MIPS 2020

A Review of the Program Requirements

AUDIENCE POLL

Today's Presenter

Denise Scott, **MM, RN-BC, CMHP**
Director, Ambulatory Services
dscott@medisolv.com

Agenda:

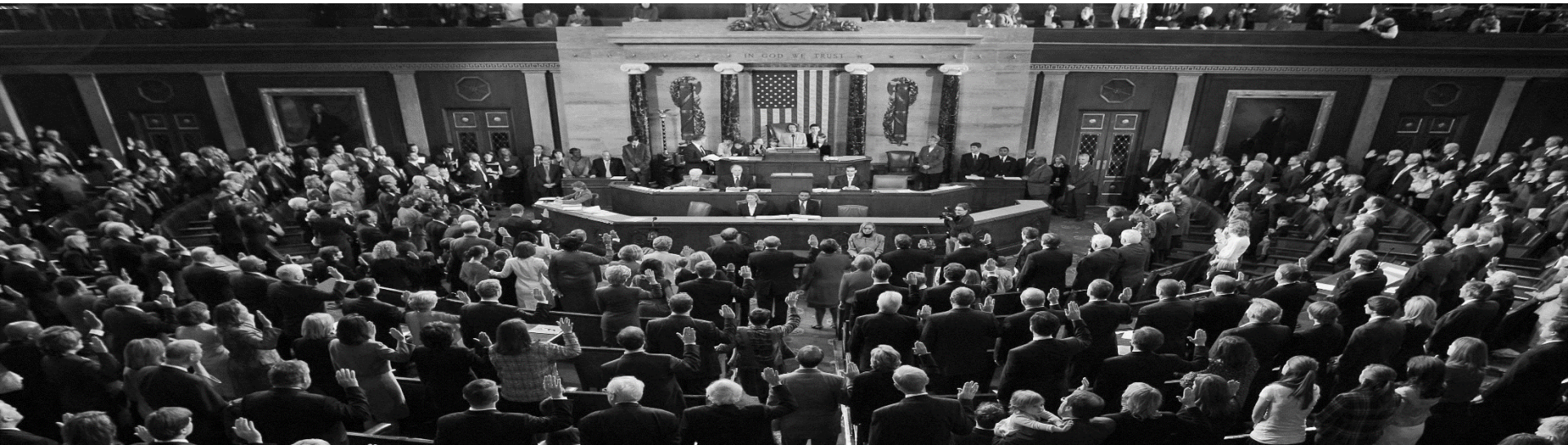
- Review the changes in Year 4
- Understand who is eligible for MIPS
- Define the reporting requirements for Quality, PI, IA & Cost in 2020
- Describe the score calculations for each category
- Provide tips and resources for preparing your clinicians for a successful reporting year

medisolv

MACRA

Medicare **A**ccess and **C**HIP **R**eauthorization **A**ct

- Signed into law April 14, 2015
- Bipartisan support
- Changes the way providers are reimbursed
- Advances focus on paying for quality vs quantity



Quality Payment Program

MIPS

- Streamlined Medicare incentive programs
- Expands participants
- Adds flexibility

APMs

- Sets thresholds for revenue and risk
- Limited to CMS designated Advanced APMs

Eligibility Requirements

Medicaid EHR Incentive Program

- Registered for Medicaid MU
  - Continue to participate through your state Medicaid
  - Collect incentives
  - Participate in MIPS if also eligible for Medicare
  - Last payment must be distributed by **12/31/2021**

MIPS Eligibility

MIPS Eligible Clinicians

- Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Specialists
- CRNAs
- Physical Therapists
- Occupational Therapists
- Qualified Speech Language Pathologists
- Clinical Psychologists
- Qualified Audiologists
- Registered Dieticians/ Nutrition Professionals

Eligibility Requirements

NOT Subject to MIPS

- EC in first year of Medicare participation
- Hospitals & Facilities (Medicare Part A)
- Medicare Advantage Plans (Medicare Part C)
- Certain APM participants
- Medicaid

Eligibility Requirements

Have >$90,000 in Part B allowed charges for covered Professional Services

AND

Provide care for >200 Medicare Part B enrolled beneficiaries

AND

Provide >200 covered professional services under PFS

Opt-In to MIPS

Providers or groups can "opt-in"

to participate in MIPS 2020

- ✓ Meet at least 1, but not all 3 of the eligibility criterion
- ✓ Will be subject to +/- or neutral payment adjustment

OR – Voluntarily report – no PFS adjustment

Must log into QPP and "opt-in" **Opt-in is irrevocable!**

Eligibility Requirements

Determination dates

- October 1, 2018 – Sept 30, 2019
  - If exempt after first period, remain exempt.
    Special status applies if determined in either period.
- October 1, 2019 – Sept 30, 2020 (no claims runout)
  - 2nd determination period used to determine
    Complex Patient bonus

Eligibility Requirements

New provider joins your practice in the last 3 months of the year

- Eligibility for the NPI will not be available on QPP – last determination period ends September 30.
- If reporting as individual – can be excluded
- If billing Medicare Part B with their NPI and group TIN, and the TIN is reporting as a group – cannot be excluded

Reporting Options

- **Individual –** Unique NPI/TIN
- **Group -** 2 or more ECs/NPIs who reassigned billing rights to a TIN
- **Virtual Group -** 2 or more TINs of 1-10 ECs who form a Virtual Group to report MIPS *(must form group and apply by Dec 31, 2019)*
- **3rd Party Intermediary –** acting on behalf of ECs or groups to submit data on measures and activities

Collection Type

- Medicare Part B Claims
- CMS Web Interface
- Electronic Clinical Quality Measures
- MIPS Clinical Quality Measures
- Qualified Clinical Data Registry
- CAHPS Survey for MIPS

Submission Type

- Direct
- Log in and Attest
- Log in and Upload
- Medicare Part B Claims
- CMS Web Interface

Reporting – Collection Type

Submitter Type	Individual MIPS EC	Group	3rd Party Intermediary
Quality	• Claims (Only if part of small practice) • MIPS Clinical Quality Measures (MIPS CQMs) • Qualified Clinical Data Registry (QCDR) • Electronic Clinical Quality Measures (eCQMs)	• Claims (Small practices only) • Web Interface ≥25 • MIPS Clinical Quality Measures (MIPS CQMs) • Qualified Clinical Data Registry (QCDR) • Electronic Clinical Quality Measures (eCQMs) • CAHPS Survey for MIPS	• Web Interface ≥25 • MIPS Clinical Quality Measures (MIPS CQMs) • Qualified Clinical Data Registry (QCDR) • Electronic Clinical Quality Measures (eCQMs) • CAHPS Survey for MIPS

Reporting – Submission Type

Submitter Type	Individual MIPS EC	Group	3rd Party Intermediary
Quality	Direct Log in and Upload Medicare Part B Claims *(ECs from small practices ONLY)*	Direct Log in and Upload CMS Web Interface ≥25 Medicare Part B Claims *(Small practices ONLY)*	Direct Log in and Upload CMS Web Interface ≥25

Reporting – Submission Type

Submitter Type	Individual MIPS EC	Group	3rd Party Intermediary
Promoting Interoperability	Direct Log in and Upload Log in and Attest	Direct Log in and Upload Log in and Attest	Direct Log in and Upload Log in and Attest

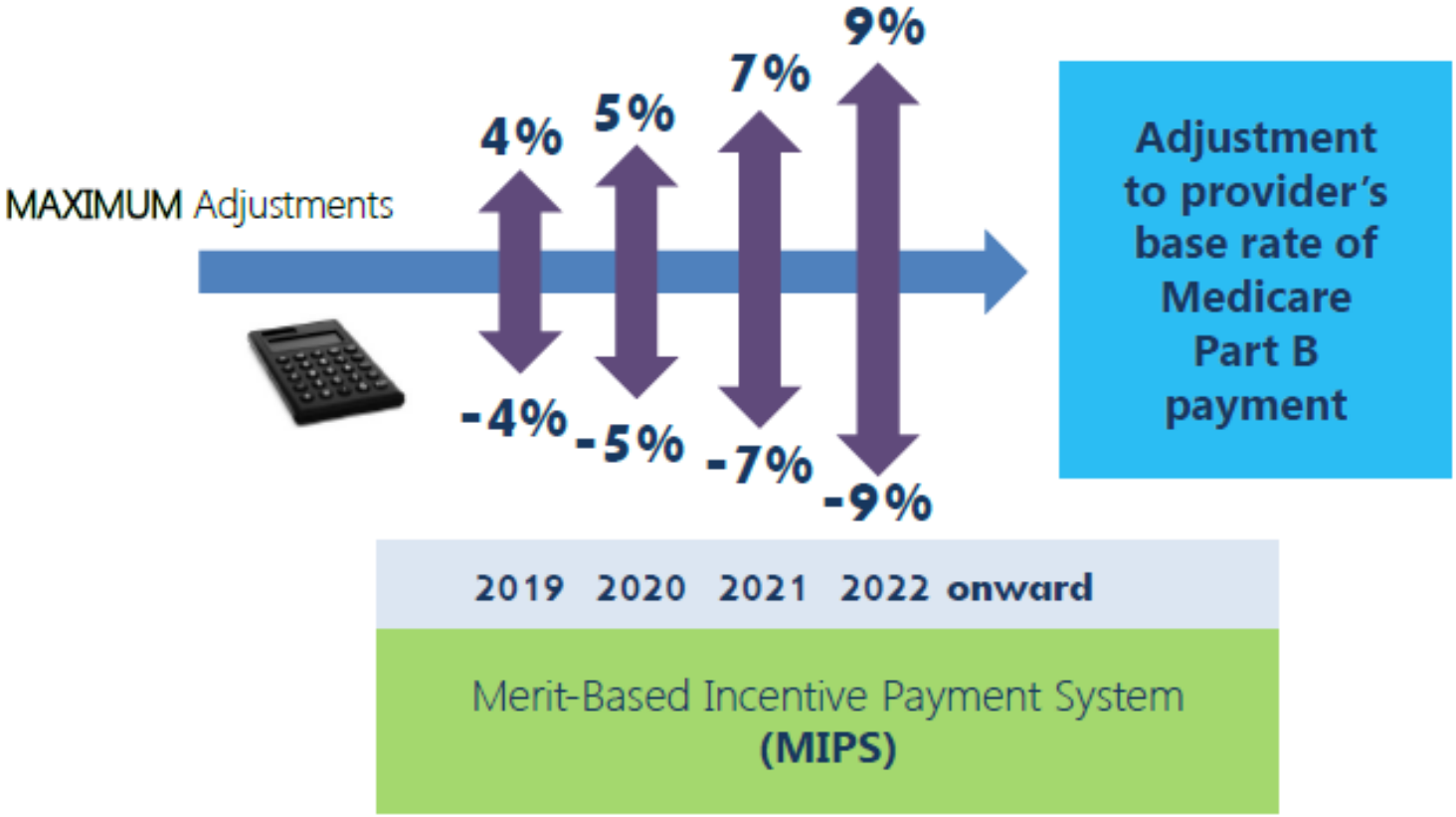
Reporting – Submission Type

Submitter Type	Individual MIPS EC	Group	3rd Party Intermediary
Improvement Activities	Direct Log in and Attest Log in and Upload	Direct Log in and Attest Log in and Upload	Direct Log in and Attest Log in and Upload

Reporting - Cost

Submitter Type	Individual MIPS EC	Group	3rd Party Intermediary
Cost	**Administrative Claims** (No submission needed)	**Administrative Claims** (No submission needed)	**None**

Payment Adjustments



Source: Center for Medicare & Medicaid Services

Deadlines

Dates to Remember

- Impacts 2022 Reimbursement
- Performance period from:
  January 1 - December 31, 2020
- Submission deadline: March 31, 2021

MIPS Scoring

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

Quality | Cost | Improvement Activities | Promoting Interoperability

MIPS Composite Performance Score

Center for Medicare & Medicaid Services

Category Performance Period

- **Quality**
  - 365 days – Calendar year
- **PI**
  - 90 consecutive day minimum
- **IA**
  - 90 consecutive day minimum
- **Cost**
  - 365 days – Calendar year

MIPS Reimbursements

Reimbursement in 2022

- **Budget neutral program**
  - Penalties fund incentives
- **45 point floor**
  - Score to avoid a negative adjustment
- **85 points**
  - Performance threshold for 2020 for exceptional performance incentives

Positive adjustments are based on performance data submitted.

MIPS Reimbursements

Only ONE way to get a 9% reduction to fee schedule in 2022

Reporting MIPS 2020

- **Performance Threshold = 45 points**
- **“Penalty Avoidance”**
  - Quality Measures: performance to meet threshold
  - Quality measures (15) + PI measures (25) + IA (7.5)
  - Full participation in IA category (15) + PI Points + Cost + Quality

MIPS Scoring

Points Available

MIPS Category	Maximum Denominator	Percent of Composite Score
Quality	60 (or 70)	**45%**
PI	100	25%
IA	40	15%
Cost	N/A	**15%**

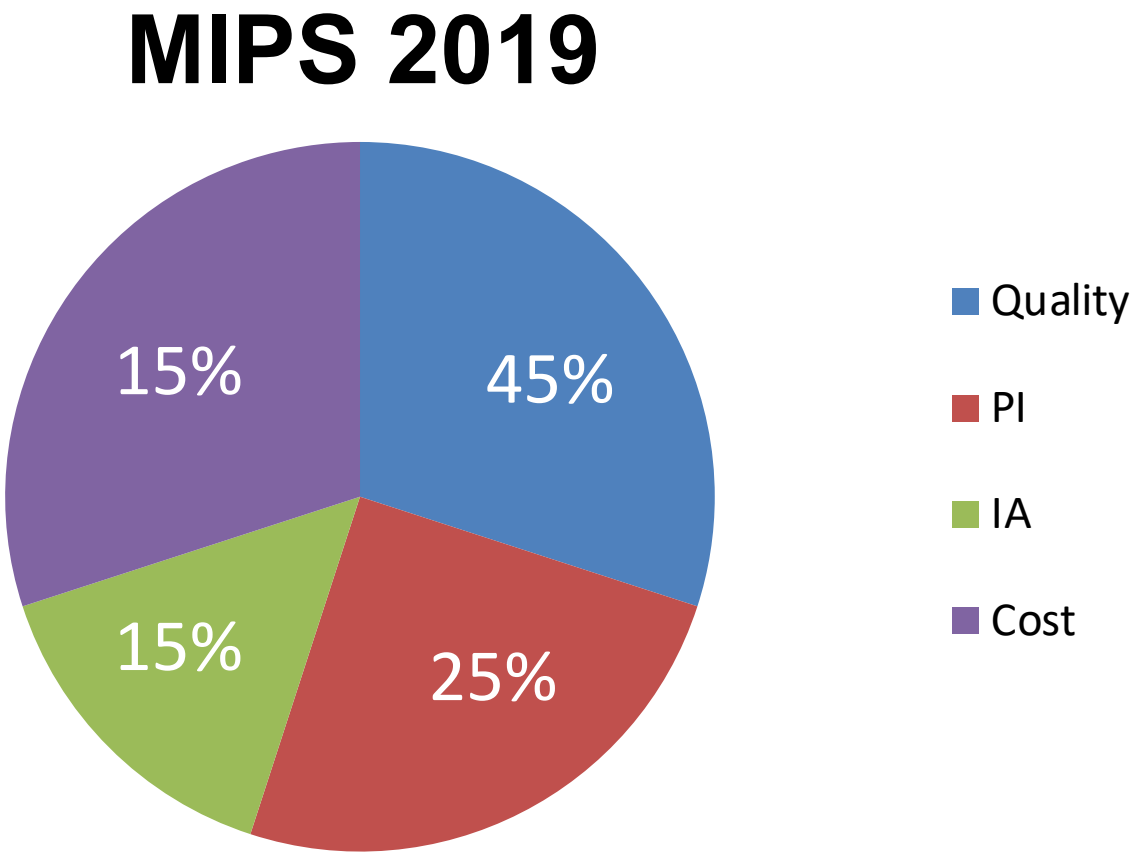
Cost Category (Formerly VBM)

- Administrative Claims: Calculated by CMS
  - Total per Capita Cost (TPCC)
  - Medicare Spending per Beneficiary – Clinician (MSPB-C)
  - **10 New Episode-based measures**
  - Total of 18 Episode-based measures

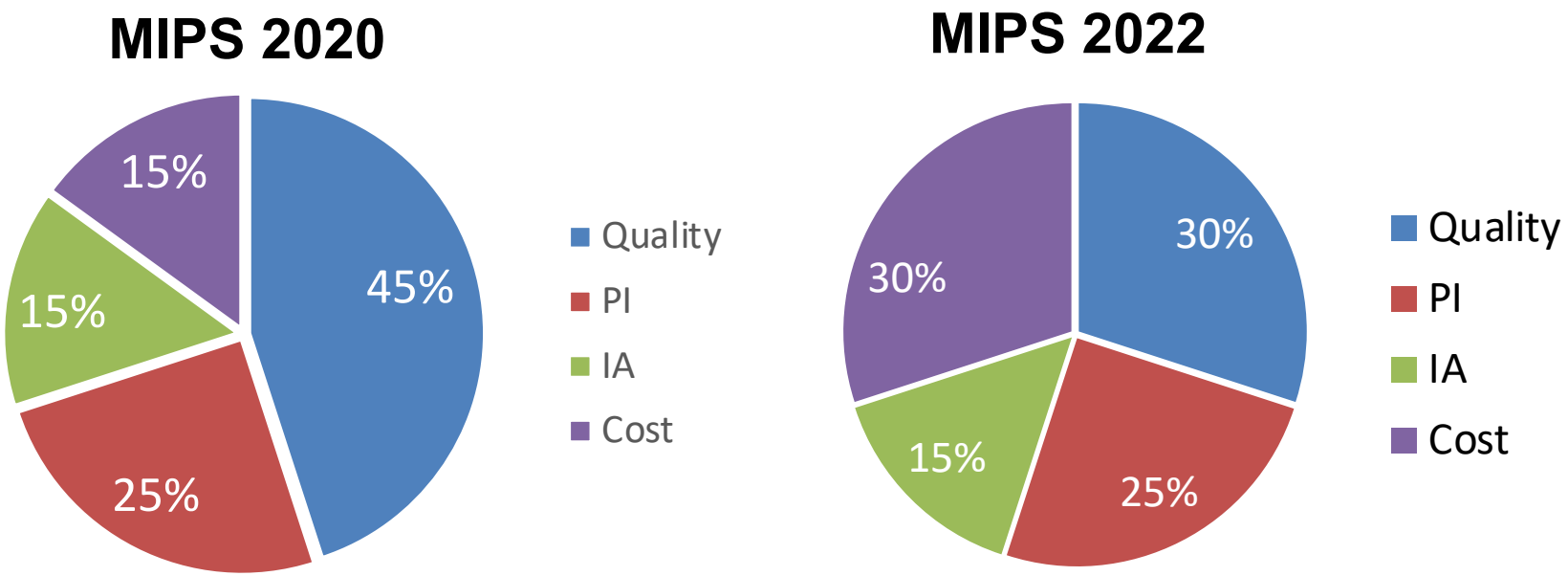
***Goal**: Reduce cost of care while increasing quality of care*

WEIGHT

Cost Category



Phase in of Cost Category



Cost Category

New Cost Measures

Measure Topic	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 COPD Exacerbation	Medical
Lower Gastrointestinal Hemorrhage (Group only)	Medical
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

Cost Category

- Performance is calculated by CMS based on which measures meet the case minimum
  - MSPB-C – 35 | TPCC – 20
- 10 new episode-based measures – inpatient & procedural
  - 13 Procedural attributed to a single provider
  - 5 Inpatient medical measures – may be attributed to many providers
- Must meet case minimum per group or individual
  - 10 procedural/ 20 inpatient

Cost Category

Tips for Cost Category

1) No submission needed – **15% of score!!!**
2) Analyze your 2018 & 2019 results on QPP
3) Review any interim reports from CMS
4) Consider submitting MACRA codes (modifier to submit with HCPCS codes)
5) Develop plan for 2020

Improvement Activities

104 Improvement Activity options

Reward clinical practice innovation & improvement activities such as:

- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Expanded Patient Access
- Population Management

Rewards PCMH & APM participation

15%

WEIGHT

IA Category

Improvement Activity Measures

- Requirements
  1. Choose from 104 Improvement Activities Measures
  2. Report on up to 4 measures for 90 consecutive days each
  3. **At least 50% of providers in group must participate in the IA**

- For Maximum performance
  - Report on a combination of measures that = 40 points
    - High weight measures = 20 pts
    - Medium weight measures = 10 pts

- For small practices (<15 ECs) / rural health, HPSA
  - Double points
    - High weight = 40 pts
    - Medium weight = 20 pts

IA Category

- **2 New IA measures for 2020**
  - IA_BE_25 – Drug Cost Transparency – High weight
  - IA_CC_18 – Tracking of Clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes – High weight

- **7 IA measures with changes**

IA-BE_7
IA_BMH_10
IA_EPA_4
IA_PM_2
IA_PSPA_7
IA_PSPA_19
IA _PSPA_28

IA Category

Tips for Improvement Activities

1) Confirm that >50% of practice locations in your TIN were a recognized PCMH or ACO/APM participant
2) Focus your improvement efforts on quality measures that you are already working on or measures pertinent to your group - prepare for MVPs
3) Document your starting point
4) Keep evidence that you worked on each measure for 90 consecutive days and the improvement made
5) **Easiest points to get in 2020**

   40 points = 15 MIPS total score points

Promoting Interoperability

Use of *2015 CEHRT* required

- Must meet Protect Pt Health Information/ SRA
- 4 Objectives
- 5 Required Measures
- 100% performance based
- Most challenging category

Bonus Points Available – **5 points**

WEIGHT

2015 CEHRT PI Measures

OBJECTIVE	MEASURES	REPORT TYPE	Max. Points
Protect Patient Health Information	Security Risk Analysis	**Required**	None
Electronic Prescribing	e-Prescribing	Numer/Denom	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP) (*Optional 2019*)	Yes/No	5 point bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	Numer/Denom	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Numer/Denom	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Numer/Denom	40 Points
Public Health and Clinical Data Exchange	Report to <u>two</u> different public health agencies or clinical data registries for any of the following: Immunization Registry ** Electronic Case Reporting ** Public Health Registry ** Clinical Data Registry ** Syndromic Surveillance **	Yes/No	10 points

PI Category

Automatic Reweighting of PI

- Hospital-based Clinicians (>75% NPIs in TIN)
- Nurse Practitioners
- Physician Assistants
- CRNAs
- Clinical Nurse Specialists
- Ambulatory Surgical Centers
- PT, OT, Speech Language Pathologists
- Clinical Psychologists
- Qualified Audiologists
- Registered Dietician/Nutrition Professionals

Exclusions for 2020

Health Information Exchange

Any MIPS EC who has fewer than 100 transitions in care or referrals or has <100 encounters with patients they have never seen before during the performance period

ePrescribing

Any MIPS EC who writes fewer than 100 permissible prescriptions during the performance period

Tips for Promoting Interoperability

1) Most likely remain your biggest challenge for 2020: get full category credit (25 points)
2) 2015 CEHRT /Implement HIE receive
3) Devise a plan to achieve points
4) Reweighting available
5) Hospital-based – 75% of NPIs in TIN defined as hospital based (decrease from 100% in 2019)
6) Must start 90 days by October 2, 2019

Quality Category

Claims – 55 EHR - 47

Registry - 196 Web - 10

Measures determined annually by Nov 1st

Choose 6 measures to report

- 1 Outcome or another High Priority measure (Pt outcomes, appropriate use, pt safety, efficiency, pt experience, care coordination)
- Or report a specialty measure set

Bonus points available

WEIGHT

Quality Cateogry

eCQMs Eliminated for 2020

- **CMS 52:**
  - HIV/AIDS: Pneumocystis Jiroveci Pneumonia Prophylaxis
- **CMS 82:**
  - Maternal Depression Screening
- **CMS 132:**
  - (564) Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- **CMS 160:**
  - Depression: Utilization of the PHQ-9 Tool

Quality Category

Collection Type Options

- **Claims** – Small practice groups and their ECs only
- **MIPS CQMs** – 6 measures or measure set
- **CMS Web Interface** – 25+ ECs, 10 quality measures

  Register with CMS by June 30, 2020
- **eCQMs**– Choose 6 or measure set
- **QCDR** – Choose 6 or measure set

One measure must be outcome measure or a high priority measure if outcome not available.

Reporting quality measures using various Collection Types allowed

- If the same measure is submitted through more than one collection type, highest score for the measure will be used
- If required outcome measure is submitted using one type and also submitted through another, there are no extra points awarded

Quality Category

Quality Measures

- **Benchmark** – Decile Scores
- **Flat Percentage-based Benchmark –** HbA1c, Controlling High BP
- **Case Minimum** – must meet to be scored for Quality measures (20 cases)
- **Scoring per quality measure** – 3 point minimum retained for small practices
- **(Eliminated 1 point** if reporting does not meet data completeness for larger practices)

MIPS Benchmark Results

Measure_Name	CMS ID	NQF ID	Measure ID	Submission Method	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Childhood Immunization Status	117v8	0038	240	EHR	Process	Y	4.76 - 6.51	6.52 - 9.08	9.09 - 13.00	13.01 - 18.17	18.18 - 23.80	23.81 - 29.32	29.33 - 41.66	>= 41.67	No
Diabetes: Hemoglobin A1c Poor Control	122v8	0059	1	EHR	Outcome	Y	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.10	9.09 - 3.34	3.33 - 0.01	0	No
Cervical Cancer Screening	124v8	0032	309	EHR	Process	Y	8.89 - 15.08	15.09 - 21.79	21.80 - 28.83	28.84 - 36.66	36.67 - 44.99	45.00 - 54.77	54.78 - 68.99	>= 69.00	No
Breast Cancer Screening	125v8	2372	112	EHR	Process	Y	12.41 - 22.21	22.22 - 32.30	32.31 - 40.86	40.87 - 47.91	47.92 - 55.25	55.26 - 63.06	63.07 - 73.22	>= 73.23	No
Pneumonia Vaccination Status for Older Adults	127v8	0043	111	EHR	Process	Y	14.13 - 23.25	23.26 - 33.02	33.03 - 43.58	43.59 - 53.96	53.97 - 63.60	63.61 - 74.54	74.55 - 85.52	>= 85.53	No
Anti-depressant Medication Management	128v8	0105	9	EHR	Process	Y	0.97 - 1.27	1.28 - 1.52	1.53 - 1.84	1.85 - 2.37	2.38 - 3.99	4.00 - 61.47	61.48 - 80.62	>= 80.63	No
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	129v9	0389	102	EHR	Process	N	--	--	--	--	--	--	--	--	--
Colorectal Cancer Screening	130v8	0034	113	EHR	Process	Y	7.35 - 15.97	15.98 - 24.66	24.67 - 33.45	33.46 - 44.39	44.40 - 56.19	56.20 - 67.91	67.92 - 82.28	>= 82.29	No

Quality Data Completeness

- When reporting quality measures, must meet data completeness criteria:
  - **Claims** – **70%** of all Medicare patients eligible for a measure
  - **eCQMs, MIPS CQMs, QCDR** – at least **70%** of all patients eligible for the measure across all payers

Quality Category

Bonus Points Still Available

Category	Measures	Bonus Points	Maximum
Quality	Additional Outcome or Patient Experience Measure	2 points each	6 point max
Quality	Additional High Priority Measure	1 point each	
Quality	CEHRT Submission	1 point each	6 point max
Quality	Improvement		Up to 10 percentage points

Additional Bonus Points

- **Small Practice Bonus**
  - 6 points added to quality numerator (<15 ECs)
- **Complex Patient Care Bonus**
  - Up to 5 points (Added to Total Score)
- **Quality Improvement Bonus**
  - Up to 10 percentage points (Added to Quality Score)

Quality Category

CAHPS Survey for MIPS

- Must advise CMS by June 30
- CMS determines if you have a big enough sample to measure

***Reminder* -** If it is determined that you cannot report CAHPS as patient experience measure, your denominator for quality will be reduced by 10 points and you will receive zero points for the measure.

FYI

- Don’t try to submit this measure more than twice if you don’t qualify
- Adjust your IA measure if you will not be using the CAHPS survey

MIPS 2020 Exceptions

- Automatic re-weighting of **Quality, PI & IA to 0%** for individual ECs in hurricane/fire areas *(Zip codes/ HRSA list)*
- A significant hardship exception for MIPS ECs in small practices (≤15) is available
- MIPS eligible clinicians whose EHR was decertified
- **Deadline to apply: December 31, 2019**

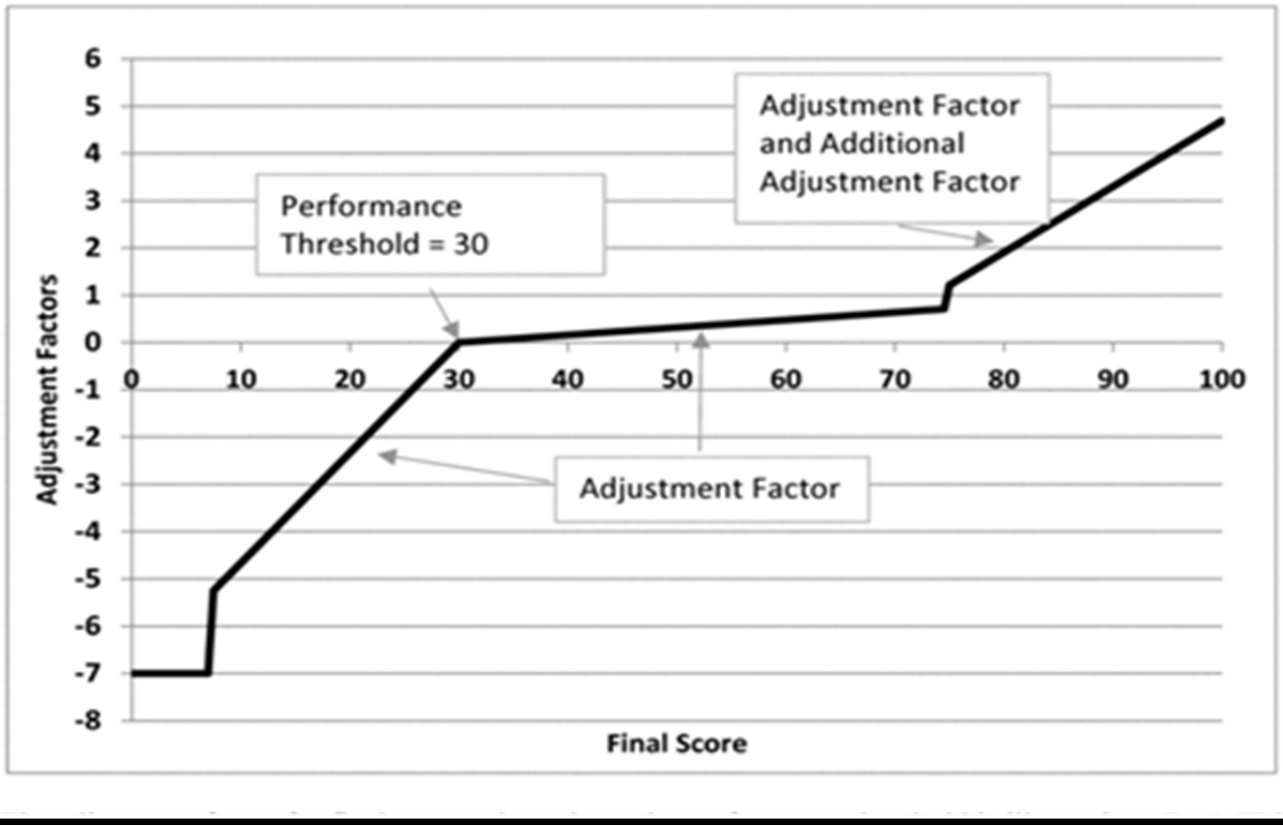
MIPS Scoring 2020

Composite Score vs Performance Threshold

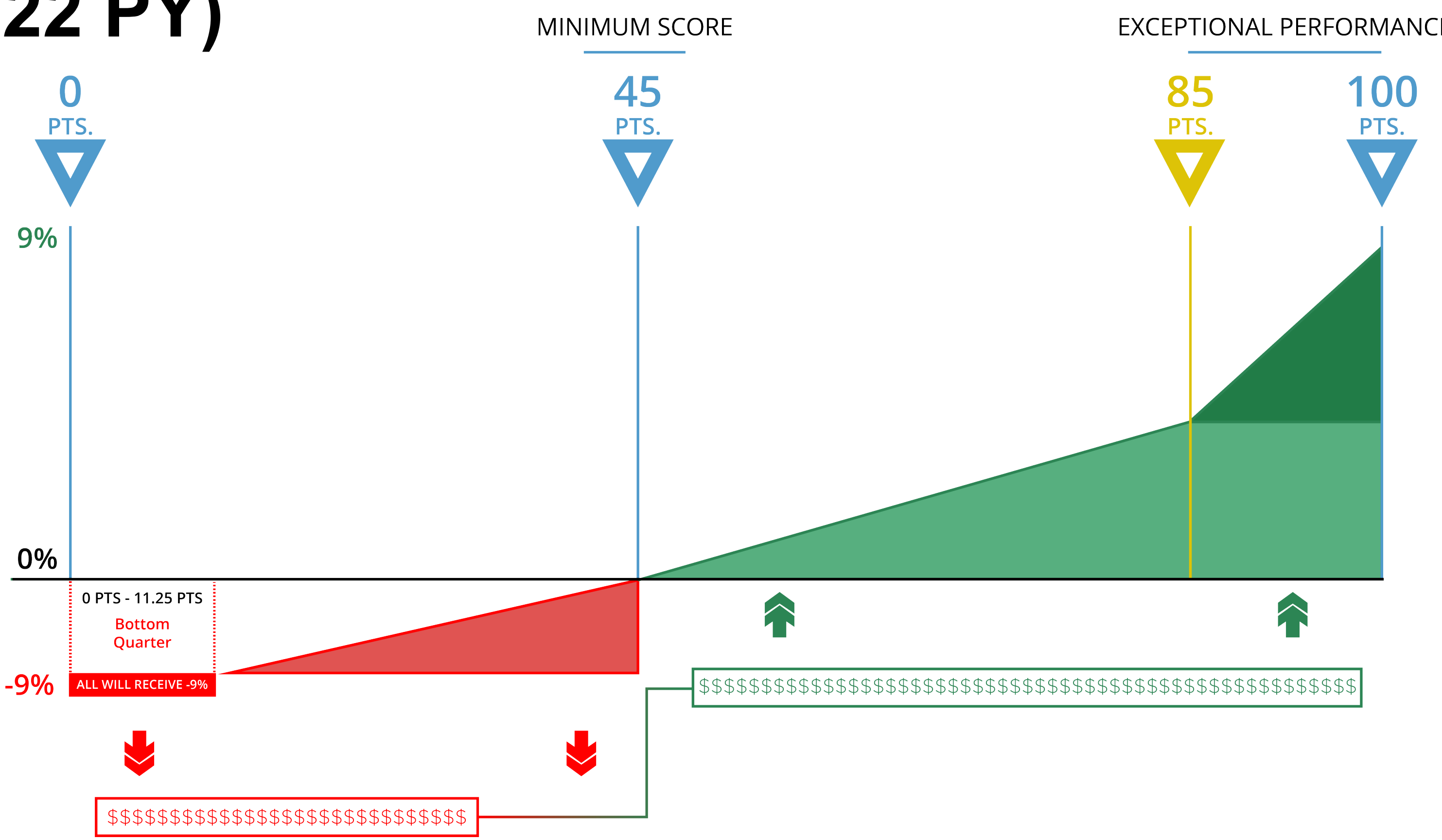
Final Total Score	MIPS 2022 Fee Schedule Adjustment
0 – 11.25	-9% (Most likely those individuals or groups scoring zero)
11.26 - 44.99	>-9% up to 0% (Negative adjustment)
45	0% (No adjustment – 2020 performance threshold)
45.01- 84.99	0.1- 8.9%x to maintain budget neutrality (Positive adjustment)
85.0 -100	Up to 9%x plus exceptional performance adjustment of 0.5%-10% (Positive adjustment)

Payment Adjustments

2021 Adjustments (2019 PY)

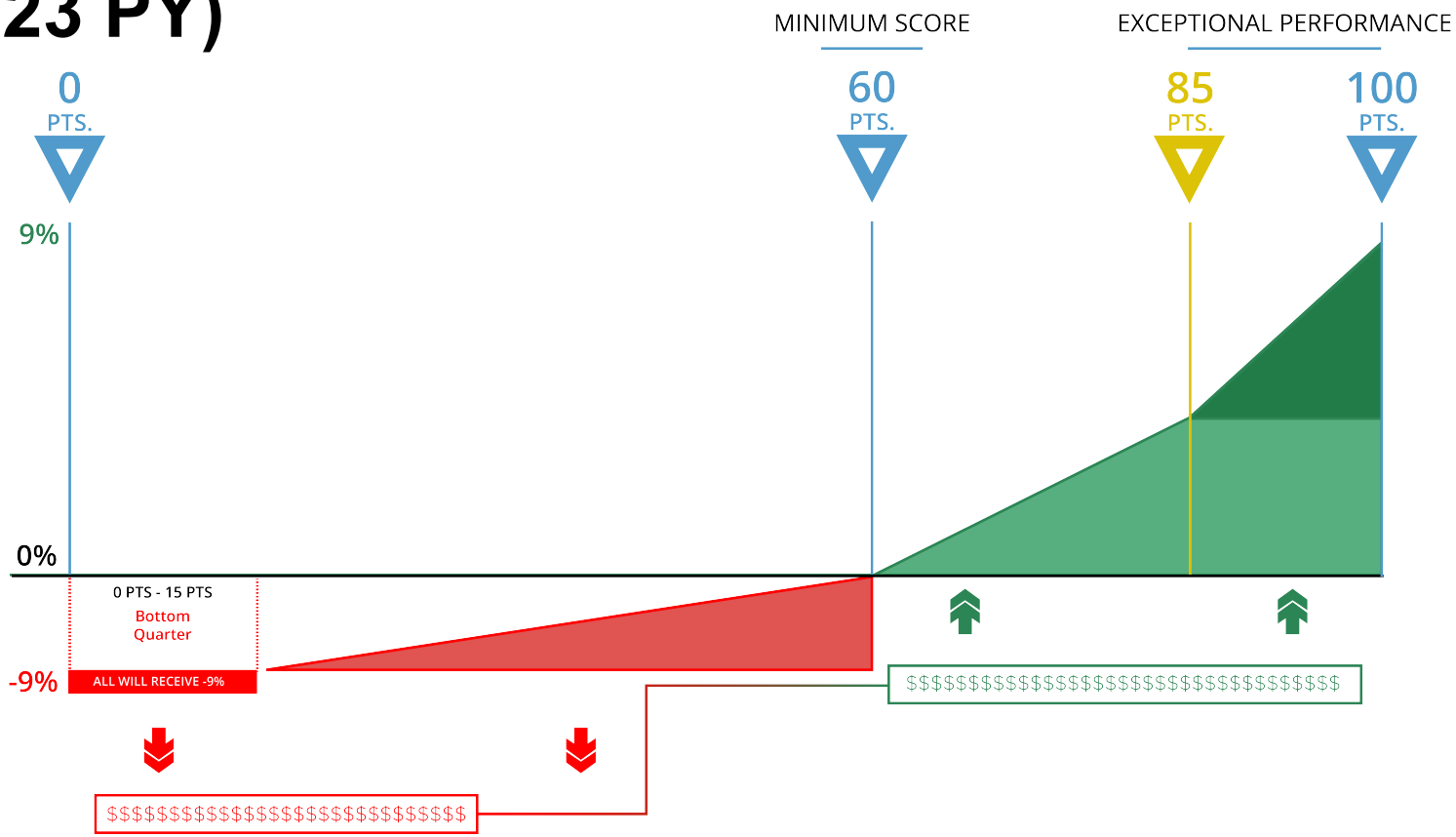


2020 Positive & Negative Adjustments (2022 PY)



Payment Adjustments

2021 Positive & Negative Adjustments (2023 PY)



Tips & Resources

- If you receive reweighting for extreme & uncontrollable circumstances resulting in no adjustment to your PFS and you submit (individual or group) any quality, PI or IA data – you will be scored based on that submission – reweighting goes away

- If you receive reweighting of the PI category and you submit PI data, you will be scored on the data submitted

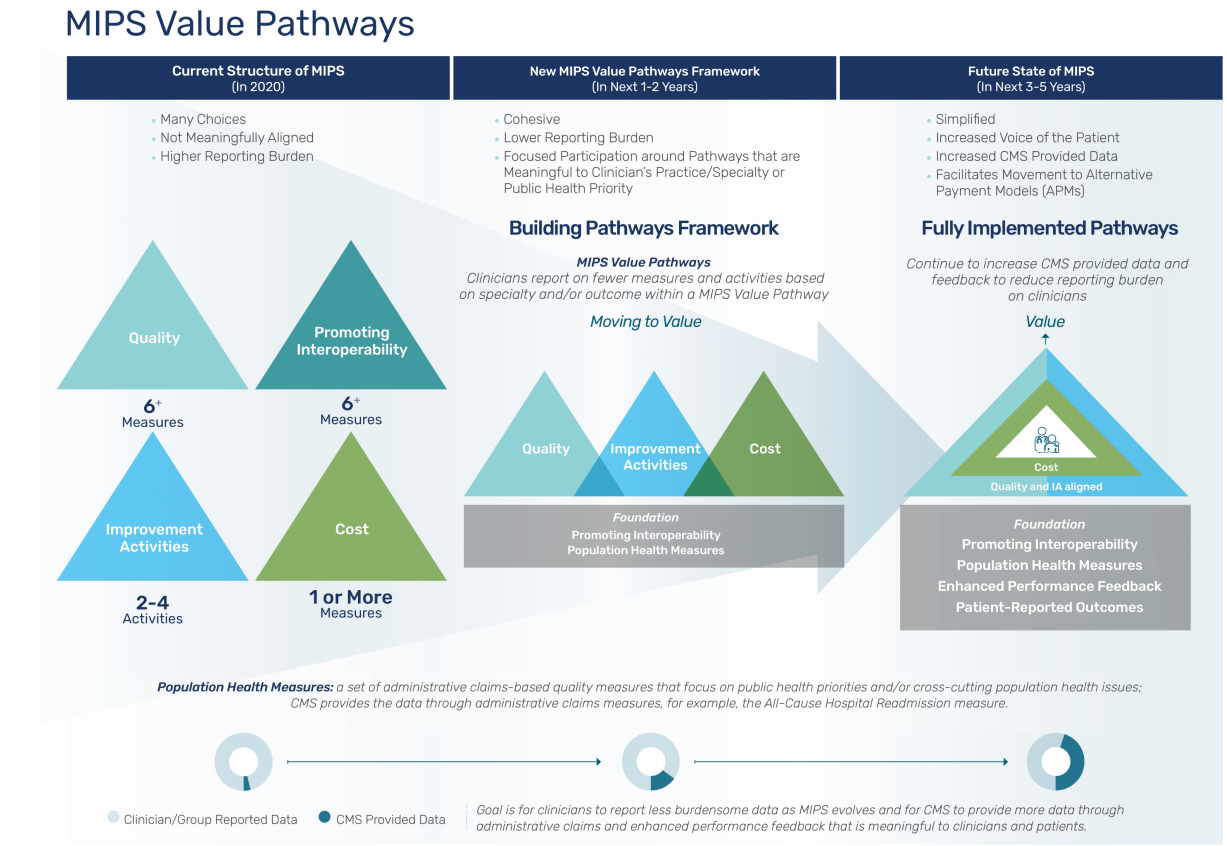
- Read 2018 QPP report – determine which special statuses and bonuses were earned for 2018 and which cost measures were calculated (good prediction for 2019)

- Targeted review must be requested within 60 days of release of performance feedback

What's to come?

- 2018 MIPS Performance **will be posted on Physician Compare**
- Cost and Quality categories must be worth 30% each of total MIPS score by 2022 – Will they change in 2021?
- **MIPS Value Pathways (MVPs) PY 2021**

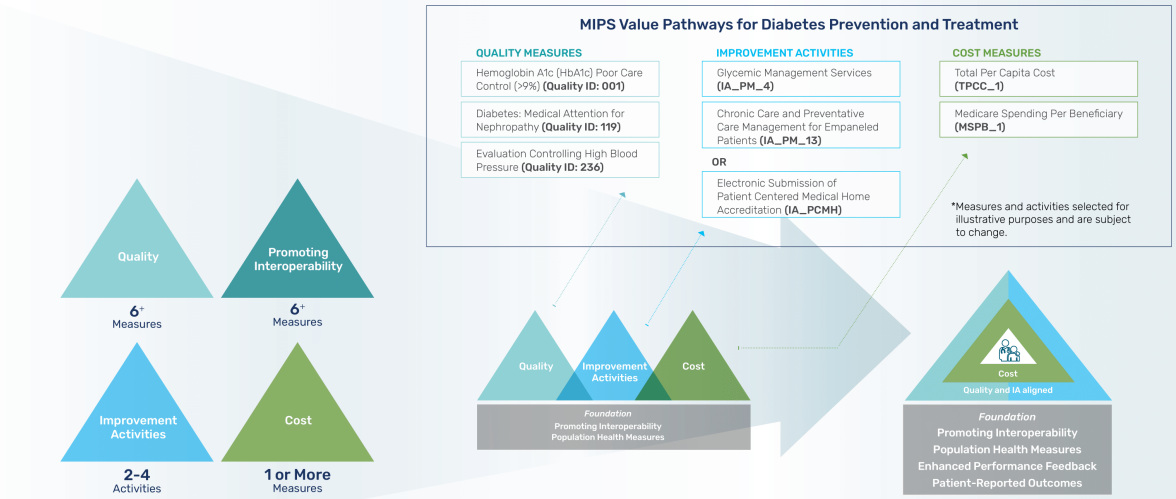
MIPS Value Pathways



Sample Diabetes MVP

MIPS Value Pathways: Diabetes Example

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



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

Tips & Resources

- **CMS QPP website – (qpp.cms.gov)**
  - Measure Selection Tools
  - Program Information
  - Participation Status
  - **Resource Library**

- **Medisolv.com**

Questions & Answers

Denise Scott, MM, RN-BC, CMHP
Director, Ambulatory Services
dscott@medisolv.com
questions@medisolv.com

K. CY 2020 Updates to the Quality Payment Program

1. Executive Summary

a. Overview

This section of the final rule sets forth changes to the Quality Payment Program starting January 1, 2020, except as otherwise noted for specific provisions. The 2020 performance period of the Quality Payment Program will build upon the foundation that has been established in the first 3 years of the program, which provides a trajectory for clinicians moving to performance-based payments, and will gradually prepare clinicians for the 2022 MIPS performance period of the program and the 2024 MIPS payment year. Participation in both tracks of the Quality Payment Program – Advanced Alternative Payment Models (APMs) and Merit-based Incentive Payment System (MIPS) – has increased from 2017 to 2018.[1] The number of QPs – Qualifying APM Participations – nearly doubled from 2017 to 2018, from 99,076 to 183,306 clinicians. In MIPS, 98 percent of eligible clinicians participated in 2018, up from 95 percent in 2017. As the Quality Payment Program continues to mature, CMS recognizes additional long-term improvements will need to occur. We have taken stakeholder input into consideration to ensure that we continue to implement the Quality Payment Program as required while smoothing the transition where possible and offering targeted educational resources for program participants. For example, in an effort to get broad feedback on our MIPS Value Pathways (MVPs) participation framework we held a public webinar specifically focused on the topic, conducted 7 listening sessions with various stakeholder groups throughout the proposed rule comment period, and engaged with clinicians and others through several other public forums. We plan to continue engaging with clinicians and other stakeholders as we move forward developing the MVPs.

While we continue efforts to strengthen the Quality Payment Program, we remain interested in clinician participation and engagement in the program, particularly as initial MVPs are developed for the 2021 MIPS performance period. We have been given flexibility in establishing the cost performance category weight and performance threshold in the early years of the Quality Payment Program. The Bipartisan Budget Act of 2018 (BBA 2018) (Pub. L. 115-123, enacted February 9, 2018) extended the flexibility and transition years within the Quality Payment Program. Beginning with the 2024 MIPS payment year (2022 performance period), as required by law, the cost performance category under MIPS will be weighted at 30 percent and the performance threshold will be set at the mean or median of the final scores for all MIPS eligible clinicians with respect to a prior period specified by the Secretary. The provisions of this rule are intended to recognize our reduced flexibility beginning with the 2024 MIPS payment year and continue to put clinicians in a position to make the transition as required by statute.

[1] Quality Payment Program (QPP) Participation in 2018: Results at a Glance https://qpp-cm-prod-content.s3.amazonaws.com/uploads/586/2018%20QPP%20Participation%20Results%20Infographic.pdf.

b. Summary of Major Provisions

(1) MIPS Value Pathways

We are committed to the transformation of MIPS, which will allow for: more streamlined and cohesive reporting; enhanced and timely feedback; and the creation of MVPs of integrated measures and activities that are meaningful to all clinicians from specialists to primary care clinicians and to patients. The new MVPs will remove barriers to APM participation and promote value by focusing on quality and cost measure and improvement activities built on foundational global or population quality measures calculated from claims-based quality data and promoting interoperability concepts.

In the CY 2020 PFS proposed rule (84 FR 40735), we proposed to apply a new MVP framework beginning with the 2021 MIPS performance period/2023 MIPS payment year to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. As discussed in section III.K.3.a.(2) of this final rule, we are finalizing a modified proposal to define MVPs at § 414.1305 as a subset of measures and activities established through rulemaking.

Additionally, we will work with stakeholders to develop MVPs as a cohesive and meaningful participation experience for clinicians with an aligned set of measures and activities that are more relevant to a clinician's scope of practice, while further reducing reporting burden and easing the transition to APMs. We refer readers to the CY 2020 PFS proposed rule (84 FR 40732 through 40745) for more information on the MVP framework.

(2) Other Major MIPS Provisions

In addition to the MVP framework, we are finalizing two significant proposals for the 2020 MIPS performance period:

- As discussed in section III.K.3.g.(3) of this final rule, we are finalizing the proposal to strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS to require measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. These policies relate to CY 2020 and CY 2021 for QCDRs.
- As discussed in section III.K.3.c.(2)(b)(iii) of this final rule, we are finalizing the proposed episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide. Further, we are also finalizing the revised total per capita cost and the Medicare Spending Per Beneficiary (MSPB) measures.

After consideration of public comments, we are not finalizing two significant proposals:

- As discussed in section III.K.3.c.(2)(a) of this final rule, we are not finalizing our proposal to weight the cost performance category at 20 percent for the 2022 MIPS payment year. Instead, we are continuing to weight the cost performance category at 15 percent in light of concerns noted regarding more detailed and actionable performance feedback. Hence, we are also continuing to weight the quality performance category, discussed in section III.K.3.c.(1)(b) of this final rule, at 45 percent. However, we will revisit increasing the weight

of the cost performance category in next year's rulemaking to ensure clinicians are prepared for the significant increase in category weight by the 2024 MIPS payment year.

- As discussed in section III.K.3.e.(3) of this final rule, we are not finalizing our proposal to set the additional performance threshold at 80 points for the 2022 MIPS payment year and instead are finalizing the additional performance threshold at 85 points for the 2022 MIPS payment year. We are also finalizing the additional performance threshold at 85 points for the 2023 MIPS payment year.

(3) Major APM Provisions

(a) Aligned Other Payer Medical Home Models

We are finalizing the proposal to add the defined term, Aligned Other Payer Medical Home Model, to § 414.1305. The definition of Aligned Other Payer Medical Home Model includes the same characteristics as the definitions of Medical Home Model and Medicaid Medical Home Model, but it applies to other payer payment arrangements. We believe that structuring this definition in this manner is appropriate because we recognize that other payers could have payment arrangements that may be appropriately considered medical home models under the All-Payer Combination Option.

Neither the current Medical Home Model financial risk and nominal amount standards nor the Medicaid Medical Home Model financial risk and nominal amount standards apply to other payer payment arrangements. Consistent with our decision to finalize our proposal to define the term Aligned Other Payer Medical Home Model, we are finalizing our proposal to amend § 414.1420(d)(2), (d)(4), and (d)(8) to apply the same Medicaid Medical Home Model financial risk and nominal amount standards, including the 50 eligible clinician limit, to Aligned Other Payer Medical Home Models.

(b) Marginal Risk for Other Payer Advanced APMs

We are finalizing our proposal to modify our definition of marginal risk when determining whether a payment arrangement is an Other Payer Advanced APM. We proposed that, in the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we will compare the average marginal risk rate across all possible levels of actual expenditures to the marginal risk rate specified in the Other Payer Advance APM financial risk criterion, with exceptions for large losses and small losses, as described in § 414.1420(d). When considering average marginal risk in the context of total risk, we believe that certain risk arrangements can create meaningful and significant risk-based incentives for performance and at the same time ensure that the payment arrangement has strong financial risk components.

(c) Estimated APM Incentive Payments and MIPS Payment Adjustments

As we discuss in section VII.F.10.a. of this final rule, for the 2022 payment year and based on estimated Advanced APM participation during the 2020 QP Performance Period, we estimate that between 210,000 and 270,000 clinicians will become Qualifying APM Participants (QPs). Eligible clinicians who are QPs for the 2022 payment year are excluded from the MIPS reporting

requirements and payment adjustment and will receive a lump sum APM Incentive Payment equal to 5 percent of their aggregate payment amounts for covered professional services for the year prior to the payment year. We estimate that the total lump sum APM Incentive Payments will be approximately $535-685 million for the 2022 Quality Payment Program payment year.

We estimate that there will be approximately 879,966 MIPS eligible clinicians for the 2020 MIPS performance period in section VII.F.10.b.(1)(b) of this final rule. The final number will depend on several factors, including the number of eligible clinicians excluded from MIPS based on their status as QPs or Partial QPs, the number that report as groups, and the number that elect to opt into MIPS in accordance with § 414.1310(b)(1)(ii). In the 2022 MIPS payment year, MIPS payment adjustments, which only apply to payments for covered professional services furnished by a MIPS eligible clinician, will be applied based on a MIPS eligible clinician's performance on specified measures and activities within four integrated performance categories. We estimate that MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments ($433 million) and positive MIPS payment adjustments ($433 million) to MIPS eligible clinicians, as required by the statute to ensure budget neutrality. Up to an additional $500 million is also available for the 2022 MIPS payment year for additional positive MIPS payment adjustments for exceptional performance for MIPS eligible clinicians whose final score meets or exceeds the additional performance threshold of 85 points that we are finalizing in section III.K.3.e.(3) of this final rule. However, the distribution will change based on the final population of MIPS eligible clinicians for the 2022 MIPS payment year and the distribution of final scores under the program.

2. Definitions

At § 414.1305, we are finalizing definitions of the following terms:

- Aligned Other Payer Medical Home Model.
- Hospital-based MIPS eligible clinician.
- MIPS Value Pathway.

We are also finalizing revisions to the following definition at § 414.1305:

- Rural area.

These terms and definitions are discussed in detail in relevant sections of this final rule.

3. MIPS Program Details

a. Transforming MIPS: MIPS Value Pathways

(1) Overview

In the CY 2020 PFS proposed rule, we proposed an MVP definition that would prepare us to apply a new MVP framework beginning with the 2021 MIPS performance period. This MVP framework would simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. We refer readers to the CY

2020 PFS proposed rule (84 FR 40732 through 40745) for more information on the MVP framework and the proposed MVP definition.

(2) Implementing MVPs

In the CY 2020 PFS proposed rule (84 FR 40735), we described the MVP framework and proposed to define a MIPS Value Pathway at § 414.1305 as a subset of measures and activities specified by CMS. We noted that MVPs may include, but will not be limited to, administrative claims-based population health, care coordination, patient-reported (which may include patient reported outcomes, or patient experience and satisfaction measures), and/or specialty/condition specific measures. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the MVP framework and proposed definition of an MVP because this could potentially reduce the complexity of the MIPS program and clinician burden. Many commenters agreed with the intent of the MVP framework to simplify MIPS, reduce burden, make the program more meaningful for clinicians and reduce barriers to movement into APMs.

Response: We thank commenters for their support.

Comment: Several commenters stated that the MVP framework was a positive first step and they would like to see further burden reduction beyond clinician measure selection burden, including the elimination of the siloed requirements and scoring approaches for each of the four performance categories. Several commenters suggested streamlined reporting or automatic credit for Promoting Interoperability and Improvement Activities performance categories. Several commenters recommended that participation in a specialty accreditation program earn credit as an improvement activity. Several commenters suggested the use of measures that satisfy the requirements of multiple performance categories in MVPs. A few commenters provided an example of linking measures: one example was to allow a clinician to report the quality measure, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), and the improvement activity, Glycemic Screening Services (IA_PM_19) to receive credit for a quality measure and improvement activity.

Response: We intend to develop MVPs in collaboration with stakeholders that align with guiding principles that include simplification and clinician burden reduction. We intend to work with stakeholders to develop MVPs that account for variation in specialty, size, and composition of clinician practices. We also intend that MVPs would allow for a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to a patient population, a specialty or a medical condition, reducing the siloed nature of the current MIPS participation experience. We believe it is important to develop MVPs in unison with stakeholders to create low burden, meaningful MVPs that move clinicians along the value continuum and facilitate movement into APMs. Experience with MVPs that measure quality of care and patient experience of care, cost, continuous practice improvement, and effective management and transfers of health information will help to reduce barriers to APM participation. We would like to work with stakeholders to identify specialty accreditation programs, such as the American College of Surgeons' Commission on Cancer Accreditation

program that demonstrate a commitment to quality improvement and alignment with MIPS quality measures. We intend to develop MVPs to connect measures across performance categories as indicated by the commenter's diabetes example above. We note that the MIPS statute requires the use of four performance categories now called Quality, Cost, Improvement Activities, and Promoting Interoperability in determining the MIPS composite performance score. While each performance category has its own requirements and associated list of measures or activities, it is possible that a single measure or activity may meet the respective criteria for inclusion in more than one performance category; however, we do not currently have any multicategory MIPS or QCDR measures available. We would be interested in working with stakeholders to pair the improvement activities and quality and cost measures, while leveraging foundational global or population health measures and Promoting Interoperability measures that would constitute an MVP. We are interested in the potential use of measures that could satisfy more than one of the four MIPS performance categories within our statutory constraints and welcome additional stakeholder engagement related to how to best structure and develop MVPs that entail low clinician burden. Feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: Many commenters indicated conditional support for the MVP framework, with concerns about the timeline and transition to MVPs in CY 2021. Many commenters requested a longer and more gradual timeline for MVP implementation. Several commenters suggested delaying MVP implementation by 1 year to CY 2022, while several others suggested a delay of a few years, with a few specifying a 2-year delay. Many commenters stated concerns that implementation in the 2021 MIPS performance period will not allow enough time to develop MVPs for all specialists, and several commenters indicated concerns about the time needed to educate clinicians on the use of MVPs. Many commenters supported MVPs as a voluntary reporting option in addition to the currently available options for MIPS participation. Several commenters recommended that MVPs be optional during a transition period. Several commenters supported the proposed MVP definition provided that MVPs are implemented as a voluntary gradual or multiyear pilot, allowing development and clinician MVP education time. A few commenters indicated that there is a need for stability in the Quality Payment Program and urged caution with implementation of the MVP framework.

Response: We have not made any proposals regarding whether participation in MVPs will be mandatory or optional. We appreciate that we need to work diligently with stakeholders to develop and propose policies regarding many aspects of implementation of MVPs in the 2021 MIPS performance period, including the extent of first year implementation or the feasibility of an initial pilot. Feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: A few commenters did not support implementing the MVP framework stating that the MVPs would create too much change and clinician confusion with a few commenters stating that MVPs would not serve the needs of their specialty (for example, dermatology, nurse practitioners, physician assistants, occupational therapy, audiology, speech language pathology), indicating insufficient numbers of quality measures for the specialty. A few commenters stated that certain clinician types, for example, nurse practitioners, have only a

single Medicare specialty designation but practice in diverse specialty areas and that a limited number of potentially assigned MVPs may leave some clinicians out. A few commenters indicated that specialty clinicians would need either multiple MVPs or an MVP with a wide variety of measures and activities, because of the range of services provided by a specialty. For example, surgeons provide a wide range of procedures from neurosurgery to spine care. A few commenters indicated that clinicians new to MIPS reporting should have a delayed MVP timeline. A few commenters stated that the MVPs, as described, would not be able to meet the stated goals because MVPs may reduce the burden of measure selection, but will not reduce the overall burden of participating in MIPS, which the commenters indicated would require removing separate requirements for scoring and reporting for each of the performance categories. Many commenters did not support transitioning towards MVPs because this would reduce clinician choice in the selection of measures and activities; and may rely on measures and activities, including population health measures, viewed as not relevant to the clinician's clinical practice.

Response: We believe achieving the goals of the MVP framework are worthwhile and understand the need to introduce change that is balanced against the burden required for clinicians to change workflows and participate in the program. A notable change for MIPS eligible clinicians with MVPs is that they would no longer select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a clinician specialty or a clinical condition. We welcome ideas from stakeholders for developing MVPs that provide further burden reduction to clinicians. We acknowledge that a single MVP may not fit the needs of all clinician types and all clinicians in the specialty and would like to work with stakeholders to determine, to the extent possible, the number of MVPs needed for specialists and which measures and activities should be included. We would like to engage with clinicians in the field and their societies to develop applicable MVPs and foundational population health administrative claims measures that are low burden and meaningful. We believe that holding all clinicians accountable for the same population health measures will align incentives, encourage coordination between clinicians and promote meaningful progress on measures. We seek ongoing engagement with stakeholders to identify population health measures that will drive collaborative, high-quality and timely care. We believe that ongoing engagement with stakeholders will lead to improved clinicians' experience with the Quality Payment Program and drive meaningful change in the delivery system. We will consider this feedback on how to best transition to MVPs and how to optimally include MVPs that meet the needs of all clinician specialties.

Comment: Several commenters requested additional information about how equity would be maintained between clinicians reporting on MVPs and those using the currently available MIPS participation options, as well as between clinicians reporting on different MVPs, indicating a concern that one MIPS participation option or MVP should not be 'easier' than others.

Response: We agree that equity is critical to MVP implementation and requested feedback on approaches we should take to create equity across MVPs and across clinician types (84 FR 40742). We intend to work with stakeholders to determine approaches to maintain equity between MVP and the MIPS participation option, as well as clinicians reporting on different

MVPs. This feedback will inform our process development as we further develop our MVP framework and unique MVPs and undertake future rulemaking.

Comment: Many commenters expressed concerns related to the population health claims-based performance measures that would be selected for use in MVPs. Many commenters did not support the use of population health claims-based measures in MVPs because of reliability, validity, attribution, lack of risk adjustment, actionability concerns, and/or unintended consequences concerns. Several commenters supported foundational use of population health claims-based measures, with a few commenters supporting use of administrative measures that are consistent with Advanced APM measures stating that administrative measures can assess quality across time and the delivery system without clinician reporting and can be applied to various clinician types including specialties.

Response: We intend to work in close partnership with stakeholders to identify measures and activities to include in MVPs. Our vision for MVPs is to connect the four performance categories while using a foundational layer of population health claims-based measures and interoperability on which to build quality, cost and improvement activity linkages. Please refer to the on line MVP graphic (https://qpp-cm-prod-content.s3.amazonaws.com/uploads/587/MIPS%20Value%20Pathways%20Diagrams.zip) that provides an overview of our vision for the MIPS future state. Implementation of a foundational population health core measure set using administrative claims-based quality measures that can be broadly applied to communities or populations can result in MVP measure tracks that provide more uniformity in the program's measures, reduce clinician reporting burden, allow focus on important public health priorities, increase the value of MIPS performance data, and reduce barriers to APM participation. Additionally, we intend to examine these concerns regarding population health measure reliability, validity, attribution and risk adjustment and the technical challenges and address them to the extent feasible by working with the measure stewards and clinician experts. We believe that interoperability is also a foundational element that would apply to all clinicians, regardless of MVP, for whom the Promoting Interoperability performance category is required. We envision an initial uniform set of Promoting Interoperability measures in each MVP and will consider customizing MVP Promoting Interoperability measures in future years. We believe that eligible clinicians could benefit from more targeted approaches that assess the meaningful use of health IT in alignment with clinically relevant MVPs. The integration of population health measures and Promoting Interoperability measures into MVPs provides a degree of standardization across all clinician types and promotes an infrastructure on which to assess and improve value-based care. Measure feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: Many commenters indicated that a critical element of specifying the measures and activities within an MVP will be stakeholder engagement. Many commenters urged us to work in tandem with clinicians and specialty societies to develop MVPs. A few other commenters suggested that specialty societies should develop MVPs. A few commenters urged us to work with multi-stakeholder consensus-based organizations such as the Core Quality Measures Collaborative and to utilize existing specialty measure set development approaches to identify a

list of measures for each MVP. A few commenters suggested that we allow stakeholders to comment on the detailed methodologies of a future MVP design and implementation plan as they become more fully developed.

Response: We appreciate the commenters' recommendations on how the measures and activities should be specified in the MVPs and for articulating the critical importance of stakeholder engagement in MVP development. In recognition of our intention to specify MVPs with stakeholder input to the extent possible, we are modifying the proposed definition of MVP at § 414.1305, by replacing the words, "as specified by CMS" with "established through rulemaking".

After consideration of the comments, we are finalizing a modification of our proposal. Specifically, we are finalizing at § 414.1305 that MIPS Value Pathway means a subset of measures and activities established through rulemaking.

(3) Requests for Feedback on MVPs

In the CY 2020 PFS proposed rule (84 FR 40739 through 40745), we requested public comments regarding several issues involving the MVPs. We received 2,100 comments related to implementation of MVPs. While we are not summarizing and responding to comments we received in this final rule, we thank the commenters for their responses and may take them into account as we develop future policies for the MVPs. We also are interested in engaging with stakeholders on additional ways to reduce burden in the MIPS program, in addition to what we have solicited comment on for MVPs. For example, in the context of MVPs, we are interested in solutions to reduce burden across all 4 MIPS categories such as use of standards such as Fast Healthcare Interoperability Resources (FHIR), number of measures across categories, reporting timeframes and data submission methods. We intend to continue a dialogue with stakeholders on these important MVP topics and may consider convening public forum listening sessions, webinars, and office hours or using additional opportunities such as the pre-rulemaking process to further understand what is important to clinicians, patients, and stakeholders and obtain further input as we develop MVPs.

Quality Payment PROGRAM

2020 Quality Payment Program Final Rule Overview Fact Sheet

History and Future Direction of the Quality Payment Program

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

The flexibilities that we have created for the Quality Payment Program, especially within MIPS, resulted in overall participation rates by MIPS eligible clinicians of 95 and 98 percent for the 2017 and 2018 performance periods, respectively.

Additionally, over 99,000 eligible clinicians became Qualifying APM Participants (QPs) based on participation in Advanced APMs in the 2017 QP Performance Period, and the number of QPs has nearly doubled to over 183,000 based on participation in Advanced APMs in the 2018 QP Performance Period.

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

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

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

We are finalizing our MIPS Value Pathways (MVPs), a participation framework that would begin with the 2021 performance period. We recognize stakeholder concerns about this timeline and are committed to a smooth transition to the MVPs that does not immediately eliminate the current MIPS framework. We will continue to engage with stakeholders to co-develop MVPs, to align with our goal of moving away from siloed performance category activities and measures and moving towards a set of measure options more relevant to a clinician's scope of practice that is meaningful to patient care.

The MVP framework aims to align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS for different specialties or conditions.

In addition, the MVP framework incorporates a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities and reduce reporting. We believe this combination of administrative claims-based measures and specialty/condition specific measures will streamline MIPS reporting, reduce complexity and burden, and improve measurement.

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

We recognize that this will be a significant shift in the way clinicians may potentially participate in MIPS, therefore we want to work closely with clinicians, patients, specialty societies, third parties and others to establish the MVPs. We want to continue developing the future state of MIPS together with each of you to ensure that we are reducing burden, driving value through meaningful participation, and, most importantly, improving outcomes for patients. We intend to develop MVPs in collaboration with stakeholders and provide opportunities for dialogue and additional feedback. We are in the process of updating the new MVPs webpage on the QPP website, which will include an MVP overview video and highlight future engagement opportunities.

Quality Payment Program Final Rule CY 2020 Overview

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

Quality Payment Program CY 2020 Finalized Policies: MIPS Highlights

(*Note*: This section provides a highlight of changes. For more details, refer to the comparison table beginning on page 9)

We proposed to continue to incrementally adjust the performance threshold, additional performance threshold for exceptional performance, and performance category weights to meet the requirements established by Congress. Beginning with the sixth year of the program (2022 performance period) the performance threshold needs to be set at the mean or median of the final scores for all MIPS eligible clinicians for a prior period, and the Quality and Cost performance categories must be equally weighted at 30% each. However, we acknowledge commenters' concerns about increasing the weight of the Cost performance category due to limited feedback on both new and existing cost measures with this performance category under MIPS.

We have finalized the following **performance thresholds and category weights** for the 2020 performance period (which equates to the 2022 payment year):

- The performance threshold is 45 points
- The additional performance threshold for exceptional performance is 85 points
- The Quality performance category is weighted at 45% (no change from PY 2019)
- The Cost performance category is weighted at 15% (no change from PY 2019)
- The Promoting Interoperability performance category is weighted at 25% (no change from PY 2019)
- The Improvement Activities performance category is weighted at 15% (no change from PY 2019)

We have also finalized the following **performance thresholds** for the 2021 performance period:

- The performance threshold is 60 points
- The additional performance threshold for exceptional performance is 85 points

We are not finalizing changes to the Quality and Cost performance category weights for the 2021 performance period at this time but will make proposals for updating these in next year's rulemaking as clinicians become more familiar with the feedback process within the Cost performance category. By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period.

For the **Quality performance category,** we are:

- Increasing the data completeness threshold to 70%,
- Continuing to remove low-bar, standard of care, process measures as we further implement our Meaningful Measures framework,
- Addressing benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment,
- Focusing on high-priority outcome measures, and
- Adding new specialty sets (Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology).

For the **Cost performance category,** we are:

- Adding 10 new episode-based measures to continue expanding access to this performance category, and
- Revising the existing Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost measures.

For the **Improvement Activities performance category**, we are:

- Reducing barriers to patient-center medical home designation by removing specific examples of entity names of accreditation organizations or comparable specialty practice programs;
- Increasing the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice needing to perform the same improvement activity; we are finalizing our proposal with modification, such that instead of requiring that a group must perform the same activity for the same continuous 90 days in the performance period as proposed, we are requiring that a group must perform the same activity during any continuous 90-day period within the same performance year;
- Updating the Improvement Activity Inventory and establishing factors for consideration for removal; and
- Concluding the CMS Study on Factors Associated with Reporting Quality Measures.

For the **Promoting Interoperability performance category, we are:**

- Including the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure (available for bonus points)
- Removing the Verify Opioid Treatment Agreement measure
- Reducing the threshold for a group to be considered hospital-based (Instead of 100% of clinicians, more than 75% of the clinicians in a group must be a hospital-based individual MIPS eligible clinician in order for the group to be excluded from reporting the measures under the Promoting Interoperability performance category and to have this category reweighted to zero.)
- Beginning with PY 2019, requiring a "yes/no" response instead of a numerator and denominator for the optional Query of PDMP measure
- Beginning with PY 2019, redistributing the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Electronic Access to Their Health Information measure (if an exclusion is claimed)

We are also focused on improving partnerships with third parties to help reduce clinician reporting burden and improve the services clinicians receive.

For **third party intermediaries**, such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries, we are:

- Requiring QCDRs and Qualified Registries to consolidate and enhance their services (beginning with the 2021 performance period) by:
    - Supporting all MIPS performance categories that require data submission; and
    - Providing enhanced performance feedback, allowing clinicians to view their performance on a given measure in comparison to other participants in the registry or QCDR.
- Raising the standards for QCDR measures, such as by
    - Requiring that QCDR measures (beginning with the 2021 performance period) be fully developed and tested prior to self-nomination; and

    - Requiring QCDRs (beginning with the 2020 performance period) to work together to harmonize their similar QCDR measures
    - Refer to the QCDR measure section of the comparison table for a comprehensive list of changes.
- Clarifying the remedial action and termination provisions applicable to all third party intermediaries (all performance periods).

Finally, recognizing the importance of providing patients with valuable information to help empower their decision-making, we will **publicly report on the Physician Compare website** aggregate MIPS data beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible. We will also publicly report an indicator if a MIPS eligible clinician is scored using facility-based measurement, as technically feasible and appropriate. We will link from Physician Compare to Hospital Compare where facility-based measure information that applies to the clinician or group would be available, beginning with Year 3 (2019 performance information available for public reporting in late 2020).

The Table beginning on page 9 describes the finalized changes to existing policies. Policies without proposed changes (such as eligible clinician types and the low-volume threshold) are included in Appendix A.

Quality Payment Program CY 2020 Final Rule: APM Highlights

For APMs, we also have finalized several updates. For the APM Scoring Standard, we finalized quality reporting options for APM participants. We have, in previous rules, attempted to streamline participation by clinicians who are in APMs. However, quality measures based on an APM's measures are not always available for MIPS scoring. In order to offer flexibility and improve meaningful measurement, we finalized, beginning in 2020, allowing APM Entities and MIPS eligible clinicians participating in APMs—where quality scoring through MIPS is not a requirement of the APM—the option to report on MIPS quality measures for the MIPS Quality performance category. APM Entities will receive a calculated score based on individual, TIN, or APM Entity reporting, similar to our approach for the MIPS Promoting Interoperability performance category.

We also will apply a minimum score of 50 percent, or an ''APM Quality Reporting Credit'' under the MIPS Quality performance category for certain APM entities participating in MIPS, where APM quality data are not used for MIPS purposes. These APM participants will receive a credit equal to 50 percent of the MIPS Quality performance category weight. APM participants will have the opportunity to submit quality measures to MIPS and their score will be added to the

credit, capped at a total of 100. Additionally, with regard to the quality performance category, we will apply the existing MIPS extreme and uncontrollable circumstances policies to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standard and who would report on MIPS quality measures.

The Table beginning on page 23 describes the finalized changes to existing policies.

Contact Us

We will continue to provide support to clinicians who need assistance. While our support offerings will reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance in order to help them successfully participate. We will continue offering direct, customized technical assistance to clinicians in small practices through our Small, Underserved, and Rural Support initiative.

We also encourage clinicians to contact our Quality Payment Program Service Center for immediate support at 1-866-288-8292 (TTY) 1-877-715-6222 Monday through Friday, 8:00 AM-8:00 PM Eastern Time or via email at QPP@cms.hhs.gov, as well as visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Changes to QPP Policies Finalized for CY 2020

Quality Payment Program CY 2020 Final Rule: MIPS Overview

Policy Area	CY 2019 Policy	CY 2020 Policy
Performance Category Weights	• Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	**No change:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%
Quality Performance Category	**Data Completeness Requirements:** • Medicare Part B Claims measures: 60% of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, and eCQMs: 60% of clinician's or group's patients across all payers for the performance period	**Data Completeness Requirements:**[1] • Medicare Part B Claims measures: **70%** sample of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, and eCQMs: **70%** sample of clinician's or group's patients across all payers for the performance period Note: Using data selection criteria to misrepresent a clinician or group's performance for a performance period, commonly referred to as "cherry-picking", results in data that is not true, accurate, or complete.
	Call for Measures: CMS seeks measures that are: • Applicable • Feasible	**Call for Measures:** In addition to current requirements: • Measures submitted in response to Call for Measures are required to demonstrate a link to existing and related cost

[1] Note: As finalized in the QPP 2019 Final Rule, beginning with the CY 2020 MIPS performance period, CMS will assign zero points for any measure that does not meet data completeness requirements for the quality performance category. Small practices will continue to receive 3 points.

Policy Area	CY 2019 Policy	CY 2020 Policy
	• Reliable • Valid at the individual clinician level • Different from existing measures For complete information on current policy, review the 2019 Call for Measures and Activities.	measures and improvement activities as appropriate and feasible.
	Measure Removal: • A quality measure may be considered for removal if the measure is no longer meaningful, such as measures that are topped out. • A measure would be considered for removal if a measure steward is no longer able to maintain the quality measure.	**Measure Removal:** In addition to current measure removal criteria: • MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking for 2 consecutive years may be removed. • We will consider a MIPS quality measure for removal if we determine it is not available for MIPS Quality reporting by or on behalf of all MIPS eligible clinicians (including via third party intermediaries).
	Modified Benchmarks to Avoid Potential Patient Risk: No special benchmarking policy. The general benchmarking policy for quality measures applies, where: • Performance on quality measures is broken down into 10 “deciles.” • Each decile has a value of between one and 10 points based on stratified levels of national performance (benchmarks) within that baseline period.	**Modified Benchmarks to Avoid Potential Patient Risk**: • Establish **flat percentage benchmarks*** in limited cases where CMS determines that the measure’s otherwise applicable benchmark could potentially incentivize treatment that could be inappropriate for particular patients. • The modified benchmarks would be applied to all collection types where the top decile for a historical benchmark is higher than 90% for the following measures: ○ **MIPS #1 ((NQF 0059):** Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Policy Area	CY 2019 Policy	CY 2020 Policy
	• A clinician's performance on a quality measure will be compared to the performance levels in the national deciles. The points received are based on the decile range that matches their performance level. • For inverse measures (like the diabetic HgA1c measure), the order is reversed – decile one starts with the highest value and decile 10 has the lowest value.	○ **MIPS #236 (NQF 0018):** Controlling High Blood Pressure *In flat percentage benchmarks, any performance rate at or above 90% would be in the top decile, any performance rate between 80% and 89.99%% would be in the second highest decile, and so on. (For inverse measures, this would be reversed – any performance rate at or below 10% would be in the top decile, any performance rate 10.01% and 20% would in the second highest decile, and so on.)
QCDRs, Qualified Registries and other Health IT vendors	• QCDRs and Qualified Registries not required to support multiple performance categories.	*Beginning with the 2021 performance period*: • QCDRs and Qualified Registries are required to provide services for the entire performance period and applicable submission period. • In the event that they must discontinue services, they must support the transition to an alternate submitter type (and as needed alternate collection type) or third party intermediary. • QCDRs and Qualified Registries are required to submit data for each category: ○ Quality; ○ Improvement Activities; and ○ Promoting Interoperability performance categories. • Health IT vendors are required to submit data for at least one category. A third party intermediary could may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups fall under the reweighting policies at

Policy Area	CY 2019 Policy	CY 2020 Policy
		§ 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(1) through (7) or § 414.1380(c)(2)(i)(C)(9)).
	Performance Feedback: • Qualified Registries and QCDRs must provide timely performance feedback at least 4 times a year on all of the MIPS performance categories that the Qualified Registry or QCDR reports to CMS.	**Performance Feedback:** <u>*Beginning with the 2021 performance period*</u>: • This feedback (still required 4 times per year) must include **information on how participants compare to other clinicians within the Qualified Registry or QCDR cohort** who have submitted data on a given measure (MIPS quality measure and/or QCDR measure). • QCDRs and Qualified Registries will be required to attest during the self-nomination process that they can provide performance feedback at least 4 times a year. • In instances where the QCDR/Qualified Registry does not receive data from their clinician until the end of the performance period, the QCDR/Qualified Registry could be excepted from this requirement. The QCDR/Qualified Registry must submit a request to CMS within the reporting period promptly within the month of realization of the impending deficiency in order to be considered for this exception.
	QCDR Measure Requirements: • QCDR measures must be beyond the measure concept phase of development. • CMS will show a preference for QCDR measures that are outcome-based rather than clinical process measures.	**QCDR Measure Requirements:** <u>*Beginning with the 2020 performance period:*</u> • In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be

Policy Area	CY 2019 Policy	CY 2020 Policy
	• Measures should address significant variation in performance. • QCDR measures are approved for use in MIPS for a single performance period.	considered for the program in subsequent years. Duplicative QCDR measures will not be approved if QCDRs do not elect to harmonize identified measures as requested by CMS within the allotted timeframe. *Beginning with the 2021 performance period*: • QCDRs must identify a linkage between their QCDR measures to the following, at the time of self-nomination: (a) cost measure; (b) Improvement Activity; or (c) CMS developed MVPs as feasible. • QCDR Measures must be **fully developed** with **completed testing** results at the clinician level and must be **ready for implementation at the time of self-nomination**. • QCDRs must collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. • CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. • A QCDR measure that does not meet case minimum and reporting volumes required for benchmarking after being in

Policy Area	CY 2019 Policy	CY 2020 Policy
		the program for 2 consecutive CY performance may not continue to be approved in the future. • At CMS discretion, QCDR measures may be approved for two years, contingent on additional factors. • Additional QCDR measures considerations include: (a) conducting an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development.
	QCDR Measure Rejections: • There is no formal policy for measure removal, as QCDR measures must be submitted for CMS approval on an annual basis as part of the self-nomination process.	**QCDR Measure Rejections:** CMS has finalized the following guidelines to help QCDRs understand when a QCDR measure would likely be rejected during the annual self-nomination process: • QCDR measures that are duplicative of an existing measure or one that has been removed from MIPS or legacy programs, which have been retired • Existing QCDR measures that are “topped out” (though these may be resubmitted in future years) • QCDR measures that are process-based (consideration given to the impact on the number of measures available for a specific specialty) Considerations and evaluation of the measure’s performance data, to determine whether performance variance exists.

Policy Area	CY 2019 Policy	CY 2020 Policy
		• QCDR measures that have the potential for unintended consequences to a patient's care • QCDR measures that split a single clinical practice/action into several measures or that focus on rare events • Whether the previously identified areas of duplication have been addressed as requested • QCDR measures that are "check-box" with no actionable quality action • QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years • QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years • Whether the existing approved QCDR measure is no longer considered robust, in instances where new QCDR measures are considered to have a more vigorous quality action, where CMS preference is to include the new QCDR measure rather than requesting QCDR measure harmonization • QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician (that is, the quality aspect being measured cannot be attributed to the clinician or is not under the direct control of the reporting clinician) • QCDR measures that focus on rare events or "never events" in the measurement period

Policy Area	CY 2019 Policy	CY 2020 Policy
Improvement Activities Performance Category	**Definition of Rural Area:** Rural area means a ZIP code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available.	**Definition of Rural Area:** Rural area means a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP Code file available. (Note that this is a technical correction, as we had previously misidentified the source file in regulation. There is no change to how we identify rural clinicians.)

	Patient-Centered Medical Home Criteria:
	To be eligible for Patient-Centered Medical Home designation, the practice must meet one of the following criteria:
	• The practice has received accreditation from one of four accreditation organizations that are nationally recognized:
	  ○ The Accreditation Association for Ambulatory Healthcare;
	  ○ The National Committee for Quality Assurance (NCQA);
	  ○ The Joint Commission; or
	  ○ The Utilization Review Accreditation Commission (URAC); OR
	• The practice is participating in a Medicaid Medical Home Model or Medical Home Model; OR
	• The practice is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition.
		Patient-Centered Medical Home Criteria:
		CMS is updating § 414.1380(b)(3)(ii)(A) and (C) removing the reference to the four listed accreditation organizations to be recognized as patient-centered medical homes and removing the reference to the specific accrediting organization for comparable specialty practices:
		To be eligible for Patient-Centered Medical Home designation, the practice must meet one of the following criteria:
		• The practice has received accreditation from an accreditation organization that is nationally recognized (such as the four organizations specified for PY 2019);
		• The practice is participating in a Medicaid Medical Home Model or Medical Home Model;
		• The practice is a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; OR
		• The practice has received accreditation from other certifying bodies that have certified a large number of

Policy Area	CY 2019 Policy	CY 2020 Policy
		medical organizations and meet national guidelines, as determined by the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following: (1) Have a personal physician/clinician in a team-based practice (2) Have a whole-person orientation (3) Provide coordination or integrated care (4) Focus on quality and safety (5) Provide enhanced access
	Improvement Activities Inventory: • Added 1 new criterion, "Include a public health emergency as determined by the Secretary." • Removed "Activities that may be considered for a Promoting Interoperability bonus."	**Improvement Activities Inventory:** • Addition of 2 new Improvement Activities. • Modification of 7 existing Improvement Activities. • Removal of 15 existing Improvement Activities.
	CMS Study on Factors Associated with Reporting Quality Measures: • MIPS eligible clinicians who successfully participate in the study receive full credit in the Improvement Activities performance category.	**CMS Study on Factors Associated with Reporting Quality Measures:** • Study year 2019 (CY 2019) is the last year of the 3-year study, as stated in CY 2019 PFS final rule. **CMS will not continue the study during the 2020 performance period.** Final study results will be shared at a later date.
	Removal of Improvement Activities: • No formal policy but invited public comments on what criteria should be used to identify improvement activities for removal from the Inventory.	**Removal of Improvement Activities:** An activity will be considered for removal if: • It is duplicative of another activity

Policy Area	CY 2019 Policy	CY 2020 Policy
		• An alternative activity exists with stronger relationship to quality care or improvements in clinical practice • The activity does not align with current clinical guidelines or practice • The activity does not align with at least one meaningful measures area • The activity does not align with Quality, Cost, or Promoting Interoperability performance categories • There have been no attestations of the activity for 3 consecutive years • The activity is obsolete
	Requirement for Improvement Activity Credit for Groups: • Group or virtual group can attest to an improvement activity if at least one clinician in the TIN participates.	**Requirement for Improvement Activity Credit for Groups:** • Group or virtual group can attest to an improvement activity when **at least 50% of the clinicians (in the group or virtual group) perform the same activity** during any continuous 90-day period within the same performance period. We are finalizing our proposal with modification, such that instead of requiring that a group must perform the same activity for the same continuous 90 days in the performance period as proposed, we are requiring that a group must perform the same activity during any continuous 90-day period within the same performance year.
Promoting Interoperability Performance Category -	Hospital-based clinicians who choose to report as a group or virtual group are eligible for reweighting when 100% of the MIPS eligible clinicians in the group meet	Hospital-based clinicians who choose to report as a group or virtual group are eligible for reweighting when **more than 75%** of the NPIs in the group or virtual group meet the

Policy Area	CY 2019 Policy	CY 2020 Policy
Hospital-Based MIPS Eligible Clinicians in Groups	the definition of a hospital-based MIPS eligible clinician.	definition of a hospital-based individual MIPS eligible clinician. No change to definition of an individual hospital-based MIPS eligible clinician.
Promoting Interoperability Performance Category	**Objectives and Measures:** • One set of objectives and measures based on the 2015 Edition CEHRT • Four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed. • Two new measures for the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement as optional with bonus points available	**Objectives and Measures:** *Beginning with the 2019 performance period:* • The optional Query of **PDMP measure** will require a **yes/no response** instead of a numerator/denominator. • We will redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Electronic Access to Their Health Information measure if an exclusion is claimed. *Beginning with the 2020 performance period:* • We will remove the Verify Opioid Treatment Agreement Measure. • We will include the Query of PDMP measure as optional with a yes/no response.
Cost Performance Category	**Measures:** • Total Per Capita Cost (TPCC) • Medicare Spending Per Beneficiary (MSPB) • 8 episode-based measures **Case Minimums:** • 10 for procedural episodes • 20 for acute inpatient medical condition episodes	**Measures:** • TPCC measure (**Revised**) • MSPB-C (MSPB Clinician) measure (**Name and specification Revised**) • 8 existing episode-based measures • **10 new episode-based measures:** 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair

Policy Area	CY 2019 Policy	CY 2020 Policy
		4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation 6. Lower Gastrointestinal Hemorrhage (applies to groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment No changes to case minimums
	Measure Attribution: • All measures are attributed at the TIN/NPI level for both individuals and groups. • Plurality of primary care services rendered by the clinician to determine attribution for the total per capita cost measure. • Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure. • For procedural episodes, we attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes). • For acute inpatient medical condition episodes, we attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management	**Measure Attribution:** • Measure attribution will be **different for individuals and groups** and will be defined in the applicable measure specifications. • TPCC attribution will require a combination of (i) an E&M services and (ii) general primary care service or a second E&M service, from the same clinician group. • TPCC attribution will **exclude certain clinicians** who primarily deliver certain non-primary care services (e.g., general surgery) or are in specialties that are unlikely to be responsible for primary care services (e.g., dermatology). • MSPB Clinician attribution will have a different methodology for surgical and medical episodes. • No changes proposed for attribution in episode-based measures (existing and new).

Policy Area	CY 2019 Policy	CY 2020 Policy
	(E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization.	
Final Score Calculation: Performance Category Reweighting due to Data Integrity Issues	• No policy to account for data integrity concerns. • Several scenarios for reweighting have previously been finalized, including extreme and uncontrollable events (all performance categories) and hardship exemptions specific to the Promoting Interoperability performance category.	• Beginning with the 2018 performance period and 2020 payment year, we will reweight performance categories for a MIPS eligible clinician who we determine has data for a performance category that are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. MIPS eligible clinicians or third party intermediaries should inform CMS of such circumstances. (CMS may also independently learn of qualifying circumstances). • If we determine that reweighting is appropriate, we will follow our existing policies for reweighting.
Performance Threshold / Additional Performance Threshold / Payment Adjustment	• Performance Threshold is set at **30 points**. • Additional performance threshold set at 75 points for exceptional performance. • As required by statute, the maximum negative payment adjustment is -7%. • Positive payment adjustments can be up to 7% (not including additional positive payment adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 7%.	*For the 2020 performance period (2022 payment year):* • Performance Threshold is set at **45 points**. • Additional performance threshold is set at **85 points** for exceptional performance. • As required by statute, the maximum negative payment adjustment is **-9%**. • Positive payment adjustments can be up to 9% (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to

Policy Area	CY 2019 Policy	CY 2020 Policy
		achieve budget neutrality, which could result in an adjustment above or below 9%. *For the 2021 performance period:* • Performance Threshold is set at **60 points**. • Additional performance threshold is set at **85 points** for exceptional performance.
Targeted Review	MIPS eligible clinicians and groups may submit a targeted review request **by September 30** following the release of the MIPS payment adjustment factor(s) with performance feedback.	*Beginning with the 2019 performance period:* All requests for targeted review must be submitted **within 60 days** of the release of the MIPS payment adjustment factor(s) with performance feedback.

Quality Payment Program CY 2020 Final Rule: APM Overview

Policy Area	CY 2019 Policy	CY 2020 Policy
APMs: Medical Home Models	Medical Home Models and Medicaid Medical Home Models have a primary care focus with participants that provide primary care, empanelment of each patient to a primary clinician and at least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; Risk-stratified care management; Coordination of care across the medical neighborhood; Patient and caregiver engagement; Shared decision-making; and/or Payment arrangements in addition to, or substituting for, fee-for-service payments.	In addition to existing definitions, we finalized a new Aligned Other Payer Multi-Payer Medical Home Model definition, which means an aligned other payer arrangement (not including Medicaid arrangements) operated by another payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation with CMS, such as a memorandum of understanding (MOU), and is determined by CMS to have the following characteristics: • A primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant; • Empanelment of each patient to a primary clinician; and • At least four of the following: planned coordination of chronic and preventive care; Patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood;

Policy Area	CY 2019 Policy	CY 2020 Policy
		patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments). • The Medicaid Medical Home Model financial risk and nominal amount standards also apply to Aligned Other Payer Medical Home Models.
APMs: Other Payer Advanced APM	**Marginal Risk:** Currently, when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we use the lowest marginal risk rate across all possible levels of actual expenditures that would be used for comparison to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30%, with exceptions for large losses and small losses as provided in CMS regulations.	**Marginal Risk:** We are finalizing that when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we will use the average marginal risk rate across all possible levels of actual expenditures that would be used for comparison to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30%, with exceptions for large losses and small losses as provided in CMS regulations.
APM Scoring Standard: Quality Performance Category	MIPS APMs receive quality scores based on their participation in the model. If no data is available for scoring, the categories are reweighted to: 75% Promoting Interoperability and 25% Improvement Activities. Exception: we will use data submitted by the Participant TIN in a Shared Saving Program ACO in the rare event that no data is submitted by the Entity.	We are finalizing allowing MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures in a manner similar to our established policy for the Promoting Interoperability performance category under the APM Scoring Standard for purposes of the MIPS Quality performance category beginning with the 2020 MIPS performance period. We will allow MIPS eligible clinicians in MIPS APMs to receive a score for the quality performance category through either individual or TIN-level reporting

Policy Area	CY 2019 Policy	CY 2020 Policy
		based on the generally applicable MIPS reporting and scoring rules for the Quality performance category. We will apply a minimum score of 50 percent, or an ‘‘APM Quality Reporting Credit’’ under the MIPS Quality performance category for certain APM entities participating in MIPS, where APM quality data are not used for MIPS purposes. In cases where this credit is applied, it will be added to the MIPS quality performance score, subject to a cap of 100 as a total score for the Quality performance category.

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

Policy Area	CY 2019 Policy	CY 2020 Policy
Public Reporting Under Physician Compare	**Release of Aggregate Performance Data:** No established schedule for release of aggregate MIPS data on Physician Compare.	**Release of Aggregate Performance Data:** Aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores, will be available on Physician Compare beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible.
	Facility-based Clinician Indicator: No policy for the facility-based clinician indicator.	**Facility-based Clinician Indicator:** Publicly report an indicator if a MIPS eligible clinician is scored using facility-based measurement, as technically feasible and appropriate. Link from Physician Compare to Hospital Compare where facility-based measure information that applies to the clinician or group would be available, beginning with Year 3 (2019 performance information available for public reporting in late 2020).

Appendix A: MIPS Policies Without Proposed Changes in CY 2020

MIPS Eligibility • Low-Volume Threshold (LVT) • Eligible Clinician Types • Opt-in Policy • MIPS Determination Period	No change
Data Collection and Submission • MIPS Performance Period • Collection Types • Submitter Types • Submission Types • CEHRT Requirements	No change
Quality Measures • Topped-Out Measures • Measures Impacted by Clinical Guideline Changes	No change
MIPS Scoring • Measure, Activity and Performance Category Scoring Methodologies • 3 Point Floor for Scored Measures • Improvement Scoring • Bonus Points: ○ Small Practice Bonus	No change

○ High-Priority Measures ○ End-to-End Electronic Reporting	
Facility-Based Clinicians • Definition and Determination • Scoring Methodology and Policies	No change

Version History Table

Date	Change Description
11/1/2019	• Original posting

Quality Payment PROGRAM

2020 Quality Payment Program Final Rule FAQs

Updated 11/7/2019

Table of Contents

Merit-based Incentive Payment System (MIPS) FAQs

General

Where can I find an overview of the policies that were finalized for the 2020 performance period?

We provide an overview of the major policies we finalized for performance period 2020 in the CY 2020 Quality Payment Program (QPP) Final Rule Fact Sheet, which includes a table comparing the previous policy to the newly finalized policy.

We will also host a public webinar in mid-November that reviews the major changes in the final rule. This webinar and registration link will be announced through the QPP listserv; you can also monitor the QPP Webinar Library on qpp.cms.gov for information about all of our upcoming and past webinars.

Finally, the Electronic Code of Federal Regulations, Subpart O, will be updated to reflect newly codified regulations. (Please note that this resource identifies policies by the payment year instead of the performance period. The 2022 payment year equates to the 2020 performance period.)

Are there any proposed policies that were not finalized?

Yes. We did not finalize:
- Any change to the weights of the Cost and Quality performance categories
- The requirement for QCDRs to foster services (such educational services) to clinicians and groups to improve the quality of care provided to patients

Both policies will be revisited in future rulemaking.

Are MIPS Value Pathways required for 2020?

No. We will begin to implement the MIPS Value Pathways (MVPs) framework gradually, beginning in the 2021 performance period. Over the coming months, we will continue to collaborate with you, using an incremental approach to create and implement the MVPs framework.

What are the certified electronic health record technology (CEHRT) requirements for the 2020 performance year?

We did not propose any changes to CEHRT requirements for 2020. Clinicians continue to need **2015 Edition CEHRT** to report data for the Promoting Interoperability performance category, and to report electronic clinical quality measures (eCQMs) for the Quality performance category.

We are scheduled to transition to a new EHR system during the performance period. What does this mean for our quality measure reporting and meeting the data completeness threshold?

We have heard from stakeholders throughout the performance period of instances where eligible clinician, groups, and/or their practices or hospitals may undergo a mid-year transition from one EHR system to another EHR system, which may impact a clinician or group's ability to submit a full 12 months of data for the quality performance period. In this situation, we encourage stakeholders to supply a report from the previous EHR for the first time period (as long as that EHR was also 2015 CEHRT) and a report from the new EHR for the second time period and aggregate the data for the full 12 months into one report prior to submitting to CMS. In other scenarios where data for the full 12 months is unavailable (for example if aggregation of EHR reports is not possible), we clarify that the data completeness threshold is always calculated off of a 12-month period.

Eligibility

How do I know if I'm eligible for MIPS in 2020?

We did not propose any changes to eligibility or to the definition of a MIPS eligible clinician for the 2020 performance period.

To be eligible for MIPS, you must:

- Be an eligible clinician type,
- Exceed the low-volume threshold, and
- Not be otherwise excluded because of your Medicare enrollment date or as a Qualifying APM Participant (QP), or as a Partial QP that has elected not to participate.

We anticipate that the QPP Participation Status Lookup Tool will be updated with initial 2020 MIPS eligibility results in February.

Last Updated: 11/7/2019

MIPS Eligible Clinician Types	Low-Volume Threshold	Other Exclusions
• Physician (including doctor of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry) • Osteopathic practitioner • Chiropractor • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • Physical therapist • Occupational therapist • Clinical psychologist • Qualified speech-language pathologist • Qualified audiologist • Registered dietitian or nutrition professional	You exceed the low-volume threshold and are a MIPS eligible clinician if you • Bill more than $90,000 in Part B covered professional services, AND • See more than 200 Part B patients, AND • Provide more than 200 covered professional services to Part B patients We evaluate individuals, groups and APM entities on the low-volume threshold. We are continuing our policy that allows clinicians, groups and APM entities who exceed 1 or 2 of these thresholds to **opt-in** to MIPS eligibility and participation.	You are excluded from MIPS if you • Enrolled in Medicare on or after January 1, 2020 • Are a Qualifying APM Participant

Are clinical social workers eligible for MIPS? Why is there a clinical social worker specialty measure set?

No. Clinical social workers continue to be excluded from MIPS in the 2020 performance period. However, we have finalized a clinical social worker measure set to help these clinicians prepare in the event that they are added to the definition of a MIPS eligible clinician through future rulemaking.

What changes were made to for the hospital-based designation for groups in the 2020 performance period?

We finalized changes to the threshold that determines whether a group is considered hospital-based. A group is considered hospital-based when **more than 75%** of the clinicians in the group are hospital-based MIPS eligible clinicians

- In 2019, we required that 100% of MIPS eligible clinicians in the group be hospital-based MIPS eligible clinicians.

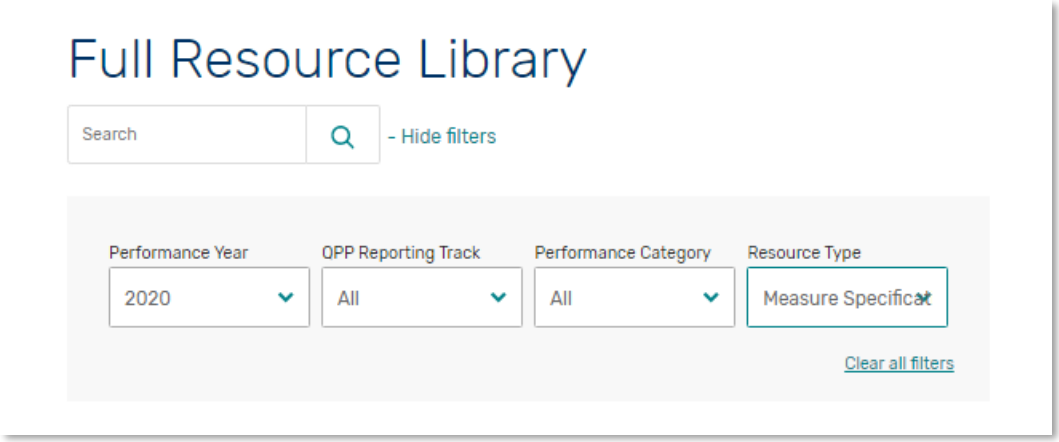
Last Updated: 11/7/2019

Measures and Activities

When will measure specifications/supporting documentation and activity descriptions be available for finalized measures/activities?

Measure specifications and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the QPP Resource Library before the performance period begins on January 1, 2020. We know these are critical resources for planning your participation and we will make these resources available as soon as possible.

We anticipate that this information will be available on the QPP Resource Library by December. (Filter by the 2020 Performance Year and choose Measure Specifications and Benchmarks as the Resource type.)



The Explore Measures & Activities tool on the QPP website will be updated for the 2020 performance period soon after in early 2020. You can also refer to Appendix A for a complete list of 2020 Cost and Promoting Interoperability measures.

When will historical quality benchmarks be available for the 2020 performance period?

The 2020 Quality Benchmarks zip file will be posted on the QPP Resource Library, shortly before the performance period begins on January 1, 2020.

Where can I find a list of topped out quality measures for the 2020 performance period?

We will identify topped out measures through the benchmarking process. The 2020 Quality Benchmarks zip file will be posted on the QPP Resource Library, shortly before the performance year begins on January 1, 2020.

Last Updated: 11/7/2019

Are there any final policies to address data issues outside of a clinician's control?

Yes. We are finalizing our proposal, beginning with the 2018 performance period and the 2020 payment year, to reweight performance categories for a MIPS eligible clinician who we determine has data for a performance category that are inaccurate, unusable, or otherwise compromised due to circumstances outside the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. MIPS eligible clinicians and third party intermediaries should inform CMS of events that they believe have resulted in compromised data. (We may also independently learn of such circumstances.) If we determine that reweighting is appropriate, we will follow our existing policies for redistributing performance category weights

Please see Tables 47-49 in the CY 2019 PFS final rule for more information on our final policies to redistribute performance category weights.

Scoring and Payment Adjustments

How does scoring work in 2020?

In general, our scoring policies are the same as performance period 2019 with some exceptions:

- Quality measures must meet a **70% data completeness** threshold.
    - Reported measures that fall below this threshold **will receive 0 points** (except for small practices that will continue to receive 3 points).
- A flat percentage-based benchmark will be applied to certain quality measures to avoid potentially incentivizing inappropriate treatment.
- For group reporting, **at least 50% of the clinicians in the group must perform an improvement activity** for the group to be able to attest to it.
- The **performance threshold** is set at **45 points.**
- The **additional performance threshold** for exceptional performance is set at **85 points**.

Note that we proposed, but did not finalize, changes to the Quality and Cost performance category weights for 2020.

While we changed the threshold for groups to be considered hospital-based, this revision doesn't change the associated scoring policy:

- As in 2019, groups designated as hospital-based qualify for automatic reweighting of the Promoting Interoperability performance category.

Did you finalize the policy as proposed for groups attesting to improvement activities?

We did finalize a policy for groups attesting to improvement activities, but the final policy differs from the proposed policy.

- Under the proposed policy, a group or virtual group would have been able to attest to an improvement activity when at least 50% of clinicians in the group or virtual group would have needed to perform the improvement activity for the **same 90-day period** during the performance year.
- Under our finalized policy, we're maintaining the 50% threshold, but clinicians can perform the activity during **any continuous 90-day period** during the performance year. (Everyone does not need to perform the activity at the same time.)

What's the maximum negative payment adjustment for the 2020 performance period/2022 payment year?

As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year and beyond is **-9%**. (The actual adjustment you will receive in the 2022 payment year will be based on your MIPS final score from the 2020 performance period.)

How many points do I need to avoid a negative payment adjustment for the 2020 performance period/2022 payment year?

The performance threshold is the number against which your final score is compared to determine your payment adjustment. The performance threshold for the 2020 performance period is 45 points. See the table below for more information about the relationship between 2020 final scores and 2022 payment adjustments.

Your Final Score for the 2020 Performance Period	Payment Impact for MIPS Eligible Clinicians in the 2022 Payment Year
0.00 – 11.25 points	-9% payment adjustment
11.26 – 44.99 points	Negative payment adjustment (greater than -9% and less than 0%)
45.00 points	Neutral payment adjustment (0%)
45.01 – 84.99 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)
85.00 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) Additional (positive) payment adjustment (scaling factor applied to account for funding pool)

Last Updated: 11/7/2019

Public Reporting on Physician Compare FAQs

What type of MIPS aggregate data will be publicly reported on Physician Compare?

Aggregate MIPS data that is publicly reported on Physician Compare will include the minimum and maximum MIPS performance category and final scores, as technically feasible, beginning with CY 2018 data.

Who will have the facility-based clinician indicator on their Physician Compare profile page?

Beginning with Year 3 (CY 2019), if a MIPS eligible clinician is scored using facility-based measurement, we will include an indicator that they were scored this way and will link from Physician Compare to Hospital Compare where facility-based measure information that applies to the clinician or group would be available, as technically feasible.

Alternative Payment Model and Advanced Alternative Payment Model FAQs

How many QPs do you expect for the 2020 QP Performance Period? How does this compare with previous QP performance periods?

We expect to see between 210,000 and 270,000 eligible clinicians become Qualified APM participants (QPs) in the 2020 Performance Period. The projected number of QPs for the 2020 QP Performance Period increased slightly over our projection for the 2019 QP Performance Period. Our previous estimate indicated that between 165,000 and 220,000 eligible clinicians would achieve QP status for the 2019 QP Performance Period. The QP Thresholds (which are established by law) did not increase from the 2019 QP Performance Period to the 2020 QP Performance Period. The number of expected participants in Advanced APMs has increased from 2019 to 2020 due to the increase in the number of Advanced APM participants in 2019.

What are the key changes for clinicians participating in MIPS APMs in the fourth year of QPP?

For the APM Scoring Standard, we are providing new quality reporting options beginning in CY 2020 for APM participants. We have, in previous rules, attempted to streamline MIPS reporting and scoring for MIPS eligible clinicians participating in MIPS APMs. However, quality measures used within certain an APM are not always available for MIPS scoring. In order to offer flexibility and improve meaningful measurement, we will allow APM Entities and MIPS eligible clinicians participating in MIPS APMs the option to report on other MIPS quality measures for the MIPS Quality performance category. APM Entities would receive a calculated score based on individual, TIN, or APM Entity reporting, similar to our approach for the MIPS Promoting Interoperability performance category.

Last Updated: 11/7/2019

We also will apply a MIPS APM Quality Reporting Credit for APM participants in MIPS APMs where quality scoring through MIPS is not a requirement of the APM. These MIPS APM participants will receive a credit equal to 50 percent of the MIPS Quality performance category weight and will have the opportunity to submit quality measures and their score will be added to the credit, subject to a total score cap of 100 for the MIPS Quality performance category.

Appendix A

Table 1. Cost measures finalized for the 2020 performance period.

Cost Measure	Status
Medicare Spending per Beneficiary Clinician measure	Updated
Total per Capita Cost measure	Updated
Episode-Based Measures: 1. Elective Outpatient Percutaneous Coronary Intervention (PCI) 2. Intracranial Hemorrhage or Cerebral Infarction 3. Knee Arthroplasty 4. Revascularization for Lower Extremity Chronic Critical Limb Ischemia 5. Routine Cataract Removal with Intraocular Lens (IOL) Implantation 6. Screening/Surveillance Colonoscopy 7. Simple Pneumonia with Hospitalization 8. ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Existing/No Change (8)
Episode-Based Measures: 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair 4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation 6. Lower Gastrointestinal Hemorrhage (groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment	New (10)

Last Updated: 11/7/2019

Table 2. Promoting Interoperability measures finalized for the 2020 performance period. (All measures are required unless otherwise indicated.)

Objective	Measure
e-Prescribing	**e-Prescribing**
	Bonus (not required): Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**
	Support Electronic Referral Loops by Receiving and Incorporating Health Information
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**
Public Health and Clinical Data Exchange	**Report to two different public health agencies or clinical data registries for any of the following:** 1. Immunization Registry Reporting 2. Electronic Case Reporting 3. Public Health Registry Reporting 4. Clinical Data Registry Reporting 5. Syndromic Surveillance Reporting

Version History Table

Date	Change Description
11/7/2019	Revised exclusions from MIPS on page 3.
11/1/19	Original version

Last Updated: 11/7/2019

MIPS Value Pathways

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
• Many Choices • Not Meaningfully Aligned • Higher Reporting Burden	• Cohesive • Lower Reporting Burden • Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority	• Simplified • Increased Voice of the Patient • Increased CMS Provided Data • Facilitates Movement to Alternative Payment Models (APMs)

Building Pathways Framework

MIPS Pathways

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

Moving to Value

Implementation to begin in 2021

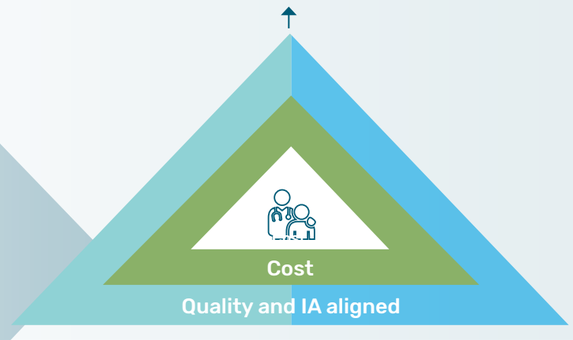
Foundation

Promoting Interoperability
Population Health Measures

Fully Implemented Pathways

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

Value



Foundation

Promoting Interoperability
Population Health Measures
Enhanced Performance Feedback
Patient-Reported Outcomes

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

Clinician/Group Reported Data CMS Provided Data

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

MIPS Value Pathways: Diabetes Example

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

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

Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area

Four performance categories feel like four different programs

Reporting burden higher and population health not addressed

Clinician/Group CMS

Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment

Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice

CMS provides more data; reporting burden on endocrinologist reduced

Clinician/Group CMS

Endocrinologist reports on same foundation of measures with patient-reported outcomes also included

Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice

CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced

Clinician/Group CMS

MIPS Value Pathways for Diabetes Prevention and Treatment

QUALITY MEASURES

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

IMPROVEMENT ACTIVITIES

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

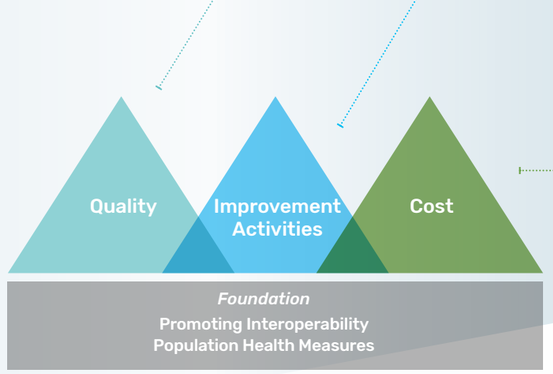
OR

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

COST MEASURES

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

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



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

MIPS Value Pathways: Surgical Example

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

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

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

MIPS Value Pathways for Surgeons

QUALITY MEASURES

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

IMPROVEMENT ACTIVITIES

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

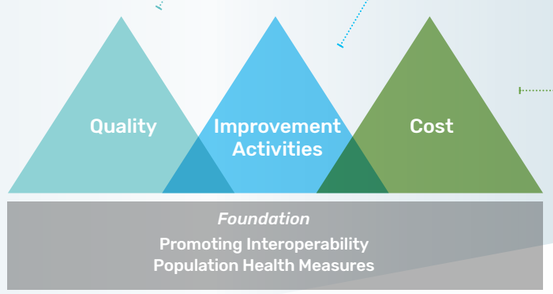
OR

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

COST MEASURES

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

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



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