrative claims-based cost measure that was used in the Physician Value Modifier Program, one of the legacy CMS initiatives that preceded the QPP. TPCC was finalized by CMS as one of the two cost measures identified for use in QPP Year 1 and it has been utilized again in each subsequent QPP year. CMS undertook reevaluation of TPCC as part of routine measure maintenance, during which stakeholders raised several areas of concern:

- Flawed attribution methodology assigns costs to clinicians over which they have no influence;
- Methodology incompletely and/or inaccurately identifies primary care clinician-patient relationships, resulting in incorrect attribution of primary care services to other clinicians;

- Attribution of costs by the measure to a single clinician or group is counterproductive to shared accountability by all of a patient’s treating physicians and could encourage fragmentation of care; and
- Measuring beneficiary risk factors at least one year before the start of the performance period may not capture more recent, serious comorbidities, leading to inaccurate risk-adjustment and underestimation of expected costs for the performance period.

CMS initiated the process for measure revision and TPCC was sent to the TEP that guides the cost-measure development process, after which a revised measure was field-tested in 2018. Informed by input from the TEP and stakeholders as well as the field-testing results, CMS now proposes to begin using the revised measure beginning with performance period 2020. CMS discusses the proposed revisions at length (see section III.K.3.c.(2)(iv) of the rule), emphasizing the following changes:¹²

- (i) Improving the identification of primary care clinician-patient relationships by using a combination of services over a short time interval that signify the start of a relationship (e.g., office visit plus an electrocardiogram or two sequential office visits);
 - The first qualifying service is termed the “candidate event” and it opens a 1-year-long clinical risk window for the physician furnishing the service. Only that portion of the risk window overlapping with a given performance period is attributed to the identified primary care clinician for that period.
- (ii) Applying exclusion and inclusion lists to the candidate event to categorize clinicians more accurately as providing primary care, or not;
 - For example, a potential candidate event performed by a specialty clinician unlikely to deliver primary care (e.g., a dermatologist) would not open a risk window.
- (iii) Determining the beneficiary’s risk score on a rolling basis each month using data from the immediately preceding 1-year period, leading to more accurate risk-adjustment; and
- (iv) Assessing beneficiary costs on a monthly rather than annual basis, so that costs better reflect contemporaneous beneficiary health status.

CMS notes that the revised measure was conditionally supported upon review by the MAP Clinician Workgroup but not supported (with potential for mitigation) by the MAP Coordinating Committee. CMS considered not using either TPCC version for 2020 but was deterred from doing so by concerns about the current paucity of episode-based measures available. Therefore, CMS is proposing to substitute the revised measure for the current TPCC version beginning with performance period 2020.

(f) Measure Revision: Medicare Spending Per Beneficiary Clinician (MSPB)

MSPB also is an administrative claims-based cost measure from the Physician Value Modifier program that was finalized by CMS along with TPCC as the other original QPP Year 1 cost measures, has been utilized again in each subsequent QPP year. CMS undertook reevaluation of

¹² The proposed and current TPCCs are compared at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-revised-TPCC-measure-specs.zip>.

MSPB as it did for TPCC as part of routine measure maintenance, during which several areas of concern emerged.

- The attribution methodology did not incorporate the team-based nature of inpatient care;
- The attribution based on the plurality of Part B service costs during an index admission potentially could attribute episodes to specialties providing expensive services instead of those providing overall care management; and
- The measure captured costs for services that are unlikely to be influenced by the clinician's care decisions.

CMS responds to the concerns by proposing a revised MSPB for performance period 2020 and subsequent years. First, CMS proposes to revise the measure's title to Medicare Spending Per Beneficiary clinician (MSPB clinician) to distinguish it from other similarly-named measures used elsewhere in the Medicare program. Second, CMS would change the attribution methodology to distinguish medical from potentially more expensive surgical episodes using the MS-DRG for the measure's index admission. Medical episode attribution initially would be at the TIN level, based upon volume of inpatient E/M services or physician/supplier claims, then to each of the TIN's clinicians who billed at least one of the attributed E/M services. A surgical episode would be attributed to the surgeon who performed any surgical service during the inpatient stay and to the surgeon's TIN. A list linking MS-DRGs to related surgical procedures is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/mspb-clinician-zip-file.zip>. Lastly, CMS proposes to add service exclusion lists aggregated by major diagnostic categories (MDCs) of unrelated costs unlikely to be under the influence of the attributed clinician. Examples provided by CMS are exclusion of orthopedic procedures occurring with MDCs 06-07, Gastrointestinal System Disorders, or cardiac valve procedures triggered by MS-DRGs under MDC 04, Pulmonary System Disorders.¹³ CMS is proposing to substitute the revised MSPB clinician measure for the current MSPB version beginning with performance period 2020.

(g) Episode-Based Measure Reliability

Proposed New Measures

CMS has previously established reliability standards for episode-based cost measures: 1) a reliability threshold of 0.4 for all measures; 2) a case minimum of 20 episodes for acute inpatient medical condition episode-based measures; and 3) a case minimum of 10 episodes for procedural episode-based measures. As shown in Table 38, reproduced below from the rule, the reliability of the 10 proposed new episode-based measures meets the threshold for the majority of reporting groups at the specified case minimums. At the individual reporting level, all of the proposed new episodes meet the reliability threshold at the case minimums except for the Lower Gastrointestinal Hemorrhage measure. CMS considered not moving forward with the noncompliant measure since MIPS allows for individual as well as group data reporting, but decided instead to restrict the use of the Lower Gastrointestinal Hemorrhage measure to group reporting. With this caveat, CMS proposes to implement all 10 new episode-based cost measures beginning in 2020 and to retain the established reliability standards.

¹³ The proposed and current MSPBs are compared at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-mspb-clinician-zip-file-zip> .

TABLE 38: Percent of TINs and TIN/NPIs that Meet 0.4 Reliability Threshold

Measure name	% TINs meeting 0.4 reliability threshold	Mean reliability for TINs	% TIN/NPIs meeting 0.4 reliability threshold	Mean reliability for TIN/NPIs
Acute Kidney Injury Requiring New Inpatient Dialysis	100.0%	0.58	85.3%	0.48
Elective Primary Hip Arthroplasty	100.0%	0.85	100.0%	0.78
Femoral or Inguinal Hernia Repair	100.0%	0.86	100.0%	0.81
Hemodialysis Access Creation	93.1%	0.63	70.1%	0.48
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	100.0%	0.69	68.0%	0.46
Lower Gastrointestinal Hemorrhage*	74.6%	0.51	0.0%	0.20
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	100.0%	0.77	100.0%	0.69
Lumpectomy Partial Mastectomy, Simple Mastectomy	100.0%	0.64	100.0%	0.60
Non-Emergent Coronary Artery Bypass Graft (CABG)	100.0%	0.82	100.0%	0.74
Renal or Ureteral Stone Surgical Treatment	100.0%	0.77	100.0%	0.65

*This measure is being proposed only for groups, see section III.K.3.c.(2)(b)(vi)(B) of the proposed rule.

Revised Measures

CMS has previously established reliability standards for the TPCC and MSPB clinician cost measures: 1) a reliability threshold of 0.4 for all measures; 2) a case minimum of 20 beneficiaries for the TPCC; and 3) a case minimum of 35 episodes for the MSPB clinician. CMS states that these standards require moderate reliability without limiting clinician participation. As shown in Table 39, reproduced below from the rule, the reliability of the TPCC and MSPB clinician measures meet the threshold for the majority of clinicians and groups at the existing case minimums. In addition to proposing to update the TPCC and MSPB clinician measures as revised, CMS further proposes to retain the established reliability standards.

TABLE 39: Percent of TINs and TIN/NPIs that Meet 0.4 Reliability Threshold for the Revised MSPB Clinician and Total per Capita Cost Measures

Measure name	% TINs meeting 0.4 reliability threshold	Mean reliability for TINs	% TIN/NPIs meeting 0.4 reliability threshold		Mean reliability for TIN/NPIs
Medicare Spending Per Beneficiary Clinician	100.0%	0.77	100.0%		0.69
Total Per Capita Cost	100.0%	0.82	100.0%		0.89

(h) Request for Comments on Future Potential Episode-Based Measure for Mental Health

CMS continues to develop episode-based cost measures to meet the needs of clinicians across the entire clinical spectrum. CMS developed through its usual episode measure process an acute inpatient medical condition episode-based measure for the treatment of inpatient psychoses and related conditions to support mental health professionals subject to the QPP. The measure, Psychoses/Related Conditions, was conditionally-endorsed by the MAP Clinician Workgroup but the MAP's Coordinating Committee disagreed and failed to support the measure for rulemaking. Concerns were raised that the measure: 1) had potential to attribute costs to clinicians without control over those costs; 2) was subject to geographic variation in community mental health resources; 3) might not account for scoring impacts of synchronous medical comorbidities; and 4) had a potential to exacerbate existing mental health care access challenges. CMS and its expert workgroup reviewed the measure, finding that the MAP's concerns were addressed by the measure specifications, and the measure was supported by the Person and Family Committee.¹⁴ CMS provides detailed rebuttals of the MAP's concerns in section III.K.3.c.(2)(b)(vii) of the rule, and notes that the measure tests well for reliability (0.7) for group and individual reporting. **CMS regards the Psychoses/Related Conditions as a desirable, high-priority addition to its Cost category measure inventory and seeks comments about proposing this measure for adoption in future rulemaking.**

(i) CMS concludes the Cost category measure section by presenting a summary table of proposed new and proposed revised cost measures for the 2020 performance period and subsequent years, reproduced below from the rule.

TABLE 40: Summary Table of Cost Measures for the 2020 Performance Period and Future Performance Periods

Measure Topic	Measure Type	Measure Status
Total Per Capita Cost (TPCC)	Population-Based	Revised and proposed for 2020 performance period and beyond
Medicare Spending Per Beneficiary Clinician (MSPB)	Population-Based	Revised and proposed for 2020 performance period and beyond
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Knee Arthroplasty	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Screening/Surveillance Colonoscopy	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond
Simple Pneumonia with Hospitalization	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond

¹⁴ The measure's specifications are available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-revised-ebcm-measure-specs.zip>.

Measure Topic	Measure Type	Measure Status
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Elective Primary Hip Arthroplasty	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Femoral or Inguinal Hernia Repair	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Hemodialysis Access Creation	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition episode-based	Proposed for 2020 Performance Period and Beyond
Lower Gastrointestinal Hemorrhage (<i>at group level only</i>)	Acute inpatient medical condition episode-based	Proposed for 2020 Performance Period and Beyond
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Renal or Ureteral Stone Surgical Treatment	Procedural episode-based	Proposed for 2020 Performance Period and Beyond

(3) Improvement Activities (IA) (§414.1355)

CMS has previously defined an improvement activity (IA) to mean an activity that MIPS-eligible clinicians, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. IA examples include establishing after-hours access to clinical advice and use of shared decision-making tools, and suggested new activities are solicited by CMS through an Annual Call for Activities. The IA performance category is usually weighted at 15 percent during MIPS scoring but may be reweighted under certain specified circumstances (e.g., participation in a MIPS APM).

(a) IA Data Submission

CMS does not propose any changes to current IA data submission mechanisms or data submission criteria for performance period 2020. CMS does propose two changes to IA reporting by groups. First, CMS proposes to increase the group reporting threshold such that at least 50 percent of a group's clinicians (counted as NPIs) would be required to complete an IA for the entire group (TIN) to receive IA category credit. This would be an increase from the current requirement that at least one clinician from the group must report for the group to receive credit. Support from stakeholders for an increase has been mixed but CMS states that meeting the higher threshold is readily achievable by groups since clinicians are now familiar with the IA category and can select from over 100 IAs in the activity inventory. CMS also considered alternatives of 25 and 100 percent thresholds, but concluded that 50 percent was reasonable and sufficient to demonstrate a group's collective commitment to practice improvement.

Second, CMS proposes a new requirement that at least 50 percent of the NPIs within a group must perform the same IA for the same continuous 90-day period within a performance year. CMS indicates that a group's patient outcomes are more likely to be positively influenced when a substantial fraction of the group's clinicians engage in the same IA. A separate attestation would be required for each IA that was completed by 50 percent or more of the group's members for the same 90-day period.

(b) Criteria for Improvement Activity Removal

To date, IA activities once added have remained in the IA inventory. CMS has previously expressed that a process for IA activity removal would be needed and states that suggestions for removal could be made through the established Annual Call for Activities process. CMS proposes 7 factors to be considered in decision-making about removing a specific activity, similar to those utilized when considering quality measure removal:

- The activity is duplicative of another existing IA.
- An alternative IA exists that is more closely linked to care quality or clinical practice improvement.
- The activity does not align with current clinical guidelines or practices.
- The activity does not align with at least one from the Meaningful Measures initiative.
- The activity does not align with either the Cost, Quality, or Promoting Interoperability performance categories.
- No clinician has attested to performing the activity for 3 consecutive years.
- The activity is obsolete.

CMS adds that the proposed factors represent factors to be taken into account in removal decisions but are not rigid requirements. CMS also notes that removal of IA from the inventory would occur during notice-and-comment rulemaking. CMS concludes by noting that its associated proposal for removing some IAs for the 2020 performance period is contingent upon finalizing the proposal for IA removal criteria.

(c) Changes to IAs for 2020

CMS proposes to add 2, modify 7, and remove 15 activities from the IA inventory for performance period 2020. Details are provided in Tables A, B, and C, respectively, of Appendix 2 of the rule. The two new activities are Drug Price Transparency and Completion of an Accredited Safety or Quality Improvement Program.

(d) CMS Study on Improvement Activities and Measurement.

CMS began the Study on Improvement Activities and Measurement in 2017, and has recruited new participants annually, to examine clinical quality workflows and data capture using a simpler approach to quality measures. Participants receive full credit (40 points) for the IA performance category. (The study name has evolved to "Study on Factors Associated with Reporting Quality Measures".) CMS proposes to end the study with the end of the 2019 performance period, at which time the sample size and volume of data collected will meet or

exceed the minimum numbers required to achieve the study's goals. If the study is ended as proposed, CMS would also end the IA reporting credit for study participants beginning with the 2020 performance period. Removal of the study from the IA list is contingent upon finalization of the IA removal criteria discussed above. Study conclusion and removal of its associated IA listing would be based upon removal factor 7 - the activity is obsolete. CMS anticipates completing analysis of the study data by Spring 2020 and would proceed to share lessons learned through CMS education and outreach events.

(e) Rural definition modification

Scoring of the IA category is adjusted for MIPS-eligible clinicians who practice in rural areas by awarding double credit for IA activities compared to non-rural practices. CMS proposes to modify the definition of rural used in making the IA scoring adjustment by making a technical correction to reference the correct zip code file. The incorrect reference was to the (HRSA) Area Health Resource File, and would be corrected to the Federal Office of Rural Health Policy (FORHP) eligible ZIP codes file. CMS states that no scoring or payment errors have resulted from the incorrect reference, as CMS was using the correct file even though the incorrect file was named in the associated regulation.

(f) Removal of References to Specific Accreditation Organizations

Scoring of the IA category may also be adjusted for practices that are designated as certified patient centered medical homes or comparable specialty practices. Criteria defining how those practices are determined to be medical homes or comparable specialty practices refer to recognition as such by several accrediting organizations (e.g., National Committee for Quality Assurance or NCQA). The accrediting organization also must be national in scope and have evidence of being used by a large number of medical organizations as their medical home model. CMS proposes to delete the references to specific accrediting organizations to avoid excluding other entities that might operate similar certification programs.

(4) Promoting Interoperability (PI) (§414.1375)

(a) Goals and Performance Periods

The Act provides that meaningful use of Certified Electronic Health Record Technology (CEHRT) be addressed as a MIPS performance category. This category was termed Advancing Care Information but was updated to Promoting Interoperability in 2018 in concert with CMS' goal of aligning CEHRT and related IT efforts across the Medicare program. The PI performance category is currently weighted at 25 percent of the overall MIPS score. After a major PI restructuring in 2019, CMS states that priorities for PI in 2020 are stability within the category, burden reduction, continued use of 2015 Edition CEHRT, enhancing EHR access by patients to support their healthcare decision-making, and continued alignment of the MIPS PI category with the Medicare PI program for hospitals and CAHs.

CMS proposes to maintain the PI performance period for both 2021 and 2022 as a minimum of one continuous 90-day period, up to and including the full calendar year. CMS states that this

proposal would provide stability within the PI category and would align with the PI program for hospitals and CAHs for those years.

(b) Changes to e-Prescribing Objective Measures

CMS addresses two PI measures: 1) Query of Prescription Drug Monitoring Program (PDMP) and 2) Verify Opioid Treatment Agreement; both were adopted for use beginning with the 2019 performance period for application to the prescribing of Schedule II controlled substances. CMS reports receiving substantial, ongoing stakeholder feedback expressing concerns about both measures. Further, CMS acknowledges that many provisions of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, Pub. L. 115-27, enacted October 24, 2018), have implications for the current utility of both measures.¹⁵ For example, the SUPPORT Act includes requirements for PDMP integration and interoperability and increases federal Medicaid matching rates to states for PDMP-related expenditures. In the rule, CMS states that its aims are to respond to stakeholder feedback and to take into account the policy implications of the SUPPORT Act.

Query of Prescription Drug Monitoring Program (PDMP)

Because PDMP characteristics differ across states, CMS prioritized flexibility in the measure's design and applicability, and made the measure optional and available for bonus points for the 2019 performance period. Despite CMS' efforts, concerns and challenges have been identified that include:

- Query of PDMP usage has not been integrated into EHR clinical workflows.
- Lacking standards-based interfaces between CEHRT and PDMPs, health care providers must manually track the number of times that they query a PDMP outside of CEHRT.
- Defining the measure more narrowly to correspond to a single workflow strategy would assist developers but be too rigid for providers attempting to comply with varying state PDMP requirements.
- IT vendors are challenged in workflow integration by the wide variation of clinical workflows and workarounds already in use by providers plus state variations in PDMP structure.
- Multiple efforts already underway are likely to have policy and regulatory impacts on measure development and implementation (e.g., pending CMS and CDC guidance on protecting the privacy of Medicaid beneficiary information maintained in and accessed through PDMP, ongoing CMS and DEA collaboration on technical requirements related to tracking Schedule II drug prescribing).
- EHR developers are reluctant to invest their resources into building IT to meet requirements and specifications that are still evolving (e.g., Query PDMP numerator and denominator).

CMS concludes that more time is needed before requiring a PDMP measure or imposing new PDPM-EHR integration requirements. Therefore, CMS proposes that the Query PDPM measure remain optional and eligible for 5-bonus points for 2020. CMS concomitantly proposes,

¹⁵ These provisions will not be discussed in detail in this summary but HPA has previously prepared a comprehensive summary of the SUPPORT Act.

beginning with the 2019 performance period, to remove the numerator and denominator as currently established for the Query PDMP measure, instead requiring simply a “yes/no” response in order to satisfy reporting on this measure and to receive the bonus. (Currently, MIPS-eligible clinicians must report at least one query of the PDMP in the numerator for satisfactory reporting and to earn the bonus.) **CMS welcomes comment on 1) the future timing of implementing a measure that requires PDMP-EHR integration; and 2) the overall value of such a measure for advancing the effective prevention and treatment of opioid use disorder (especially in relation to the requirements of the SUPPORT Act).**

Verify Opioid Treatment Agreement

CMS previously finalized this measure as optional for the 2019 and 2020 performance periods. As for the Query of PDMP measure, CMS has heard significant concerns from stakeholders about the Verify Opioid Treatment Agreement measure including: 1) lack of defined data elements, structure, standards and criteria for the electronic exchange of opioid treatment agreements; 2) absence of a clear basic definition of an opioid treatment agreement; 3) insufficient guidance about how exactly to calculate the look-back period (30 cumulative days of opioid prescriptions in a 6-month period), such as accounting for opioid use during an included inpatient admission; 4) necessity for manual calculation by providers to report on the measure; and 5) lack of consensus concerning clinical efficacy of the various options for such agreements.

CMS concludes that the measure as currently structured is vague, burdensome, and provides limited clinical value to clinicians. CMS, therefore, proposes to remove the Verify Opioid Treatment Agreement measure from the PI category beginning with performance period 2020 and for subsequent years. Based upon the many issues raised during assessment of the Query of PDMP and Verify Opioid Treatment Agreement measures, CMS invites comment through a series of RFIs (see section III.K.3.c.(4)(g) of the rule and section III.K.3.c.(4)(f) of this summary).

(c) Health Information Exchange Objective

Support Electronic Referral Loops by Sending Health Information Measure

This measure was formerly named “Send a Summary of Care” measure and was given its current name for 2019 reporting. The measure had a potential participation exclusion that was retained for the renamed measure, but CMS did not specify how the points for the renamed measure would be redistributed were the exclusion to be claimed. CMS now proposes that the 20 points assigned to the renamed measure would be redistributed to the Provide Patients Access to Their Health Information measure were the exclusion to be claimed.¹⁶ The proposed revision would be applicable beginning with the 2019 performance period and subsequent years.

Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure

For performance year 2019, this measure replaced two existing measures, titled, respectively, the “Request/Accept Summary of Care” and “Clinical Information Reconciliation” measures. A potential participant exclusion was established at that time for the new measure. However, the

¹⁶ The exclusion applies to any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

language of the exclusion subsequently has been misconstrued by some users. CMS, therefore, proposes to revise the exclusion to provide clarity; the revised exclusion would read “Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period”. The revised exclusion language would become applicable beginning with the 2019 performance period and subsequent years. The 20 points currently associated with the measure would continue to be distributed to the Provide Patients Access to Their Health Information measure, were the exclusion to be claimed.

CMS presents all of the proposed changes to the objectives and measures of the Promoting Interoperability performance category for 2020 in detail as Table 41, which may be found at the end of section III.K.3.c.(4) of the rule.

(d) Scoring Methodology

CMS notes having extensively revised the PI performance category scoring methodology for use in 2019 and subsequent years (see 83 FR 59785 through 59796). In Table 42 (reproduced below from the rule, CMS presents the scoring methodology for the PI category as it would be applied beginning with performance period 2020, if the proposed PI measure and objective changes described above are finalized. The table does not reflect the potential point redistributions if exclusions are claimed as described above.

TABLE 42: Proposed Scoring Methodology for the Performance Period in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing**	10 points
	Query of PDMP	5 points (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information**	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information**	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting** Electronic Case Reporting** Public Health Registry Reporting** Clinical Data Registry Reporting** Syndromic Surveillance Reporting**	10 points

**Exclusion available for participants with low-volumes of certain types of encounters

(e) Additional PI Performance Category Considerations

PI Reporting by Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

CMS previously established a policy for the 2017, 2018, and 2019 performance periods to assign a weight of zero to the PI performance category if CMS determines that there are not sufficient measures applicable and available to these clinician types, as many were ineligible to participate in the Medicare or Medicaid EHR Incentive Programs (which have been succeeded by the Promoting Interoperability program). Should a clinician of a type eligible for reweighting choose to report PI data, that clinician would instead be scored for the PI category using their data and the scoring policies currently in effect for other types of MIPS-eligible clinicians.

CMS has analyzed PI data submitted during the 2017 performance period to reassess whether reweighting is in fact appropriate. CMS found a paucity of data that could be definitively linked to clinicians of the types eligible for reweighting. CMS also notes that the PI category measures and scoring have undergone substantial restructuring since 2017. CMS concludes that a valid determination as to whether the currently available PI category measures would suffice for meaningful reporting by the relevant clinician types is not possible at this time. Therefore, CMS proposes to maintain the established policy of reweighting the PI category to zero for these clinician types for the 2020 performance period but scoring any clinician who submits PI data during that period.

PI Reporting by Physical Therapists, Occupational Therapists, Qualified Speech-language Pathologists, Qualified Audiologists, Clinical Psychologists, and Registered Dieticians or Nutrition Professionals

For similar reasons, CMS proposes to treat physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals in the same manner as the previously discussed group (nurse practitioners, etc.) for potential PI category reweighting for performance year 2020 and subsequent years. For those clinician groups, CMS states it will periodically revisit whether reweighting remains appropriate.

PI Reporting by Groups of Hospital-Based MIPS-eligible Clinicians

CMS has previously defined a hospital-based MIPS-eligible clinician as one furnishing 75 percent or more of his or her covered professional services in one or more of the following settings, as identified by their Place of Service (POS) codes: inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), off-campus outpatient hospital (POS 19), or emergency room (POS 23) based on claims for a MIPS determination period. The determination period sets the time interval from which claims are collected to make the determination of “hospital-based”. CMS has previously established a policy to assign a weight of zero to the PI performance category for a hospital-based MIPS-eligible clinician, unless that clinician chooses to report PI data, in which case the clinician will be scored using their data and the scoring policies currently in effect for other MIPS-eligible clinicians.

CMS currently requires that when clinicians elect to report PI data as a group, the data of all MIPS-eligible clinicians in the group must be aggregated, including those who otherwise would

qualify for PI reweighting to zero percent, unless all of group's clinicians qualify for reweighting. Stakeholders have informed CMS that the existing policy is too restrictive because staffing challenges often lead to the frequent inclusion of *locum tenens* clinicians by hospital-based groups. Since *locum tenens* clinicians frequently practice in a variety of settings, inclusion of even one such clinician in a hospital-based group could preclude the group from PI category reweighting.

CMS finds the stakeholder concerns to be valid and proposes to revise current policy. Beginning with performance year 2020, CMS proposes to define a hospital-based MIPS eligible clinician as one who furnishes 75 percent or more of his or her covered professional services in settings with POS codes POS 21, POS 22, 19, or 23 (based on claims for a MIPS determination period) and that the definition would also include a group or virtual group in which more than 75 percent of the NPIs billing under the group's or virtual group's TIN meet the definition of a hospital-based individual MIPS eligible clinician. CMS also proposes conforming changes to other pertinent regulations.

PI Reporting by Groups of Non-Patient Facing MIPS-eligible Clinicians

CMS currently defines a non-patient facing MIPS eligible clinician to mean an individual who bills 100 or fewer patient facing encounters (including Medicare telehealth services), during the MIPS determination period, and to mean a group or virtual group provided that more than 75 percent of the NPIs billing under the group's or virtual group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician. For consistency and clarity, CMS proposes to adopt language similar to that proposed for hospital-based clinician groups in the regulations applicable to non-patient facing groups (i.e., that 75 percent or more, rather than 100 percent of a non-facing clinician group's members must qualify as non-patient facing in order for the entire group to be eligible for PI category reweighting).

(f) Future Direction of the Promoting Interoperability Performance Category

1. Request for Information (RFI) on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category.

CMS is seeking comment on performance category measures that are specifically relevant to clinical priorities or goals of opioid use disorder (OUD) prevention and treatment. CMS is interested in new measures that:

- Include evidence of positive impact on outcome-focused improvement activities, and the opioid crisis overall;
- Leverage the capabilities of CEHRT where possible;
- Are based on well-defined clinical concepts, measure logic and timing elements that can be captured by CEHRT in standard clinical workflow and/or routine business operations;
- Align with clinical workflows so that data used in its calculation is collected as part of a standard workflow;
- Are applicable to all clinicians (for example, those practicing as individuals or in a group, or those in urban as well as rural areas);
- Could align with other MIPS performance categories; and

- Are represented by a measure description, numerator/denominator or yes/no attestation statement, and possible exclusions.

2. RFI on NQF and CDC Opioid Quality Measures

CMS is interested in feedback on potential measures of clinical and process improvements that are specifically related to the opioid epidemic. NQF and CDC have developed measures relating to opioid prescribing and CMS specifically requests feedback on those measures. In particular, CMS is interested in measures that describe activities that can be supported by CEHRT.

Recognizing that some changes to the NQF or CDC measures may be necessary, it seeks comment on any recommended modifications. In addition, CMS wishes to know how the two sets of measures potentially overlap; whether the measures could be somehow combined (CMS uses the term “correlated”) to create new measures, and which measures would best advance health IT and information exchange.

CMS specifically seeks comment on three NQF measures that it believes can be supported using CEHRT. CMS is interested in how the use of technology can be incorporated into the measure guidance:

- Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940).
- Use of Opioids from Multiple Providers in Persons Without Cancer (NQF #2950).
- Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer (NQF #2951).

CDC measures were developed to measure implementation of the CDC Prescribing Guidelines.¹⁷ CMS is seeking comment on which of the 16 CDC quality improvement opioid should be considered for the Promoting Interoperability performance category.¹⁸ CMS also specifically requests comment on whether different types of measures are necessary for OUD prevention and treatment.

3. RFI on a Metric to Improve Efficiency of Providers within EHRs

CMS explains that one of the benefits of EHRs should be to increase the efficiency of health care processes, but the results of its implementation have been more variable. Stakeholders have identified ways in which the potential benefits of EHRs have not been realized and in some cases have increased rather than reduced administrative burden.

CMS believes that adopting more efficient workflows and technologies, examples of which are included in the ONC draft report “Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs” could improve patient care and interoperability. It seeks comment on how implementing some of those processes can be measured and encouraged as part of the Promoting Interoperability performance category.¹⁹

¹⁷ CDC Prescribing Guideline available at <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

¹⁸ Measures for supporting those guidelines available at “*Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain*”; <https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf>.

¹⁹ The ONC report is available at <https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing->

Specifically, CMS requests responses to the following questions:

- What are useful ways to measure the efficiency of health care processes that use health IT? What are measurable outcomes that could demonstrate greater efficiency in costs or resources that can be linked to the use of health IT?
- What is hindering providers' ability to achieve greater efficiency?
- What are specific technologies, capabilities, or system features that could increase the efficiency of provider interactions with technology; for instance, alternate authentication technologies that can simplify provider logon? How could providers be rewarded for adoption and use of these technologies?
- What are key administrative processes that can benefit from more efficient electronic workflows; for instance, conducting prior authorization requests? How can CMS measure and reward providers for their uptake of more efficient electronic workflows?
- How can CMS incentivize efficiency?

4. RFI on Provider to Patient Exchange Objective

As part of the MyHealthEData initiative, CMS has launched several initiatives related to data sharing and interoperability for patients including the MIPs Promoting Interoperability performance category. That category puts a heavy emphasis on patient access to their health information as measured through the Provide Patients Electronic Access to their Health Information measure. In the CY 2019 PFS proposed rule, CMS requested public comment on an activity in which MIPS eligible clinicians could obtain credit for maintaining an “open API.” CMS explains that this is a standards-based API which allows patients to access their health information through a preferred third-party application.

Several commenters raised concerns about the security of patient data and the potential for cyber-attacks. CMS points out, however, that HIPAA Security & Privacy Rules continue to apply. CMS notes that ONC has proposed but not yet finalized a new criterion for a standards-based API that requires use of the HL7 Fast Healthcare Interoperability Resources (FHIR®) standard.

Immediate Access.

CMS is seeking comment on whether MIPS-eligible clinicians should make patient health information available immediately through an open, standards-based API, no later than the business day after it is available to the MIPS eligible clinicians in their CEHRT. This would differ from the existing Provide Patients Electronic Access to Their Health Information measure that specifies that they provide the patient such information within 4 business days of its availability to the MIPS-eligible clinicians. CMS seeks comment on the barriers to providing such access and whether certain data elements are more or less able to be shared within one business day.

Persistent Access and Standards-based APIs.

[burden-relating-use-health-it-and-ehrs.](#)

In addition, as the existing Provide Patients Electronic Access to Their Health Information measure does not specify any operational expectations associated with enabling patients' access to their health information (only that it be timely), CMS seeks comment on whether the measure should be revised to be more specific with respect to the experience patients should have regarding their access (e.g., requiring "persistent access" without requiring a patient to reauthorize their application and re-authenticate themselves). In addition, CMS is interested in whether stakeholders would support a bonus under the Promoting Interoperability performance category for early adoption of an API that meets ONC's proposed FHIR standard for certified APIs in the interim period before that ONC criterion is finalized or implemented.

EHI Export.

ONC has also proposed a safe and secure patient-focused export criterion which would encourage that patients and health IT users are able to export an entire EHR for a single patient or group of patients. This would be useful for patients who need access to their full medical record and for health care providers who are switching EHR systems. CMS seeks to build on the ONC proposal and is interested in feedback on the potential addition of an alternative measure under the Provider to Patient Exchange requiring clinicians to use technology certified to the EHI criterion to provide a patient with their complete electronic health data contained within an EHR. Specifically, CMS seeks feedback on:

- Whether the addition of the alternative measure would be effective in encouraging the availability of all data stored in health IT systems?
- How would such a measure be scored?
- If the certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure or as an attestation measure?
- How would such an alternative measure impact burden?
- If stakeholders believe this will be burdensome, in what other way(s) might an alternative measure be implemented that may result in burden reduction?
- Which data elements would be of greatest clinical value or of most use to health care providers to share in a standardized electronic format if the complete record is not immediately available?
- Should CMS consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long-term care, behavioral health, and home and community-based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should be considered?
- What criteria should be used to identify high priority health IT activities for the future for use under the PI performance category?
- Are there additional health IT activities that should be considered to advance priorities for nationwide interoperability and spur innovation?

Patient Matching.

CMS is seeking comment for future consideration on ways that ONC and CMS can facilitate private sector efforts to improve patient matching noting that health care providers must be able to share patient health information and accurately match a patient to his or her data from a different health care provider. CMS seeks comment on whether CMS and ONC patient matching

efforts increase burden on providers and whether stakeholders have other suggestions to promote such interoperability that do not increase burden.

5. RFI on Integration of Patient-Generated Health Data into EHRs Using CEHRT

CMS is exploring, for the Promoting Interoperability performance category, ways to incentivize providers to advance and take advantage of the emerging use of Patient Generated Health Data (PGHD) and is considering adopting new elements related to PGHD that represent clearly defined uses; are linked to positive outcomes; and advance the capture, use and sharing of PGHD. CMS notes that any future PGHD measure would not need to be a traditional measure. It could potentially be a measure to which a provider would attest to rather than reporting in the traditional fashion. CMS believes this would reduce reporting burden.

CMS specifically seeks comment on:

- What are the potential uses for PGHD as part of treatment and care coordination across clinical conditions and care settings that are most promising?
- Should the Promoting Interoperability performance category explore ways to reward providers for engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?
- Should health care providers be expected to collect information from their patients outside of scheduled appointments or procedures?
- Should the Promoting Interoperability performance category explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?

6. RFI on Activities that Promote Safety of the EHR

CMS is continuing to explore ways to mitigate the safety risks that arise from implementing technology and seeks comments on ways that the Promoting Interoperability performance category can reward MIPS eligible clinicians for activities that reduce errors associated with EHR implementation. One possible approach CMS may pursue is to reward MIPS-eligible clinicians with points toward their Promoting Interoperability performance category score for attesting to performance of an assessment based on one of the ONC SAFER Guides. ONC SAFER Guides provide healthcare organizations with instruction on conducting self-assessments to optimize the safety and safe use of EHRs.²⁰

CMS is considering offering points for those clinicians that attest to having conducted an assessment in two of the nine SAFER areas: High Priority Practices and/or Organizational Responsibilities. Alternatively, CMS may consider points for review of all nine of the SAFER areas. CMS requests comment on this approach, on alternatives to SAFER Guides, or other approaches to reward activities to reduce safety risk associated with EHR implementation.

²⁰ Available at <https://www.healthit.gov/topic/safety/safer-guides>.

(5) APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

The APM scoring standard (§414.1370) applies to MIPS eligible clinicians identified on the Participation List of an APM entity participating in a MIPS APM. It is designed to reduce reporting burden for these clinicians by avoiding duplicative data submission to MIPS and the MIS APMs, and to avoid possibly conflicting incentives between the two. Clinicians participating in MIPS APMs receive quality scores based on their participation in the model. If no quality data are available for scoring, the MIPS categories are reweighted to 75% Promoting Interoperability and 25% Improvement Activities.

CMS expects that the following 10 APMs will satisfy the requirements to be MIPS APMs for the 2020 MIPS performance period. The final determinations will be announced via the QPP website.

- Comprehensive ESRD Care Model (all Tracks),
- Comprehensive Primary Care Plus Model (all Tracks),
- Next Generation ACO Model,
- Oncology Care Model (all Tracks),
- Medicare Shared Savings Program (all Tracks),
- Medicare ACO Track 1+ Model,
- Bundled Payments for Care Improvement Advanced
- Maryland Total Cost of Care Model (Maryland Primary Care Program), and
- Vermont Medicare ACO Initiative.
- Primary Care First (All Tracks)

In this rule, new approaches are proposed for scoring the quality performance category for MIPS APMs. CMS has found that many MIPS APMs run on different timelines that do not align with MIPS performance periods and deadlines for data submission, scoring and performance feedback. As a result, it is often not operationally possible to collect and score quality performance data for purposes of the MIPS. Although the possibility of reweighting of the quality category was anticipated, CMS does not believe this should occur regularly.

- Allowing Clinicians Participating in MIPS APMs to Report on MIPS Quality Measures. CMS proposes to allow MIPS APM clinicians to report on MIPS quality measures in the same way that it currently permits them to report for the Promoting Interoperability category under the MIPS APM scoring standard. This policy would begin with the 2020 performance period. Specifically, CMS would attribute one quality score to each MIPS eligible clinician in an APM Entity by looking at both individual and TIN-level data submitted for the eligible clinician and using the highest reported score, excepting scores reported by a virtual group. It would then use the highest individual or TIN-level score attributable to each MIPS eligible clinician in the APM Entity to determine an average, which would be the APM Entity score. A clinician with no quality performance category score would contribute a score of zero to the aggregate APM Entity group score. Only scores reported by an individual clinician or a TIN reporting as a group would be used. Virtual group level reporting would be excluded because CMS believes these scores are too far removed from a clinician's performance on quality measures for purposes of the APM scoring standard.

- APM Quality Reporting Credit. Beginning with the 2020 performance period, CMS proposes to apply a minimum score of 50 percent (one half of the highest potential score for the quality performance category), called an “APM Quality Reporting Credit”, to APM Entity groups participating in MIPS APMs, with the exceptions described below. The credit would be added to any MIPS quality measure scores CMS receives, with a cap of 100 percent for the quality category. For example, if the additional MIPS quality score were 70 percent, it would be added to the 50 percent credit for a total of 120 percent, but the total assigned would be 100 percent.

In offering this proposal CMS discusses how the statute recognizes the possibility of overlap between the requirements of MIPS and those of an APM, including the exclusion of QPs and partial QPs that do not elect to participate in MIPS. In particular the statute requires that participation by a MIPS-eligible clinician in an APM earns the clinician a minimum score of one-half of the highest potential score for the improvement activities performance category because of overlapping requirements. CMS is making its proposal because it believes APM participation similarly requires significant investment in quality, which, due to operational constraints, cannot always be reflected in a MIPS quality performance category score.

The proposed APM Quality Reporting Credit would not apply to APM Entities reporting only through a MIPS quality reporting mechanism according to the requirements of their APM, such as the Medicare Shared Savings Program, which requires participating ACOs to report through the CMS Web Interface and the CAHPS for ACOs survey measures. This is because in these cases no burden of duplicative reporting would exist for participants, and there would not be any additional unscored quality measures for which to give credit. CMS notes that if an APM Entity group in this circumstance fails to report on required quality measures, individual eligible clinicians and TINs in the group would be able to report quality measures for purposes of calculating a quality performance score. They would, however, remain ineligible for the APM Quality Reporting Credit because no burden of duplicative reporting would exist.

- Additional Reporting Option for APM Entities. CMS proposes that if an APM Entity has reported quality measures to MIPS through a MIPS submission type and using a MIPS collection type on behalf of the APM Entity group, it would use that quality data to calculate an APM Entity group level score for the quality performance category. It does this recognizing that some APMs currently require participants to report on MIPS quality measures, and believes this approach would ensure that all participants in an APM Entity group receive the same final MIPS score, while reducing reporting burden to the greatest extent possible.
- Bonus Points and Caps for the Quality Performance Category. Under previously adopted policies, CMS applies bonus points when scoring the quality performance category at the APM Entity group level. Under the proposed rule, these adjustments would already be factored in when calculating an individual or TIN-level quality performance category score before the quality scores are rolled-up and averaged to create the APM Entity group

level score. Therefore, it believes that it would be inappropriate to continue to calculate these adjustments at the APM Entity group level in cases where an APM Entity group's quality performance score is reported by its composite individuals or TINs. However, in the case of an APM Entity group that reports on MIPS quality measures at the APM Entity group level, CMS would continue to apply any bonuses or adjustments that are available to MIPS groups for the measures reported by the APM Entity and to apply these adjustments at the APM Entity group level.

- **Special Circumstances**. Currently, clinicians subject to MIPS APM scoring are not eligible under the extreme and uncontrollable circumstances policies established for other MIPS-eligible clinicians. Because in this proposed rule CMS would permit eligible clinicians participating in MIPS APMs to report on MIPS quality measures and be scored for the quality performance category under the general MIPS rules, CMS proposes to make these clinicians eligible for the extreme and uncontrollable circumstances policies as well. This proposal would be effective with the 2020 performance year and would apply only to the quality performance category. In general, clinicians under these special circumstances may qualify for zero percent weighting of the quality performance category. However, CMS proposes the following policies with respect to weighting and scoring the quality performance category for a MIPS APM clinician under special circumstances.
 - A clinician who could qualify for zero percent weighting of the quality category would not receive a zero percent weighting of the quality performance category if they are part of a TIN reporting at the TIN level that includes one or more MIPS-eligible clinicians who do not qualify for a zero percent weighting. The TIN would not need to report data for the qualifying MIPS eligible clinician, but would continue to report for the group, and all clinicians in the TIN would count towards the TIN's weight when calculating the aggregated APM Entity score for the quality performance category
 - For a solo practitioner who qualifies for zero percent weighting or in a case where all MIPS eligible clinicians in a TIN qualified for the zero percent weighting, reporting on the quality performance category would not be required and the category would be assigned a weight of zero when calculating the APM Entity's quality performance category score.
 - If quality performance data were reported for one or more TIN/NPIs in an APM Entity group, a quality performance category score would be calculated and applied to all MIPS eligible clinicians in the group. The quality performance category would be weighted at zero percent if all clinicians in all TINs of an APM Entity group qualify for a zero percent weighting.
 - **CMS welcomes comments about how best to address the technical infeasibility of scoring quality for many of our MIPS APMs, and whether the proposed policy or some other approach may be an appropriate path forward for the APM entity group scoring standard in CY 2020.**
- **Exclusion of Virtual Groups from APM Entity Group Scoring**. Current policies exclude virtual groups' MIPS scores when calculating APM Entity group scores. For clarity,

CMS proposes explicit language in the regulatory text at § 414.1370(e)(2) stating this exclusion.

- **Request for Comment on APM Scoring Beyond 2020. CMS seeks comment on potential policies to be included in next year's rulemaking to further address the changing incentives for APM participation under MACRA.** It seeks to design the APM scoring standard to continue to encourage appropriate shifts of MIPS eligible clinicians into MIPS APMs and eventually into Advanced APMs while ensuring fair treatment for all MIPS-eligible clinicians.

CMS notes that as the QP threshold increases in future years, more Advanced APM participants may be subject to MIPS under the APM scoring standard, while at the same time the MIPS performance threshold will be increasing and thereby reducing the impact of the APM scoring standard on participants' ability to achieve a neutral or positive payment adjustment under MIPS.

Policies discussed in the proposed rule as under consideration (assuming the proposed APM Quality Reporting Credit is finalized) and on which CMS seeks comment are:

- Sunsetting the proposed APM Quality Reporting Credit after a specific number of years
- Sunsetting the proposed APM Quality Reporting Credit for MIPS APMs that are not also Advanced APM tracks
- Sunsetting the proposed APM Quality Reporting Credit for APM Entities in one-sided risk tracks
- Retaining different APM Quality Reporting Credits for Advanced APMs and MIPS APMs

CMS also seeks comments and suggestions on other ways in which it could modify the APM scoring standard to continue to encourage MIPS eligible clinicians to join APMs, with an emphasis on encouraging movement toward participation in two-sided risk APMs that may qualify as Advanced APMs.

MIPS APM Performance Feedback. MIPS-eligible clinicians who are scored under the APM scoring standard receive performance feedback from CMS. Citing confusion with reporting on the 2017 performance year, CMS intends to better align treatment of Shared Savings Program ACOs and their participant TINs with other APM Entities and, where appropriate, with other MIPS groups. Therefore, in addition to other performance feedback, CMS will provide TIN-level performance feedback to ACO participant TINs including information available to all TINs participating in MIPS, including the applicable final scores for MIPS-eligible clinicians billing under the TIN, regardless of their MIPS APM participation status.

d. MIPS Final Score Methodology

(1) Performance Category Scores

(a) Background

For the 2022 MIPS payment year (2020 performance period) CMS proposes to build on the scoring methodology adopted for the transition years, recognizing that as it moves forward with the MIPS Value Pathways Framework it is likely to propose changes to the scoring methodology in future rulemaking. Specifically, CMS expects in the future to revisit and remove the 3-point floor, bonus points, and assigning points for measures without a benchmark.

Scores developed for each of the four MIPS performance categories are used to calculate a final score, which is translated into the MIPS adjustment.

(b) Scoring the Quality Performance Category

CMS proposes to extend a number of policies for scoring the quality performance category to payment year 2022 (2020 performance period) that the current regulatory text at §414.1380(b) limits to payment years ending in 2021. In addition, a change is proposed in the method used to calculate performance benchmarks for certain measures to avoid encouraging inappropriate treatment, and CMS seeks comment on scoring the possible future changes to the CAHPS for MIPS discussed earlier.

- **3-Point Floor**. For the 2022 payment year, CMS proposes continuation of the 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period. It plans to revisit this policy in future rulemaking in light of the MVP framework.
- **Scoring Measures that Do Not Meet Case Minimum, Data Completeness, and Benchmarks Requirements**. Table 43 in the proposed rule summarizes the proposed scoring policies for measures that are submitted but cannot be scored because they do not meet case minimum or data completeness requirements, or because they do not have a benchmark. These are previously adopted policies do not apply to Web interface or administrative claims measures. As previously adopted, the 2020 performance period will be the first for which CMS will assign zero points to measures that do not meet data completeness requirements, except that small practices will continue to receive 3 points.
- **Incentives to Report High-Priority Measures**. CMS proposes to maintain for the 2022 payment year the cap on high-priority bonus points, which is set to equal 10 percent of the total possible measure achievement points that the MIPS eligible clinician could receive in the quality performance category. High-priority measure bonus points do not apply for CMS Web Interface reporters. CMS clarifies that in order for a measure to qualify for high-priority bonus points it must meet established case minimum and data completeness requirements and not have a zero performance; it does not need to have a benchmark.
- **Incentives to Use CEHRT to Support Quality Performance Category Submissions**. CMS proposes to continue for 2022 assignment of bonus points for end-to-end electronic reporting. The policy only applies to data submitted by direct, login and upload, and CMS Web Interface that meet the criteria finalized in the 2017 QPP final rule (81 FR 77297) and not to the claims submission type, which does not meet those criteria. CMS believes that in the future under the MVP policies it will be possible to incorporate eCQMs without providing these bonus points.
- **Improvement Scoring**. CMS proposes to continue the previously adopted policy so that for the 2022 payment year, it will compare the eligible clinician's quality performance category achievement percent score for the 2020 performance period to an assumed quality performance category achievement percent score of 30 percent if the MIPS eligible clinician

earned a quality performance category score less than or equal to 30 percent for the 2019 MIPS performance period.

Modifying Benchmarks to Avoid Potential for Inappropriate Treatment. A proposed change for the 2020 performance period would modify the way benchmarks are calculated for certain measures. Benchmarks are established by collection type, using performance data from all available sources, including MIPS-eligible clinicians and APMs, to the extent feasible, during the applicable baseline or performance period.

Responding to concerns that benchmarks for some measures may incentivize inappropriate treatment of some patients in order for clinicians to score in the highest decile, CMS proposes to use a flat percentage benchmark for certain measures. The measures of concern are those with a benchmark that is set at very high or maximum performance in the top decile, where clinicians may be encouraged to over treat patients regardless of the individual patient's circumstances, in order to achieve the highest performance level.

Specifically, CMS proposes to establish benchmarks based on flat percentages in cases where it determines that a measure's otherwise applicable benchmark could potentially incentivize inappropriate treatment. Under the proposal, any performance rate at or above 90 percent would be in the top decile and any performance rate above 80 percent would be in the second highest decile, and so forth for the remaining deciles. CMS believes the measures involved are high-priority or outcome measures for clinicians to focus on and it wants to avoid having clinicians receive a low score when they adhere to the most appropriate treatment. It identifies the flat percentage approach as simple and straightforward and similar to the method used to set benchmarks in the Shared Savings Program, and for some MIPS measures that are collected through the CMS Web Interface.

In order to identify the measures to which the flat percentage benchmark would apply, CMS medical officers would assess if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure benchmark. This assessment would consider whether the measure specifications allow for clinical judgment to adjust for inappropriate outcomes, if the benchmarks for any of the measure's collection types could put patients at risk by setting a potentially harmful standard for top decile performance, or whether the measure is topped out. The assessment would take into account all available information, including the medical literature, published practice guidelines, and feedback from clinicians, groups, specialty societies, and the measure steward. CMS would propose the modified flat benchmark through rulemaking. The proposed policy would be effective beginning with the 2020 performance period (2022 MIPS payment adjustment year). **CMS seeks comment on future actions it should take to help determine to which measures to apply the flat percentage benchmarking to; for example, convening a technical expert panel.**

CMS has identified two measures for which it proposes to use benchmarks based on flat percentages to avoid potential inappropriate treatment. They are MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and MIPS #236 (NQF 0018): Controlling High Blood Pressure. CMS has determined that these measures lack comprehensive denominator exclusions and risk-adjustment or risk-stratification, and therefore could encourage over treatment of patients in order to meet numerator compliance. CMS believes that all benchmarks

associated with these measures could be affected. Specifically, it proposes to use the flat percentage benchmarks for all collection types where the top decile for any measure benchmark is higher than 90 percent under the performance-based benchmarking methodology. Based on the 2019 performance period benchmarks, CMS anticipates using the flat percentage benchmark for the Medicare Part B claims and the MIPS CQM collection types for these two measures. **CMS seeks comment on whether it should use a different criterion than the 90 percent top decile benchmark it proposes, and whether it should consider different methodologies for the modified benchmarks such as excluding the top decile; increasing the required data completeness for the measure to a very high level (for example, 95 to 100 percent); and using performance period benchmarks rather than historical benchmarks.**

Request for Feedback on Additional Policies for Scoring the CAHPS for MIPS Survey Measure. **As discussed above** (section III.K.3.c.(1)(b) of this summary) **CMS is considering expanding the information collected in the CAHPS for MIPS survey measure, and in this section of the proposed rule seeks comment on scoring.** One consideration is adding narrative questions to the survey, which would invite patients to respond to a series of open ended questions and describing their care experience in their own words. CMS is interested in learning from organizations with experience scoring narrative information, including methodologies. It would work with stakeholders on user testing before proposing any such methodology in future rulemaking. CMS is also considering adding a CAHPS for MIPS survey question that would allow patients to provide a score for their overall experience and satisfaction rating related to a recent health care encounter, and is interested in feedback regarding how to score this measure.

(c) Facility-Based Measures Scoring Option for the 2021 MIPS Payment Year for the Quality and Cost Performance Categories

CMS proposes no changes to the previously adopted policies under which a facility-based measurement scoring option is available to certain facility-based individual clinicians. Clarifying language is proposed for the regulatory text. Table 44 in the proposed rule, included for informational purposes, displays the Inpatient Hospital Value-Based Purchasing program measures for FY 2021. These measures are used in determining the facility-based quality and cost performance category scores for the CY 2020 MIPS performance period/2022 MIPS payment year.

(d) Scoring the Improvement Activities Performance Category

CMS refers readers to a previous section of the proposed rule (discussed in section III.K.3.c.(3) of this summary) for discussion of scoring the improvement activities performance category.

(e) Scoring the Promoting Interoperability Performance Category

CMS refers readers to a previous section of the final rule (discussed in section III.K.3.c.(4) of this summary) for discussion of scoring the promoting interoperability performance category.

(2) Calculating the Final Score

For the 2021 MIPS payment adjustment, the final score is calculated using the following formula: (Quality performance category percent score \times Quality performance category weight) + (Cost performance category percent score \times Cost performance category weight) + (Improvement

$(\text{Activities performance category score} \times \text{Improvement Activities performance category weight}) + (\text{Promoting Interoperability performance category score} \times \text{Promoting Interoperability performance category weight}) \times 100 + \text{the complex patient bonus, not to exceed 100 points.}$

In this rule CMS proposes to continue the complex patient bonus for the 2022 MIPS payment year and to establish reweighting policies for the 2022, 2023 and 2024 payment years.

(a) Complex Patient Bonus for 2022 MIPS Payment.

CMS proposes to continue for 2022 the complex patient bonus adjustment, which is meant to protect access to services for complex patients and avoid disadvantaging the clinicians who care for them. CMS continues to see this bonus as a short-term solution and discusses previous analyses it undertook to consider whether the data support continuation of the complex patient bonus adjustment, as well as to consider newer work of the Assistant Secretary for Planning and Evaluation regarding socioeconomic status and the quality of care.

Table 45 of the proposed rule shows the preliminary results of CMS' updating its previous analysis looking at the relationship between final scores and two potential indicators of patient complexity: medical complexity as measured through Hierarchical Condition Category (HCC) risk scores; and social risk as measured through the proportion of patients with dual eligible status. The analysis estimated 2022 MIPS payment year scores using 2017 performance period data. CMS observes (1) a consistent relationship between the dual eligible ratio quartiles and the average MIPS final scores only for individuals (not groups), where the average MIPS final score decreases as the quartile increases; and (2) slight differences in the average HCC risk score and dual eligible ratio quartiles for groups, but virtually no difference for average HCC risk score for individuals. CMS notes that more data or more recent data might bring different results. In the absence of more data and further analysis from ASPE, CMS believes it would be premature to take steps other than continuing the complex patient bonus at this time. `

(b) Final Score Performance Category Weights

As discussed in section III.K.3.c.(1)(b) of the rule, CMS proposes to modify the performance category weights for the 2022, 2023 and 2024 payment years. The table below shows the weights previously finalized for the 2020 and 2021 payment years along with the proposed weights from Table 45 in the proposed rule.

Previously Finalized and Proposed Weights by MIPS Performance Category and MIPS Payment Year

Performance Category	MIPS Payment Year				
	2020	2021	2022 (Proposed)	2023 (Proposed)	2024 (Proposed)
Quality	50%	45%	40%	35%	30%
Cost	10%	15%	20%	25%	30%
Improvement Activities	15%	15%	15%	15%	15%
Promoting Interoperability	25%	25%	25%	25%	25%

Flexibility for Weighting Performance Categories. CMS previously adopted policies for redistributing performance category weights under certain circumstances, such as when it cannot

reliably calculate a performance category score because there is no measure applicable and available to a clinician or when it cannot reliably calculate a score for the measures in the cost category, among others.

In this rule, CMS proposes that beginning with the 2020 payment year, it would redistribute the weight of any performance category if it determines, based on information known to the agency prior to the beginning of the relevant MIPS payment year, that data for a MIPS-eligible clinician are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician and its agents. The reweighting would not be voided by the submission of data for the Promoting Interoperability performance category as is the case with other significant hardship exceptions.

The proposed reweighting would take into account both what control the clinician had directly over the circumstances and what control the clinician had indirectly through its agents (i.e., any individual or entity, including a third party intermediary as described acting on behalf of or under the instruction of the MIPS eligible clinician). **CMS solicits comments on this approach and possible alternatives for reweighting in circumstances in which clinicians are not culpable for compromised data while maintaining financial incentives for clinicians, third party intermediaries and other parties to prevent and correct compromised data.**

Third party intermediaries are asked to inform MIPS-eligible clinicians if the intermediary believes data may have been compromised, and to notify CMS of any clinicians so affected. Clinicians also are encouraged to contact CMS directly; CMS notes that knowing submission of compromised data may result in remedial action against the submitter.

CMS proposes that the determination of whether this reweighting applies would be made on a case-by-case basis. Relevant factors include whether the affected MIPS-eligible clinician or its agents knew or had reason to know of the issue; whether the clinician or agents attempted to correct the issue; and whether the issue caused the data submitted to be inaccurate or unusable for MIPS purposes. **CMS solicits feedback on these factors and any additional factors it should consider.** If CMS determines that the conditions for reweighting are met, it would notify the clinician through the quarterly confidential reports or other routine QPP communication channels. CMS emphasizes that if a MIPS-eligible clinician has submitted compromised data for a performance category after the start of the payment year, the clinician would not qualify for reweighting under this proposal.

Redistributing Performance Category Weights. CMS previously adopted policies for redistributing performance category weights under the flexibilities discussed above. In general, where possible weights are redistributed to the quality performance category because clinicians have the most experience reporting quality measures. CMS has previously stated that it would be inappropriate to redistribute weight to the cost category because clinicians have limited experience with being scored on these measures.

In this rule CMS proposes to modify the redistribution of category weights for the 2022 payment year from the 2021 redistribution policies. The changes would (1) reflect the proposed changes in category weights described earlier (i.e., increasing the cost weight by 5 percentage points and reducing the quality weight by the same); (2) no longer redistribute any weight to the

improvement activities category and (3) in the case of redistributing the cost category weight, to redistribute some weight to the promoting interoperability category where available instead of all weight to the quality category. This is intended to recognize the importance of interoperability.

The proposal to no longer redistribute any other category weights to the improvement activities category is made because CMS believes the category only reflects attestations of whether certain improvement activities were completed, and at this point in the MIPS program CMS believes it is important to prioritize measures that show a variation in performance. Under the proposal, the improvement activities category would never receive a weight greater than 15 percent. In a case where the quality and promoting interoperability category weights were both being redistributed; the cost category weight would be 85 percent and the improvement category 15 percent. CMS also believes this proposal would discourage clinicians from choosing not to report quality measures.

Beginning with the 2023 payment determination, CMS proposes to begin redistributing weight from other categories to the cost category. That is because elsewhere in this rule (section III.K.3.c.(2)) CMS is proposing substantial changes to the cost category, including changes to the MSPB measure and the addition of 10 new episode-based cost measures. It believes that clinicians are gaining experience with these measures and for the 2023 payment year it is appropriate to begin redistributing weight to this category.

In general, category weights would be redistributed so that the quality and cost performance categories are almost equal. For example, beginning with the 2024 MIPS payment year, if the improvement activities performance category is the only performance category to be reweighted to zero percent, quality and cost would be 40 and 35 percent, respectively.

Tables 47, 48 and 49 in the proposed rule show the specific performance category reweighting policies proposed for the 2022, 2023 and 2024 payment determinations, respectively. The tables show how weights would be redistributed among the remaining categories under various scenarios such as redistributing the cost category weight among the other three categories or redistributing the quality and promoting interoperability weights between the remaining two categories, and so forth.

e. MIPS Payment Adjustments

(1) Establishing the Performance Threshold

The Secretary is required to annually compute a performance threshold for purposes of determining the MIPS payment adjustment factors. The threshold is either the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary. The statute provided for special rules for the initial 2 years of the MIPS, and as a result of the BBA of 2018, an additional special rule applies for the third year through the fifth year (payment in 2021 through 2023). The newer additional special rule requires the Secretary to increase the performance threshold for each of the three specified years to ensure a gradual and incremental transition to the performance threshold specified for year six (2024).

The previously adopted and proposed performance thresholds, along with CMS' current estimate of the 2024 performance threshold are shown here:

2019	2020	2021	2022 Proposed	2023 Proposed	2024 (estimated)
3 points	15 points	30 points	45 points	60 points	70.74*

*Mean of the actual MIPS scores for 2019.

In estimating the 2024 performance threshold and proposing the thresholds for 2022 and 2023, CMS reviewed actual data for the first year of MIPS (2019 payment/ 2017 performance), and used those data to also model performance under rules for 2021 payment. The mean and median of final scores for the 2020 payment year were not available for the proposed rule. Instead, for this rule performance scores for 2020 were estimated using a variety of older data from the PQRS, VM and other sources. This modeling is discussed in the Regulatory Impact Analysis (RIA) section of the 2018 PFS final rule. Table 51 from the proposed rule, reproduced below, shows the mean and median data on which CMS relied in its latest proposals. CMS anticipates that the actual mean and median performance scores for the 2020 MIPS payment year will be available before the final rule is released.

TABLE 51: Potential Values for Estimated Performance Threshold for the 2024 MIPS Payment Year Based on the Mean or Median Final Score for the 2019 MIPS Payment Year; 2020 MIPS Payment Year; and 2021 MIPS Payment Year

	2019 MIPS Payment Year * (points)	2020 MIPS Payment Year ** (points)	2021 MIPS Payment Year *** (points)
Mean Final Score	74.01	80.30	69.53
Median Final Score	88.97	90.91	78.72

Source: CY 2019 PFS final rule RIA * , *** (83 FR 60048); CY 2018 Quality Payment Program final rule RIA ** (82 FR 53926 through 53950).

* Mean and median final scores based on actual final scores for 2019 MIPS payment year.

** Mean and median final scores based on information available in the RIA because actual final scores for the 2020 MIPS payment year were not available in time for this proposed rule.

*** Mean and median final scores based on estimated final scores from 2021 MIPS payment year.

CMS chose the mean score for 2019 (74.01) as the estimated performance target for 2024 because it is based on actual data, is more achievable than the median (88.97), and generally falls in the middle of the values referenced in Table 51. It recognizes that using information from the early years of MIPS has numerous limitations, and the distribution of final scores for 2024 payment year may be very different given the changes in eligibility and scoring policies over the years. For example, Table 51 illustrates that CMS expects the mean and median scores for the 2021 payment year to be lower than those for earlier years.

Using 74.01 as the estimated 2024 performance threshold, CMS proposes thresholds of 45 points for 2022 and 60 points for 2023. CMS believes that this would establish a consistent 15 point increase for years 3 through 6 of the MIPS and would meet the statutory requirement for a gradual and incremental transition to the 2024 performance threshold. In addition, CMS believes this proposal could incentivize higher performance by clinicians. As described in item (3) below,

CMS offers examples of how the 45-point threshold could be met by clinicians in various circumstances, including a small practice.

Comments are specifically sought on several issues, including the proposed performance thresholds for 2022 and 2023; whether and how CMS should use information on actual performance in 2020 to set a different 2022 performance threshold in the final rule; whether the increase in the performance threshold from 2021 should be more gradual or steeper; and on alternative thresholds. CMS states that for 2023, it alternatively considered whether the performance threshold should be set at 55 points or 65 points.

(2) Additional Performance Threshold for Exceptional Performance

CMS proposes the additional performance thresholds for exceptional performance for the 2022 and 2023 MIPS payment years to be 80 points and 85 points, respectively, an increase from 75 points previously established for 2021. Clinicians with final scores at or above the additional performance threshold are eligible to share in the \$500 million available for additional payments for exceptional performance. The statutory basis for setting this threshold is discussed along with CMS' logic in rejecting the use of the 25th percentile of the range of scores above the performance threshold, which it says would establish additional performance thresholds that are below the mean and median final scores for earlier years shown in Table 51.

These proposed thresholds are described as “minimal and incremental” increases over the 2021 additional performance threshold of 75 points. CMS notes that to achieve these points a clinician would have to perform well on multiple categories and would have to submit data for the quality category. It recognizes that the higher thresholds may reduce the number of clinicians who receive additional MIPS payment adjustments, but notes that the maximum additional adjustment paid to those who meet the threshold would increase if the \$500 million available for these payments were distributed among fewer clinicians. CMS believes that it is appropriate to further incentivize exceptional performance in years 4 and 5 of the MIPS program.

CMS invites comments on the proposed thresholds and alternatives. It considered maintaining the exceptional performance threshold for 2022 at 75 points and setting it even higher at 85 points. It also considered proposing 80 points as the threshold for both 2022 and 2023. Comments are sought on whether the exceptional performance thresholds should be changed if CMS modifies the base performance thresholds (i.e., the 45 points and 60 points) in the final rule.

(3) Example of MIPS Adjustment Factors

Figure 1, copied from the proposed rule (including original blurry features and random “chart area” text box), illustrates how scores would be converted into adjustment factors for 2022 payment. The proposed performance threshold is 45 points, and the applicable percentage is 9 percent. As shown, clinicians with a final score of 45 points would receive a 0 percent adjustment. The scale for other scores is not completely linear for two reasons. First, all clinicians with a final score between 0 and ¼ of the performance threshold (0 and 11.25 in the example) receive the lowest negative adjustment of -9 percent. Second, the linear sliding scale line for the positive adjustment factor is affected by the budget neutrality scaling factor. If the

budget neutrality scaling factor is greater than 0 and less than or equal to 1.0, then the adjustment factor for a final score of 100 would be less than or equal to 9 percent. If the scaling factor is above 1.0, but less than or equal to the specified limit of 3.0, then the adjustment factor for a final score of 100 would be higher than 9 percent. CMS anticipates that with a performance threshold of 45 points, the scaling factor would be less than 1.0 and the payment adjustment for clinicians with a final score of 100 would be less than 9 percent.

CMS indicates that for Figure 1, the illustrative budget neutrality scaling factor is 0.203; MIPS eligible clinicians with a final score of 100 would receive an adjustment factor of 1.83 percent (9.0 percent X 0.203). As shown next, however, this clinician would also receive an additional (exceptional performance) adjustment factor.

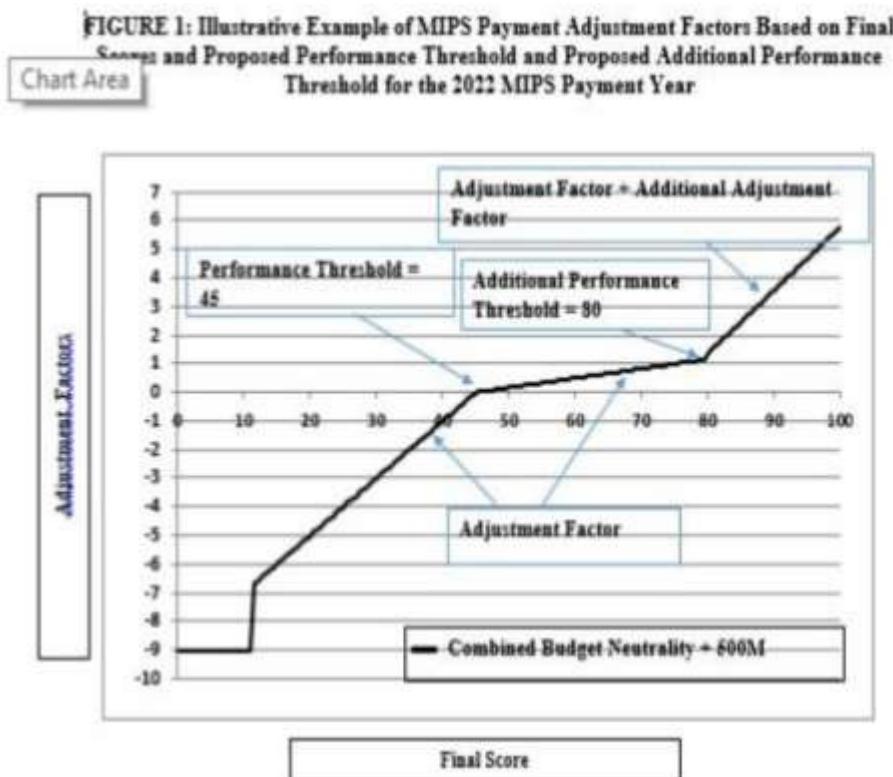
The exceptional performance threshold is 80. A score of 80 would receive an additional adjustment factor of 0.5 percent and the factor would increase to the statutory maximum of 10 percent for a perfect final score of 100, with a separate scaling factor applied to ensure distribution of the \$500 million payments. CMS also indicates that for Figure 1, the illustrative scaling factor for the additional adjustment is 0.395; a clinician with a final score of 100 will receive an additional adjustment factor of 3.95 percent (10 percent X 0.395), and therefore a total adjustment of 5.78 percent (1.83 percent + 3.95 percent).

The actual MIPS payment adjustments will be determined by the distribution of performance scores; the greater the number of clinicians above the threshold, the more the scaling factors will decrease, and vice versa.

Table 52 in the proposed rule compares the point system and associated adjustment adopted for the 2020 MIPS and 2021 payment years as previously finalized, and the 2022 and 2023 payment years as proposed in this rule. For 2023, the proposed performance threshold would increase to 60 points, and the additional performance threshold would be 85 points.

In addition, the proposed rule includes examples of how MIPS-eligible clinicians can achieve a final score at or above the proposed 45-point performance threshold. The examples reflect a clinician in a small practice submitting 5 quality measures and 1 improvement measure; a group submission that is not a small practice; and a non-patient facing MIPS-eligible clinician.

FIGURE 1: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2022 Payment Year



Note: The adjustment factor for final score values above the performance threshold is illustrative. For MIPS eligible clinicians with a final score of 100, the adjustment factor would be 9 percent times a scaling factor greater than zero and less than or equal to 3.0. The scaling factor is intended to ensure budget neutrality, but cannot be higher than 3.0. MIPS clinicians with a final score of at least 80 points would also receive an additional adjustment factor for exceptional performance. The additional adjustment factor is also illustrative. The additional adjustment factor starts at 0.5 percent and cannot exceed 10 percent and is also multiplied by a scaling factor that is greater than zero and less than or equal to 1. MIPS eligible clinicians at or above the exceptional performance threshold will receive the amount of the adjustment factor plus the additional adjustment factor. This example is illustrative only, as the actual payment adjustments may vary based on the distribution of final scores for MIPS eligible clinicians.

f. Targeted Review and Data Validation and Auditing

(1) Targeted Review

MIPS-eligible clinicians or groups may request a targeted review of the calculation of the MIPS payment adjustment factor and the additional MIPS payment adjustment factor. The request must be made within 60 days from the day CMS makes the adjustment factors available, and ends on September 30 of the year prior to the payment year, or at later date specified by CMS. If CMS determines a review is warranted and requests additional information, this must be received within 30 days of the request. Decisions based on the targeted review are final, and there is no further review or appeal.

In this rule, CMS proposes several modifications:

- Support staff and third party intermediaries (e.g., qualified registry, health information technology vendor, or QCDR) would be allowed to submit a targeted review request on behalf of an eligible clinician or group. Because third party intermediaries do not have access to the performance feedback for clinicians and groups, CMS would share with these designated entities a web link to the targeted review request form.
- Beginning with the 2019 performance period, the timeline for targeted review requests would be modified (clarified) to require that all targeted review requests be made during the targeted review request submission period, which is the 60-day period that begins the day that CMS makes the adjustment factors available. CMS would have authority to extend this period.
- A request for targeted review could be denied if the request is duplicative of another targeted review request; the request is not submitted during the targeted review request submission period; or is outside the scope of targeted review.
- Documentation submitted for a targeted review would have to be retained by the submitter for 6 years from the end of the MIPS performance period. This aligns with the existing requirement for the auditing of entities submitting MIPS data.
- Other clarifying changes to the regulatory text are proposed.

(2) Data Validation and Auditing

Existing regulations require that MIPS-eligible clinicians and groups that submit data and information for purposes of MIPS must certify that to the best of their knowledge the data is true, accurate and complete. In response to inquiries, CMS notes that using data selection criteria to misrepresent a clinician or group's performance, referred to as "cherry picking," results in data that are not true, accurate or complete. If CMS believes that cherry picking may be occurring it may subject the clinician or group to auditing, and in the case of improper payment institute a reopening and revision of the MIPS payment adjustment. The regulations regarding data validation and auditing appear at §414.1390.

g. Third Party Intermediaries

Under current policy, MIPS data may be submitted on behalf of an eligible clinician, group or virtual group by a QCDR, qualified registry, health IT vendor or a CMS-approved survey vendor. Specific requirements apply to each of these types of entities. In general, to be approved as a third party intermediary, the entity's principal place of business and any data retention must be in the U.S.; the entity must be able to indicate the source of any data derived from CEHRT; must certify the information as true, accurate and complete to the best of its knowledge; and other requirements must be met.

In this rule CMS proposes new requirements for approval as a third party intermediary and new requirements for QCDRs and qualified registries specifically.

(1) Performance Categories Supported by Third Party Intermediaries

Beginning with the 2021 performance period, QCDRs and qualified registries would have to be able to submit data for each of the three MIPS performance categories requiring data submission: quality (except for CAHPS); improvement activities; and promoting interoperability (if the clinician or group is using CEHRT). Health IT would have to be able to submit for at least one of the three categories. Currently, third party intermediaries *may* submit data for any of the categories, and CMS has heard from stakeholders who would like to use their QCDR or qualified registry for reporting all three categories, but the registry only offers quality reporting. **CMS seeks comment on the benefits and burdens of this proposal and whether it should be extended to health IT vendors.** It notes that 72 percent of QCDRs are supporting all three categories.

An exception would be provided for QCDRs and qualified registries that represent clinicians that are eligible for reweighting of the Promoting Interoperability category (e.g., physical therapists). These intermediaries would not be required to support the Promoting Interoperability category. CMS would use the self-nominating vetting process to determine whether the intermediary must support the Promoting Interoperability category. **CMS seeks comments on whether to narrow or broaden this proposed exception.**

(2) Approval Criteria for Third Party Intermediaries

CMS proposes two new requirements for approval of third party intermediaries. First, the entity would have to agree to provide services for the entire performance period and data submission period. Second, the entity would have to agree that prior to discontinuing services during a performance period, it would support the transition of MIPS-eligible clinicians and groups to an alternate intermediary or data submission mechanism according to an approved CMS transition plan. This is intended to avoid situations that have occurred in which a third party intermediary withdraws during a performance period, affecting the ability of clinicians and groups to participate in the MIPS program.

(3) QCDRs

a. QCDR Approval Criteria

In addition to the proposed requirement discussed above for supporting data submission for three performance categories, CMS proposes two additional new requirements for QCDRs.

- Among other elements, the definition of a QCDR includes fostering improvement in the quality of care provided to patients. CMS proposes to require that beginning with the 2023 MIPS payment year, QCDRs must foster services to clinicians and groups to improve the quality of care provided to patients by providing educational services in quality improvement and leading quality improvement initiatives. CMS says this might include the intermediary educating clinicians by providing reports on areas of improvement by clinical condition for specific clinical care criteria or using its data to identify best practices by high performers on a specific metric. (These quality improvement services provided by a QCDR are distinguished from activities undertaken

by clinicians and reported under the improvement activities performance category.) The QCDR would describe its quality improvement services as part of the self-nomination process for CMS review and approval, and would be included in the qualified posting for approved QCDRs.

- The existing requirement that QCDRs provide timely performance feedback at least 4 times a year on all the performance categories it reports to CMS would be modified beginning with the 2023 MIPS payment year. The 4 times a year minimum would continue and the QCDR would be required to provide specific feedback to clinicians and groups on how their performance on a measure compares with others submitting data to the QCDR. Exceptions may occur if the QCDR does not receive data from the clinician until the end of the performance period. **CMS seeks comment on other exceptions that may be necessary.** The QCDR would attest during the self-nominating process that they can provide the required feedback at least 4 times a year.

In addition to these proposals, **CMS solicits comment on two additional issues for future rulemaking.** The specific issues are (1) whether clinicians, groups, and virtual groups who utilize a QCDR should be required to submit data throughout the performance period, and prior to the close of the performance period (that is, December 31st) and (2) whether clinicians and groups can start submitting their data starting April 1 to ensure that the QCDR is providing feedback to the clinician or group during the performance period.

b. QCDR Measures

Measure Considerations. CMS proposes to codify existing requirements for QCDR measure considerations and to add a number of measure-specific requirements for QCDR measures that it says would generally align with MIPS measure policies as described earlier (III.K.3.c) The previously finalized policies that would be codified in a new §414.1400(b)(3)(iv) identify measure considerations for approval to include preference for outcome measures and measures addressing (1) patient safety and adverse events; (2) appropriate use of diagnosis and therapeutics; (3) care coordination; and (4) efficiency, cost, and resource use. The proposed new policies would begin with the 2020 performance period:

- CMS may consider the extent to which a QCDR measure is available for MIPS reporting through QCDRs other than the measure owner. CMS may not approve a measure that is not available for reporting through other QCDRs.
- Prior to measure development QCDRs “should” conduct an environmental scan of measures from QCDRs, MIPS and PQRS legacy measures and use CMS quality measure development plan and measures management system to identify measures gaps. Note that the preamble states that CMS would give greater consideration to measures for which the QCDR took these steps, although the proposed regulatory text omits this statement.
- CMS would place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive calendar year reporting periods. Those measures that do not meet these benchmarking thresholds may not continue to be approved. CMS notes this is parallel to a proposal elsewhere in the rule for MIPS measures. In the case of a low-reported

measure that does not meet benchmarking thresholds but is important to a specialty practice, a QCDR may develop and submit a QCDR measure participation plan for CMS consideration. The plan would include the QCDR's detailed plans and changes to encourage more clinicians and groups to submit data on the measure. The plan might include development of a specific education and communication plan; update the measure specifications to encourage broader participation (subject to CMS review and approval); or require reporting of the measure as a condition of reporting through the QCDR. CMS would evaluate whether the participation plan was effective in sufficiently increasing reporting volume on the measure for benchmarking.

QCDR Measure Requirements. Two previously finalized QCDR measure considerations are now proposed as requirements for QCDR measures. CMS would require that for approval, QCDR measures be beyond the concept phase of measure development and address significant variation in performance.

Beginning with the 2021 performance period, CMS proposes to require the following at the time of self-nomination:

- QCDRs must link their measures to a cost measure, an improvement activity and a CMS-developed MVP.²¹ CMS would consider exceptions if the potential QCDR measure meets the other requirements but does not have a clear link to one of these categories.
- Measures must be fully developed with completed testing results at the clinician level (as defined by the CMS Measure Management System blueprint: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf>). This is consistent with criteria for MIPS measures. CMS understands that this proposal would result in additional costs for QCDRs to develop measures; some QCDRs perform testing prior to submitting measures for approval while others do not.
- QCDRs must collect data on a measure as appropriate to the measure type prior to submitting the measure for CMS approval during the self-nomination period. The data collected would have to demonstrate that the measure is valid and reflects an important clinical concept, and could be used to demonstrate a performance gap and whether the measure is implementable. CMS strongly encourages QCDRs to collect data for 12 months prior to submission to increase the chance that the measure can be benchmarked.

Duplicative QCDR Measures. Beginning with the 2022 MIPS payment year (2020 performance year) CMS proposes that it may reject a duplicative measure if areas of duplication it has identified are not addressed by the QCDR within one year. Specifically, after the self-nomination period, CMS will review QCDR measures and where similar measures exist CMS may provisionally approve measures for one year with the condition that the QCDR address certain areas of duplication in order to be considered for the program in subsequent years. Addressing these areas might require more than one QCDR to collaborate on a single measure.

QCDR Measure Rejections. Currently, no measure rejection criteria are specified. CMS proposes that the criteria it would use for rejection of QCDR measures beginning with the 2021

²¹ The proposed rule is unclear as to whether a QCDR would need to demonstrate links to one of the three areas listed or to all three of them.

performance period would include the 14 factors listed in the proposed rule, although others could be applied. The listed factors that could be the basis of rejection include those addressing duplication with other measures; topped-out measures; process measures; potential unintended consequences; actionable quality actions; benchmarking thresholds; robustness; clinician attribution; and rare or “never” events.

Measure Review Process. Currently, QCDR measure approvals are year-to-year, and CMS proposes to implement, at its discretion, 2-year approval of QCDR measures that meet the requirements for approval. However, the second-year approval could subsequently be revoked if the measure is topped out; duplicative of a more robust measure; reflects an outdated clinical guideline; requires harmonization with another measure; or the QCDR is no longer in good standing. (For a QCDR no longer in good standing CMS would not remove a measure mid-year.)

(4) Qualified Registries

CMS proposes to update the requirements for qualified registries to reflect its proposal (discussed above) to require support for all three performance categories where data submission is required and to modify the requirements regarding qualified registry feedback to be parallel with those proposed for QCDRs as described above. Under the proposal, beginning with the 2023 MIPS payment year (2021 performance period), registries would need to attest during the self-nomination process that they can provide feedback 4 times a year or provide a rationale for why this requirement cannot be met. Specific feedback on how clinicians and groups compare to others submitting data on a given measure to the registry would be required. Exceptions may occur if the qualified registry does not receive data from the clinician until the end of the performance period. **CMS solicits comments on other exceptions that may be necessary.**

In addition to these proposals, **CMS solicits comment on two additional issues for future rulemaking.** The specific issues are (1) whether clinicians, groups, and virtual groups who utilize a qualified registry should be required to submit data throughout the performance period, and prior to the close of the performance period (that is, December 31st) and (2) whether clinicians and groups can start submitting their data starting April 1 to ensure that the registry is providing feedback and the clinician or group during the performance period.

(5) Remedial Action and Termination of Third Party Intermediaries

CMS proposes changes to the regulatory text regarding enforcement of the requirements for third party intermediaries. It is concerned that some intermediaries may not appreciate their compliance obligations or the implications of non-compliance. First, CMS proposes to clarify that remedial action and termination provisions are triggered if it determines that a third party intermediary falsely certifies that the data it submitted to CMS are true, accurate and complete to the best of its knowledge. Second, it proposes to clarify that its authority to bring remedial actions or terminate a third party intermediary for submitting data that is inaccurate, unusable or otherwise compromised extends beyond the specific examples set forth in the regulatory text (i.e., beyond instances of TIN/NPI mismatches, formatting issues, calculation errors or data audit discrepancies affecting more than 3 percent of the clinicians or groups for which data was submitted).

h. Public Reporting on Physician Compare

Data Available. CMS proposes to add detail to §414.1395(a) to more completely describe the data available for public reporting on Physician Compare. Proposed new paragraph (1) would be amended to state that CMS posts on Physician Compare information regarding the performance of MIPS-eligible clinicians (in existing regulations), *including but not limited to, final scores and performance category scores for each MIPS eligible clinician; and the names of eligible clinicians in Advanced APMs and to the extent feasible, the names and performance of such advanced APMs.* (Italicized language would be new.)

Proposed new paragraph (2) (discussed in section III.K.3.h.(2) of the rule) would state that CMS periodically posts aggregate information on the MIPS including the range of final scores and range of performance for each performance category.

Proposed new paragraph (3) would state that, where appropriate, publicized information may not be representative of a clinician's entire patient population, services provided, or health conditions treated.

Timeframe for Posting. CMS states that although it previously finalized a policy to periodically post aggregate information on the MIPS, it has not to date established a timeframe for doing so. Now that CMS has experience with the data, it is proposing to post aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS-eligible clinicians, beginning with Year 2 (CY 2018 data, available starting in late CY 2019). CMS seeks comment on any other aggregate information that stakeholders would find useful for future public reporting on Physician Compare.

Quality. CMS does not propose changes to reporting on quality performance category information, but is seeking comment on adding patient narratives to the Physician Compare website. It states that consumers have consistently expressed interest in seeing narrative reviews, quotes and testimonials as well as a single overall "value indicator" on the Physician Compare website. Comments are sought on the value and considerations for publicly reporting such information and notes that in section III.K.3.c.(1)(c)(i) of this proposed rule, CMS also sought comments regarding adding narrative reviews into the CAHPS for MIPS group survey in future rulemaking.

To add such information to Physician Compare, the data would need to meet public reporting standards (in §414.1395(b)) and be reviewed in consultation with the Physician Compare Technical Expert Panel. CMS seeks comment on the value of collecting and publicly reporting information from narrative questions, as well as publishing a single "value indicator" reflective of cost, quality and patient experience and satisfaction with care for each MIPS eligible clinician and group, on the Physician Compare website. CMS will consider stakeholder comments in the development of any future regulation and notes that it will also address all related patient privacy safeguards under existing laws including those related to the privacy of individually identifiable health information.

Promoting Interoperability. CMS does not propose any changes regarding publicly reporting Promoting Interoperability category information, but refers readers to the Interoperability and Patient Access proposed rule (84 FR 7646 through 7647), where CMS describes a proposal to include an indicator on Physician Compare for the eligible clinicians and groups that submit a “no” response to any of three prevention of information blocking attestation statements. To report successfully in this category, a MIPS eligible clinician must attest to “yes” responses for each of those statements which are intended to verify that the clinician has not taken any actions to limit or restrict the compatibility or interoperability of CEHRT. CMS notes that comments related to this provision would be outside the scope of this proposed rule, so readers wishing to comment are directed to the Interoperability and Patient Access proposed rule cited above (at <https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and>).

Facility-based Clinician Indicator. CMS informs readers that it has determined how it will display facility-based MIPS-eligible clinician quality and cost information on Physician Compare. It considered two options for public reporting: (a) displaying hospital-based measure-level performance information on Physician Compare profile pages, including scores for specific measures and the hospital overall rating; or (b) including an indicator showing that the clinician or group was scored using the facility-based scoring option with a link from the clinician’s Physician Compare profile page to the relevant hospital’s measure-level performance information on Hospital Compare.

CMS concluded that a link from the clinician’s Physician Compare profile page to the relevant hospital’s performance information on Hospital Compare is preferable and proposes to make available for public reporting an indicator on the Physician Compare profile page or downloadable database that displays if a MIPS-eligible clinician is scored using facility-based measurement. In addition, CMS proposes to provide a link to facility-based measure-level information for such MIPS-eligible clinicians on Hospital Compare, as technically feasible; and to post this indicator on Physician Compare with the linkage to Hospital Compare beginning with CY 2019 performance period data available for public reporting starting in late CY 2020 and for all future years, as technically feasible.

4. Overview of the Alternative Payment Model (APM) Incentive

a. Background of the APM Incentive Pathway of the QPP

CMS begins its discussion of the APM pathway for payment of eligible clinicians as proposed for 2020 by highlighting some facets of the APM Incentive program.

- For payment years 2019 and 2020, eligible clinicians can become Qualifying APM Participants (QPs), and thereby be excluded from MIPS, based only upon their extent of Advanced APM participation (i.e. payments or patient counts, through the “Medicare Option”). All “Advanced APMs” are sponsored by CMS.
- For payment years 2021 and later, QP status also can be reached by combining Advanced APM participation with “Other Payer Advanced APM” participation (i.e., through the “All-Payer Combination Option”). Payment arrangements that may qualify as Other

Payer Advanced APMs include those between eligible clinicians and Medicare Health Plans, Medicaid programs, CMS Multi-Payer Models, and what CMS terms “Remaining Other Payers”. Determinations of whether an APM sponsored by a payer other than Medicare (“Other Payer”) meets criteria to be treated as an Other Payer Advanced APM are made by CMS using the Payer Initiated or Eligible Clinician Initiated process.

- A clinician reaching QP status for any payment year from 2019 through 2024, will receive a lump sum incentive payment for that year, equal to 5 percent of their immediately preceding year’s estimated aggregate payments for Part B covered professional services. No lump sum incentives will be paid after 2024. Beginning with payment year 2026, QPs will receive a higher annual PFS update than non-QPs.²²

CMS reviews the criteria that must be satisfied for a payment arrangement to be considered an Advanced APM. The criteria are set in statute and all must be met.

- Participants are required to use CEHRT.
 - All APM Entities within an Advanced APM must require at least 75 percent of their eligible clinicians to use CEHRT in clinical care delivery.
- Payment for covered professional services must be based at least in part on quality measures comparable to those of the MIPS Quality performance category.
 - Beginning with performance year 2020, at least one of the measures must be finalized on the MIPS final list of measures; endorsed by a consensus-based entity; or determined by CMS to be evidence-based, reliable, and valid. At least one of the measures also must be an outcome measure, if available.

Participating APM Entities must be able to bear risk for more than nominal monetary losses. CMS approaches this criterion as having two parts: 1) describing ways to bear risk (e.g., repayment, forfeiture future payment; the “financial standard”), and 2) what constitutes more than nominal monetary losses (e.g., percentage of revenues, actual loss amount; “the nominal amount standard”). Other than for Medical Home Models, the applicable revenue-based nominal amount standard will remain at 8 percent through the 2024 QP Performance Period.²³ For models not expressing risk in terms of revenues, the total expenditure-based nominal amount standard will remain indefinitely at 3 percent

Medical Home Exception

Any (Medicare-sponsored) APM that 1) meets the CEHRT and Quality criteria; 2) is a Medical Home Model (defined at §414.1305); and 3) has been expanded under section 1115A(c) of the Act, is considered to be an Advanced APM.²⁴ Absent expansion, a modified nominal amount standard with a more gradual risk percentage progression (described at §414.1415(c)(4)) is applied to APMs meeting the Medical Home Model definition.

²² Beginning in CY 2026, the update to the “qualifying APM conversion factor” is set at 0.75% for QPs and the update to the “nonqualifying APM conversion factor” is set at 0.25% for non-QPs.

²³ The QP Performance Period is defined as extending from January 1 through August 31 of the calendar year that is 2 years prior to the related payment year.

²⁴ As yet, no medical home models have been expanded under section 1115A(c) of the Act.

CMS expects that the following 11 APMs will satisfy the requirements to be Advanced APMs for the 2020 MIPS performance period. The final determinations will be announced via the QPP website.

- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track),
- Comprehensive ESRD Care Model (Two-Sided Risk Arrangement),
- Comprehensive Primary Care Plus Model (all Tracks),
- Next Generation ACO Model,
- Oncology Care Model (Two-Sided Risk Arrangement),
- Medicare Shared Savings Program (Track 2, Basic Track Level E, and the ENHANCED Track),
- Medicare ACO Track 1+ Model,
- Bundled Payments for Care Improvement (BPCI) Advanced
- Maryland Total Cost of Care Model (Maryland Care Redesign Program, Maryland Primary Care Program),
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative), and
- Primary Care First (General and High-Need Population Options)

b. Aligned Other Payer Medical Home Model

CMS proposes to add the term Aligned Other Payer Medical Home Model, to be defined as a payment arrangement with the following features:

- Is operated by a payer other than Medicare or Medicaid;
- Formally partners with CMS in a CMS Multi-Payer Model that also is a Medical Home Model:
 - The partnership is described by a written expression of alignment and cooperation, such as a memorandum of understanding (MOU).
- Has a primary care focus (i.e., the included practice must include primary care practitioners and offer primary care services) and empanels each patient to a primary clinician; and
- Demonstrates at least 4 of the following: planned coordination of chronic and preventive care; patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood; patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

CMS notes that this definition is purposefully structured to parallel existing language that defines a Medical Home Model (applicable under Medicare) and a Medicaid Medical Home Model. CMS, however, emphasizes that the three medical home models (Medicare, Medicaid, and Aligned Other Payer), though similarly defined, are distinct from one another. Further, CMS proposes to limit the term Aligned Other Payer Medical Home Model specifically to other payers' payment arrangements that are aligned with CMS Multi-Payer Models that are themselves Medical Home Models.²⁵ CMS cites recent experience showing that aligned medical

²⁵ The Comprehensive Primary Care Plus model (CPC+) is an example of a CMS Multi-Payer Model that also is a Medical Home Model that has not yet been expanded.

home model participants typically resemble Medicaid medical home model participants in size, revenues, and limited ability to bear risk. That said, CMS also emphasizes that participants in the various medical home models do vary in their risk-bearing abilities regardless of payer, so that the existing 50-clinician limit would apply to the proposed Aligned Medical Home model. (When a medical home model participant has more than 50 clinicians, the generally applicable standards apply rather than the medical home financial and nominal amount standards. For full details see §414.1415(c)(7).)

c. Bearing Risk: Defining Excess Expenditures

Context

When assessing whether a model meets the Advanced APM Financial criterion, CMS first examines how risk-bearing is described (e.g., in terms of returning payment received or of future payment withholding), termed the financial standard. Second, CMS determines if the actual amount at risk (potential monetary losses by the APM) exceeds the nominal amount threshold, termed the nominal amount standard. Both standards (financial and nominal amount) differ for medical home models from those for other models; the former are referred to as “medical home standards” and the latter as “generally applicable” standards. The current generally applicable nominal standards are 8 percent for models with risk expressed in terms of revenue (revenue-based) and 3 percent total risk for other models. (The remainder of this section will focus on the generally applicable standards, since the medical home standard does not depend upon expected expenditures; see §414.1415(c)(2)).

Since the QPP’s inception, CMS has acquired extensive experience with the design and evaluation of APM financial structures. For QPP Year 1, CMS proposed 3 dimensions of risk for use when assessing if a model’s design meets the generally applicable nominal risk standard: 1) marginal risk, the percentage of (actual – expected) expenditures for which an APM Entity would be liable; 2) minimum loss rate, or MLR, the percentage by which actual expenditures may exceed expected expenditures without triggering financial risk for the APM Entity; and 3) total potential risk, the maximum potential payment for which an APM Entity could be held liable. For simplicity, CMS finalized only the total potential risk parameter for Medicare-sponsored Advanced APMs, anticipating that their model designs always would incorporate appropriately strong risk levels. (For use in assessing risk under Other Payer Advanced APMs, CMS retained all 3 risk dimensions.) CMS states an expectation that the participants within a model meeting the nominal amount standard should face: 1) the potential for financial losses based on expenditures in excess of the model’s benchmark or episode target price, and 2) a meaningful possibility that a participating APM entity might exceed the benchmark or episode target price.

CMS voices having become concerned that a model’s risk-bearing and nominal monetary loss parameters can satisfy current regulations but may be structured in a way that actually limits risk-bearing to inappropriately low levels. CMS links insufficient risk-bearing to the definition of expected expenditures, a number that is part of virtually all calculations of amounts for which APMs might be at risk. CMS offers the example that an APM could have a sufficient total risk to meet the benchmark-based nominal amount standard and a sharing rate that results in an adequate marginal risk rate if actual expenditures exceed expected expenditures. However, that

same APM's level of expected expenditures, reflected in its benchmark or episode target price, could be set in a way that substantially reduces the loss that the APM Entity would reasonably expect to incur. High expected expenditures increase the likelihood that a participant's actual expenditures will be near or less than the benchmark or episode target price, resulting in small or no monetary loss by the participant. High expected expenditures can result from factors such as using non-representative baseline data for benchmarking (e.g., data only from high cost regions or too old to reflect current medical practice), or basing adjustments that are made to benchmarks in order to account for possible expenditure increases that may be viewed as desirable, on flawed assumptions (e.g., rates of patient compliance with behavioral interventions). CMS states that increased costs due to proper patient risk-adjustment are not considered excess expenditures.

Given the foregoing, for 2020 and thereafter, CMS proposes to revise the definition of expected expenditures (at §414.1415(c)(5)), when used for assessing risk-bearing, to exclude excess expenditures. CMS would require that the expected expenditures under the terms of the APM not exceed the Medicare Part A and B expenditures for a participant in the absence of the APM. If the expected expenditures do exceed those that would occur in the model's absence, the excess expenditures would not be counted towards meeting the nominal amount standard.

d. Request for Comment: Excluded Items and Services under Full Capitation Arrangements

CMS has previously established that a full capitation arrangement meets the Advanced APM financial risk criterion. A full capitation arrangement is one in which: 1) a predetermined payment (e.g., per capita) is made through the APM to cover all items and services furnished to a beneficiary population during a fixed time period; and 2) no settlement or reconciliation with CMS is performed. (Arrangements between CMS and MA organizations are not considered capitation arrangements under the QPP.²⁶) More recently, CMS has become aware that other payers' capitation arrangements contain lists of services excluded from the capitation rate, such as hospice care, organ transplants, and out-of-network emergency services.

CMS indicates an intent to assess whether CMS should allow capitation arrangements to be judged as "full" capitation if they categorically exclude specified items or services from payment through the capitation rate. **To that end, CMS seeks comment on the following issues.**

- Are there common industry practices to exclude certain categories of items and services from capitated payment rates?
 - If so, are there common principles or reasons for excluding those categories?
- What percentage of the total cost of care do such exclusions typically account for under what is intended to be a "full" global capitation arrangement?
- How do non-Medicare payers define service categories that are excluded from global capitation payment arrangements?

For Other Payer Advanced APMs, CMS has similarly defined a full capitation arrangement that meets the Other Payer Advanced APM financial risk criterion. CMS also seeks comment on the

²⁶ The Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, an Innovation Center initiative, was designed to test options for counting MA participation towards the QP threshold. Announced on July 12, 2018, the MAQI demonstration was discontinued on August 1, 2019 due to low participation rates.

above questions as part of considering whether other payers' arrangements that exclude specified services from the capitation rate should be determined by CMS to satisfy the Other Payer Advanced APM financial risk criterion.

e. QP and Partial QP Determinations

Application of Partial QP Status

Clinicians (each identified by an NPI) may belong to more than one group (identified by a TIN) and may reassign their billing rights across different groups, so that multiple TIN/NPI combinations are associated with a single clinician. When an individual reaches QP status through participation in one group, CMS has considered the individual to be a QP for all of his or her TIN/NPI combinations when calculating the APM incentive bonus payment. Currently, CMS applies this approach in a similar way to individuals reaching Partial QP status: the election of a partial QP to be exempt from MIPS reporting and payment adjustment is applied to all of his or her TIN/NPI combinations. Since Partial QP status is not linked to additional payment, a clinician who might qualify for a positive MIPS adjustment through one TIN/NPI combination could be precluded from receiving that adjustment by reaching Partial QP status under another TIN/NPI combination and electing MIPS exemption under the latter TIN/NPI.

CMS has recently considered in detail the scenario of the clinician with multiple TIN/NPI combinations who does not independently reach Partial QP status for each TIN/NPI arrangement. CMS expresses concern that the potential loss of the positive MIPS adjustment by a Partial QP clinician under this scenario could discourage participation in Advanced APMs. CMS, therefore, proposes that beginning with the 2020 QP performance period, Partial QP status would apply only to the TIN/NPI combination(s) through which an individual attains Partial QP status, if the clinician elects MIPS exemption.

APM Entity Termination

Current regulations are designed to ensure that APM Entities and their member clinicians face more than nominal financial risk for at least the full QP performance period of a year in which they attain QP or Partial QP status. Nevertheless, CMS expresses concern about scenarios in which an APM Entity terminates (voluntarily or not) from an Advanced APM at a date on which the entity would not yet have incurred financial accountability under the terms of the APM. Such scenarios could arise because terms of the agreements between Advanced APMs and CMS can vary, giving flexibility that is intended to foster innovation. Currently, the QP or Partial QP status of the entity's clinicians would not be affected by "early termination", even though they would have reached their status through an Advanced APM that in fact did not satisfy the Advanced APM financial risk criterion. CMS proposes to eliminate such scenarios for performance year 2020 and subsequent years. Revised regulatory language explicitly would state that an eligible clinician is not a QP or Partial QP for the year, if an APM Entity were to terminate before incurring financial risk under the terms of the Advanced APM, for the year in which the QP Performance Period occurs.

f. All-Payer Combination Option and Other Payer Advanced APMs

Context

The All-Payer Combination became available to clinicians starting with the 2019 QP Performance Period, and 2021 will be the first payment year under this option. Through the All-Payer option, groups and individual clinicians may achieve QP or Partial QP status by reaching pre-defined levels (thresholds) of participation in both (Medicare-sponsored) Advanced APMs and those sponsored by other payers. A minimum level of Advanced APM participation is required; that is, QP status cannot be reached based solely on participation in Other Payer Advanced APMs. Tables 56 and 57, reproduced below from the rule, show the thresholds; the material in these tables has been previously finalized and has appeared in prior rules.²⁷ When determining if a clinician, a TIN, or an APM Entity is a QP, CMS actually makes a series of determinations so that the Medicare Option is applied first (using the payment and patient count thresholds) followed by the All-Payer option (using both thresholds); the most favorable result from the series of determinations is applied to the clinician, TIN, or entity.

TABLE 56: QP Payment Amount Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Payment Count Threshold					
Medicare Minimum	N/A	N/A	25%	25%	25%
Total			50%	50%	75%
Partial QP Payment Count Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			40%	40%	50%

TABLE 57: QP Patient Count Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			35%	35%	50%
Partial QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	10%	10%	10%
Total			25%	25%	35%

Payment arrangements that may qualify as Other Payer Advanced APMs include those between clinicians and Medicare Health Plans, Medicaid programs, and what CMS terms “Remaining Other Payers”. All of the information necessary to make an Advanced APM determination is maintained by CMS, and the Agency automatically performs determinations annually, releasing

²⁷ Figures 2 and 3 of the rule depict the QP determination decision trees for both the Medicare and All-Payer Combination options. The material in these has been previously finalized and published in prior rules.

an Advanced APM list thereafter. CMS lacks the corresponding information about APMs sponsored by others, and determinations of Other Payer Advanced APM status are performed by CMS upon request. Requests may originate from payers (Payer Initiated process), and from clinicians or APM entities (Eligible Clinician Initiated process). CMS maintains a list of Other Payer Advanced APMs.²⁸

Other Payer Advanced APM Criteria

CMS has previously finalized the criteria by which it makes “Advanced” status determinations for APMs sponsored by others. The Other Payer Advanced APM criteria are designed to parallel the Advanced APM criteria, but are not identical; all must be met to earn Advanced status.

- Participants are required to use CEHRT.
 - All APM Entities within an Other Payer Advanced APM must require at least 75 percent of their eligible clinicians to use CEHRT in clinical care delivery beginning in 2020 (up from 50 percent in 2019).
- Payment for covered professional services must be conditioned at least in part on quality measures comparable to those of the MIPS Quality performance category.
 - Beginning with performance year 2020, at least one of the measures must be finalized on the MIPS final list of measures; endorsed by a consensus-based entity; or determined by CMS to be evidence-based, reliable, and valid. At least one of the measures also must be an outcome measure, if available. The 2020 change is not retroactive; models determined to be Other Payer Advanced APMs for prior performance years would not be affected.
- Participating Other Payer APM Entities must be able to bear risk for more than nominal monetary losses. CMS again approaches this criterion as having two parts: 1) describing ways to bear risk (e.g., repayment to payer), and 2) what constitutes more than nominal monetary losses (e.g., percentage of expenditures). The generally applicable nominal risk standard for Other Payer Advanced APMs is as follows:
 - The applicable revenue-based nominal amount standard remains at 8 percent through the 2024 QP Performance Period;
 - The total potential risk has been set previously at 4 percent;
 - The terms of an Other Payer Advanced APM agreement must require a marginal risk rate of at least 30 percent; and
 - The terms of an Other Payer Advanced APM agreement must require an MLR of no more than 4 percent.

Medicaid-sponsored Advanced APM Exception

APMs sponsored by Medicaid (Title XIX) are considered one type of Other Payer APM, and they must meet all of the Other Payer Advanced APM criteria described above. An exception is provided for Medicaid-sponsored medical home models. A modified nominal amount standard with a more gradual risk percentage progression is applied to APMs meeting the Medicaid Medical Home Model definition (model defined at §414.1305, risk progression found at §414.1415(c)(2)). This exception is analogous to that provided to Medicare-sponsored Medical Home Models.

²⁸ The current list is available at <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/395/2019%20MHP%20OP%20APM%20Determination%20List.pdf>.

g. Aligned Other Payer Medical Home Models Advanced Status Determinations

CMS refers to the definition of an Aligned Other Payer Medical Home Model (section III.K.1.b.(3)(a) of the rule and section III.K.4.b. of this summary). CMS proposes that a payment arrangement structured as an Aligned Other Payer Medical Home Model would be required to meet the Other Payer Advanced APM CEHRT and Quality criteria. CMS also proposes that the financial risk and nominal amount standards for Medicaid-sponsored medical homes would be extended to apply to Aligned Other Payer medical homes. Additionally, CMS proposes that under the terms of either a Medicaid or Aligned Other Payer Medical Home Model, any required payments from the APM Entity (e.g., for failure to meet the model's cost metrics) would be made directly by the entity to the payer (the Medicaid agency or the Other Payer, respectively).

CMS proposes that requests by payers for Advanced Other Payer APM status determinations for their aligned medical homes would be submitted beginning in 2020 through the Payer-Initiated Process already established for Remaining Other Payers (i.e., not Medicaid or Medicare Health Plans). Similarly, CMS proposes that eligible clinicians and APM Entities would submit their requests for determinations through the Eligible clinician Initiated Process.

h. Generally Applicable Other Payer Advanced APM Nominal Amount Standard

Marginal Risk

The Other Payer Advanced APM generally applicable nominal amount standard includes a requirement that the terms of the model agreement specify a marginal risk rate of at least 30 percent, with marginal risk representing the percentage of actual minus expected expenditures for which an APM Entity would be liable. Some model agreements incorporate a sliding scale for marginal risk, so that the marginal risk rate percentage varies with the magnitude of the loss (e.g., a smaller percentage as the loss amount increases). When assessing model agreements having variable marginal risk rates, CMS has heretofore required the model to apply at least a 30 percent marginal risk rate percentage at all levels of loss, so that the 30 percent rate serves as a floor or minimum standard for all levels of total loss. CMS now proposes instead, for models with a variable marginal risk rate, to require that the average marginal risk rate across the entire range of potential losses would be used to assess compliance with the 30 percent marginal risk rate. CMS notes that the exceptions for large losses and small losses specified at §414.1420(d)(5)(ii) and (iii), respectively, would not change. CMS also describes an example calculation of average marginal risk rate in the rule (Table 58). CMS anticipates that changing the approach to calculating marginal risk would help to protect other payer APM entities from potentially catastrophic losses. CMS concludes that the proposed approach represents an alternative way of expressing risk than an inappropriate lowering of risk-bearing.

Expected Expenditures

Section III.K.4.c.(2)(b) of the rule (see section II.K.4.c of this summary addresses the definition of Expected Expenditures in the context of ensuring appropriately robust levels of risk under (Medicare-sponsored) Advanced APM model agreements. CMS now repeats much of that discussion, as it also applies to assessing the extent of financial risk to be borne under Other Payer Advanced APM model agreements. CMS reaches the conclusion that a flawed definition

of Expected Expenditures could allow an Other Payer Advanced APM to meet the relevant nominal risk standard but actually bear low levels of risk. Therefore, CMS proposes to amend the definition of Expected Expenditures for use when making Other Payer Advanced APM determinations in a manner similar to that proposed for application to (Medicare-sponsored) Advanced APMs.

5. QPP Technical Revisions

CMS proposes several technical revisions to the QPP regulations. In general, these are designed to accomplish the following:

- To clarify (e.g., that a regulation applies beginning with a performance year and to subsequent years rather than applying only to a single year);
- To correct inadvertent errors made in dates (e.g., one month errors in the dates for releasing guidance related to the Other Payer Advanced APM determination timeline);
- To correct erroneous citations embedded in otherwise correctly-written regulations;
- To correct omissions in making conforming changes; and
- To correct inadvertent terminology errors.

Full details are provided in section III.K.5. of the rule.

CMS concludes this section with Table 59 (modified and reproduced below) that summarizes the proposed processes and timelines for submitting requests for Other Payer Advanced APM determinations for QP Performance Period 2020.

TABLE 59: Proposed Other Payer Advanced APM Determination Process for Medicaid, Medicare Health Plans, and Remaining Other Payers for QP Performance Period 2020

Proposed Other Payer Advanced APM (OP AAPM) Determination Process for Medicaid, Medicare Health Plans, and Remaining Other Payers for QP Performance Period 2020 (modified from Table 59 of the proposed rule)				
Payer Type	Payer Initiated	Date	Eligible Clinician (EC) Initiated	Date
Medicaid Title XIX	Guidance sent to STATES Submission Opens STATES	Jan 2019	Guidance to ECs Submission Opens ECs	Sept 2019
	Submission Closes STATES	April 2019	Submission Closes ECs	Nov 2019
	CMS Notifies STATES CMS Posts OP AAPM List	Sept 2019	CMS Notifies STATES & ECs CMS Posts OP AAPM List	Dec 2019
Medicare Health Plans (MHP)	Guidance available for MHP Submission Opens MHP	April 2019	Guidance available to ECs Submission Opens ECs	Aug 2020

Proposed Other Payer Advanced APM (OP AAPM) Determination Process for Medicaid, Medicare Health Plans, and Remaining Other Payers for QP Performance Period 2020
(modified from Table 59 of the proposed rule)

Payer Type	Payer Initiated	Date	Eligible Clinician (EC) Initiated	Date
	Submission Closes MHP	June 2019	Submission Closes ECs	Nov 2020
	CMS Notifies MHP CMS Posts OP AAPM List	Sept 2019	CMS Notifies ECs CMS Posts OP AAPM List	Dec 2020
Remaining Other Payers (ROP)	Guidance available to ROP Submission Opens ROP	Jan 2019	Guidance available to ECs Submission Opens ECs	Aug 2020
	Submission Closes ROP	June 2019	Submission Closes ECs	Nov 2020
	CMS Notifies ROP CMS Posts OP AAPM List	Sept 2019	CMS Notifies ECs & ROP CMS Posts OP AAPM List	Dec 2020

IV. Regulatory Impact Analysis: Changes Due to the Quality Payment Program

CMS estimates that approximately 55 percent of the nearly 1.5 million clinicians billing to Part B (818,391) will be assigned a MIPS score for 2022 because others will be ineligible for or excluded from MIPS. Table 113, reproduced below, provides the details of clinicians' MIPS eligibility status for 2022 MIPS payment year (2020 MIPS performance year). CMS notes it is difficult to predict whether clinicians will elect to opt-in to participate in MIPS with the proposed policy; CMS assumes 33 percent of the clinicians who exceed at least one but not all low-volume threshold criteria and submitted data to 2017 MIPS performance period would elect to opt-in to the MIPS program.

TABLE 113: Description of MIPS Eligibility Status for CY 2022 MIPS Payment Year Using the 2020 PFS Proposed Assumptions***

Eligibility Status	Predicted Participation Status in MIPS Among Clinicians*	Number of Clinicians	PFS allowed charges (\$ in mil)***
Required eligibility (always subject to a MIPS payment adjustment because individual clinicians exceed the low-volume threshold in all 3 criteria)	Participate in MIPS	203,027	\$48,306
	Do not participate in MIPS	17,954	\$4,054
Group eligibility	Submit data as a	566,164	\$14,145

(only subject to payment adjustment because clinicians' groups exceed low- volume threshold in all 3 criteria and submit as a group)	group		
Opt-In eligibility (only subject to a positive, neutral, or negative adjustment because the individual or group exceeds the low- volume threshold in at least 1 criterion but not all 3, and they elect to opt-in to MIPS and submit data)	Elect to opt-in and submit data	31,246	\$1,497
Total Number of MIPS Eligible Clinicians and the associated PFS allowed charges		818,391*	68,002
Not MIPS Eligible			
Potentially MIPS eligible (not subject to payment adjustment for non-participation; could be eligible for one of two reasons: 1) meet group eligibility or 2) opt-in eligibility criteria)			
Below the low-volume threshold (never subject to payment adjustment; both individual and group is below all 3 low-volume threshold criteria)	Not applicable	77,450	\$403
Excluded for other reasons (Non-eligible clinician type, newly- enrolled, QP)	Not applicable	202,684	\$9,322
Total Number of Clinicians Not MIPS Eligible		665,769	19,002
Total Number of Clinicians (MIPS and Not MIPS Eligible)		1,484,160	87,004

*Estimated MIPS Eligible Population

** This table also does not include clinicians impacted by the automatic extreme and uncontrollable policy (approximately 13,000 clinicians and \$2,763 million in PFS allowed charges).

*** Allowed charges estimated using 2016 and 2017 dollars. Low volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount.

In the aggregate, CMS estimates that for the 2022 payment year, it would redistribute about \$586 million in payment adjustments on a budget neutral basis. The maximum positive payment adjustments are 5.8 percent after considering the MIPS payment adjustment and the additional MIPS payment adjustment for exceptional performance. CMS estimates that 87.3 percent of eligible clinicians are expected to have a positive or neutral payment adjustment and 12.7 percent will have a negative payment adjustment. Table 114, reproduced below, shows the impact of payments by practice size and based on whether clinicians are expected to submit data to MIPS. CMS estimates that clinicians in small practices (1-15 clinicians) participating in MIPS would not perform as well as larger sized practices. For example, almost one-quarter of clinicians in small practices (1-15 clinicians) are expected to receive a negative payment adjustment compared with about 8 percent for clinicians in very large practices (100+). CMS notes that it is using 2017 performance period submission data for these calculations as 2018 data were not available in time to incorporate. CMS plans to use data from the 2018 MIPS performance period for the final rule.

Table 114: MIPS Estimated Payment Year 2022 Impact on Total Estimated Paid Amount by Participation Status and Practice Size*

Practice Size*	Number of MIPS eligible clinicians	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount**
Among those submitting data***					
1) 1-15	145,457	76.5%	41.2%	23.5%	0.9%
2) 16-24	42,691	81.9%	40.8%	18.1%	1.1%
3) 25-99	189,603	85.3%	44.4%	14.7%	1.3%
4) 100+	422,686	92.5%	62.4%	7.5%	2.1%
Overall	800,437	87.3%	53.2%	12.7%	1.4%
Among those not submitting data					
1) 1-15	16,116	0.0%	0.0%	100.0%	-8.1%
2) 16-24	674	0.0%	0.0%	100.0%	-8.2%
3) 25-99	953	0.0%	0.0%	100.0%	-8.3%
4) 100+	211	0.0%	0.0%	100.0%	-8.5%
Overall	17,954	0.0%	0.0%	100.0%	-8.2%

*Practice size is the total number of TIN/NPIs in a TIN.

** 2016 and 2017 data used to estimate 2020 performance period adjustments. Payments are trended to 2022.

***Includes facility-based clinicians whose quality data is submitted through hospital programs.

CMS estimates that approximately 175,000 to 225,000 eligible clinicians will become QPs for the 2022 and a total of \$500 to \$600 million in incentive payments will be made.

Limitations of CMS Analysis

Importantly, CMS describes several limitations to the analysis underlying the tables. CMS bases its analyses on the data prepared to support the 2018 performance period initial determination of clinician and special status eligibility, participant lists using the 2019 predictive APM Participation List, 2017 QPP Year 1 data and CAHPS for ACOs. The scoring model results assume that 2017 QPP Year 1 data submissions and performance are representative of 2020 QPP data submissions and performance. In particular, CMS anticipates that clinicians may submit more performance categories to meet the higher performance threshold to avoid a negative payment adjustment. In addition, because CMS used historic data, it assumes that participation in the three performance categories in MIPS Year 1 would be similar to MIPS Year 4 performance.

CMS states that given these limitations and others, there is considerable uncertainty around its estimates.