Quality Payment Program Year 3

Final Rule Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment, and established a quality payment incentive program -- the Quality Payment Program. This program provides clinicians with two ways to participate: through Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

We continue striving to implement the program as Congress intended while focusing on simplification and burden reduction, drawing on the flexibilities included in the Bipartisan Budget Act of 2018, smoothing the transition where possible, and offering targeted educational resources for program participants. We've also never lost sight of supporting a pathway to participation in Advanced APMs, and Year 3 is a reflection of that effort.

Similar to the first two transition years, we will continue to support all clinician practices with a focus on those that are small, independent, and/or rural. And, most importantly, the beneficiaries are always at the heart of our policies. We will continue adopting policies that protect the safety of our beneficiaries and strengthen the quality of the health care they receive.

The Year 3 policies are reflective of the feedback we received from many stakeholders including overall burden reduction, improving patient outcomes and reducing burden through meaningful measures and expanding participation options to other clinicians, to name a few updates. We've also received feedback from stakeholders regarding the added value of the Quality Payment Program. To that point, we are using your feedback to (1) assess the current value of the program for clinicians and beneficiaries alike and (2) implement the program in a way that is understandable to beneficiaries, as they are the core of the Medicare program. We will continue offering our free, hands-on technical assistance to help individual clinicians and group practices participate in the Quality Payment Program.

This document provides a high-level overview of the final Year 3 policies.

Quality Payment Program Year 3: MIPS Highlights

The first two transition years of the MIPS were implemented gradually to reduce burden and provide flexible participation options, to allow clinicians to spend less time on regulatory requirements and more time with patients. As a result, in the first year of the program, we experienced a remarkably high participation rate. We've taken what we've learned in Year 1, which you'll see in the 2019 Final Rule, and used this data as part of our data modeling process that helps us to project future eligibility, rates of performance, payment adjustments, and more.

For Year 3, we are continuing to build on what is working, and we are using your feedback to improve program policies. In terms of quality measures, we will continue to identify low-value or low-priority process measures and focus on meaningful quality outcomes for patients and streamlined reporting for clinicians. Through seven awarded cooperative agreement partnerships, CMS will work closely with external organizations—such as clinical professional

organizations and specialty societies, patient advocacy groups, educational institutions, independent research institutions, and health systems—to develop and implement measures that offer the most promise for improving patient care. We believe that the Meaningful Measures Initiative and this MACRA grant funding opportunity to develop measures for the Quality Payment Program will improve our quality measures over time.

Some prominent Year 3 policies adopted in this final rule include expanding the definition of MIPS eligible clinicians to include new clinician types (physical therapists, occupational therapists, speech-language pathologists, audiologists, clinical psychologists, and registered dietitians or nutrition professionals), adding a third element to the low-volume threshold determination, and giving eligible clinicians who meet one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy). We are also adding new episode-based measures to the Cost performance category, restructuring the Promoting Interoperability (formerly Advancing Care Information) performance category, and creating an option to use facility-based Quality and Cost performance measures for certain facility-based clinicians.

Expanded Participation Options for Year 3

- New eligible clinician types:
  - Physical therapist
  - Occupational therapist
  - Qualified speech-language pathologist
  - Qualified audiologist
  - Clinical psychologist
  - Registered dietitian or nutrition professionals
- Clinicians or groups will be able to **opt-in to MIPS** if they meet or exceed at least one, but not all, of the low-volume threshold criteria.

We are continuing to reduce burden and offer flexibilities to help clinicians successfully participate by adopting the following policies:

- Overhauling the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record interoperability and patient access while aligning with the Medicare Promoting Interoperability Program requirements for hospitals.
- Moving clinicians to a single, smaller set of objectives and measures with scoring based on measure performance for the Promoting Interoperability performance category.
- Allowing the use of a combination of collection types for the Quality performance category.
- Retaining and increasing some bonus points
- For the Cost and Quality performance categories, providing the option to use facility-based scoring for facility-based clinicians, who are planning to participate in MIPS as individuals or as a group. Facility-based measurement does not require data submission, but to be recognized as a group for scoring purposes, a facility-based group would need to submit data for the Improvement Activities or the Promoting Interoperability performance categories. We expect to release a facility-based scoring preview in Q1 of 2019.

We're also committed to continue helping small practices in Year 3 by:

- Increasing the small practice bonus to 6 points, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus;

- Continuing to award small practices 3 points for submitted quality measures that don't meet the data completeness requirements;
- Allowing small practices to continue submitting quality data for covered professional services through the Medicare Part B claims submission type for the Quality performance category;
- Providing an application-based reweighting option for the Promoting Interoperability performance category for clinicians in small practices;
- Continuing to provide small practices with the option to participate in MIPS as a virtual group; and
- Offering our no-cost, customized support to small and rural practices through the Small, Underserved, and Rural Support (SURS) technical assistance initiative.

Lastly, you'll notice the use of new language that more accurately reflects how clinicians and vendors interact with MIPS (i.e. Collection types, Submitter types, etc.). We've solicited and listened to your feedback and are finalizing these new terms in order to implement the program in a way that is understandable to both participants and beneficiaries. We understand that this terminology is different than what was previously used and may cause some initial confusion. We've defined the terms here for you.

New MIPS Terms

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

Bipartisan Budget Act of 2018

Enacted on February 9, 2018, the Bipartisan Budget Act of 2018 provides us with flexibility to continue the gradual transition in MIPS for three more years. Although the Bipartisan Budget Act of 2018 was enacted after the publication of the Calendar Year (CY) 2018 Quality Payment Program final rule, we were able to implement adjustments to the low-volume threshold calculations for Year 2 of the program prior to the release of Year 3 rules. In the CY 2019 Physician Fee Schedule final rule, we will continue using this authority to help further reduce clinician burden.

Key Changes to MIPS in the Bipartisan Budget Act of 2018 include:

- Providing flexibility in the weighting of the Cost performance category in the final score for three additional years. For year 3, we are finalizing the Cost performance category at 15 points.
- Allowing flexibility in establishing the performance threshold for three additional years (program years 3, 4, and 5) to ensure a gradual and incremental transition to the estimated performance threshold for the sixth year of the program based on the mean or median of final scores from a prior period. For the 2019 performance period, we are finalizing a performance threshold of 30 points along with an additional performance threshold of 75 points for exceptional performance.

Quality Payment Program Year 3: APM Highlights

We are building on many of the changes we made for Year 2 of the program, and we are finalizing policies, including:

- Updating the Advanced APM Certified Electronic Health Record Technology (CEHRT) threshold so that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT, and for Other Payer Advanced APM, as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75%.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs and Other Payer Advanced APMs through performance year 2024.
- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.
    - Establishing a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement (or up to 5 years). We are finalizing this streamlined process to reduce the burden on payers and eligible clinicians.
    - Allowing QP determinations at the TIN level, in addition to the current options for determinations at the APM entity level and the individual level, in instances when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity. This will provide additional flexibility for eligible clinicians under the All-Payer Combination Option.
    - Moving forward with allowing all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period.
- Streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM criteria to reduce confusion and burden among payers and eligible clinicians submitting payment arrangement information to CMS.
- Clarifying the requirement for MIPS APMs to assess performance on quality measures and cost/utilization.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.

Overview of Final MIPS Policies for CY 2019		
Policy Area	**Year 2 (Final Rule CY 2018)**	**Year 3 (Final Rule CY 2019)**
MIPS Eligibility	**Eligible clinician types include:** • Physician • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • A group that includes such professionals (required by statute)	**Eligible clinician types include:** Same as year 2, with the following additions: • Physical therapist • Occupational therapist • Qualified speech-language pathologist • Qualified audiologist • Clinical psychologist • Registered dietitian or nutrition professionals
Low-Volume Threshold (LVT)	• To be excluded from MIPS, clinicians and groups must meet one of the following two criterion: 1. have ≤ $90K in Part B allowed charges for covered professional services **OR** 2. provide care to ≤ 200 Part B-enrolled beneficiaries	• The low-volume threshold now includes a third criterion for determining MIPS eligibility • To be excluded from MIPS, clinicians or groups need to meet one or more of the following three criterion: 1. Have ≤ $90K in Part B allowed charges for covered professional services; 2. Provide care to ≤ 200 Part B-enrolled beneficiaries; **OR** 3. Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)
Opt-in	• Not Applicable	• Starting in Year 3, clinicians or groups can opt-in to MIPS, if they meet or exceed at least one, but not all three, of the low-volume threshold criteria. • A virtual group election in Year 3 is considered a low-volume threshold opt-in for any prospective member of the virtual group (solo practitioner or group) that exceeds at least one, but not all, of the low-volume threshold criteria.

MIPS Determination Period	**Varied determination periods to evaluate clinicians and groups for the low-volume threshold and special statuses** **Two Determination Periods for the Low-Volume Threshold (LVT):** • First 12-month segment: Sept. 1, 2016 to Aug. 31, 2017 (including a 30-day claims run out) • Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out) **A single determination period for identifying small practices and hospital-based, ASC-based, or non-patient facing clinicians.** • Sept. 1, 2016 to Aug. 31, 2017	**Creation of a unified MIPS Determination Period:** • Created a streamlined and consistent "MIPS determination period" which will be used to evaluate clinicians and groups for: o The low-volume threshold o Non-patient facing status o Small practice status o Hospital-based and ASC-based statuses • The MIPS determination period includes two 12-month segments: o First 12-month segment: Oct. 1, 2017 to Sept. 30, 2018 (including a 30-day claims run out) o Second 12-month segment: Oct. 1, 2018 to Sept. 30, 2019 (does not include a 30-day claims run out). Note that these 12-month segments now align with the fiscal year and begin October 1st.
Virtual Groups	**In general, group policies apply to virtual groups, except:** • A virtual group will be considered a small practice if it contains 15 or fewer clinicians. • A virtual group will be designated as rural or HPSA practice if more that 75% of the NPIs billing under the virtual group's TINs are located in a ZIP code designated as a rural area or HPSA. • A virtual group will be considered non-patient facing if more than 75% of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual	**Virtual group policies remain the same as Year 2, with the following change:** • Beginning with 2019 the virtual group eligibility determination period aligns with the first segment of data analysis under the MIPS eligibility determination period. o For example: Oct. 1, 2017 to Sept. 30, 2018 (including a 30-day claims run out)

	MIPS eligible clinician during the non-patient facing determination period.	
	Virtual group election: • Must be made by December 31 of the calendar year preceding the applicable performance period, and cannot be changed during the performance period. • The election process can be broken into two stages: Stage 1 (which is optional) pertains to virtual group eligibility determinations, and stage 2 pertains to virtual group formation.	**Virtual Group election is the same as Year 2, with the following change:** • As part of the virtual group eligibility determination period, TINs can inquire about their TIN size prior to making an election during a 3-month timeframe, which begins on October 1 and end on December 31 of the calendar year prior to the applicable performance period. TIN size inquiries can be made through Quality Payment Program Technical Assistance organizations. These resources will continue to be available to stakeholders.
	To meet the **eligibility requirements**, each member of a virtual group must establish a formal written agreement prior to an election • A designated virtual group representative must e-mail a virtual group election to MIPS_VirtualGroups@cms.hhs.gov by December 31 of the calendar year prior to the start of the applicable performance period.	The requirement for virtual groups to have a formal written agreement between each member of a virtual group remains the same for Year 3 • For 2019, a designated virtual group representative must e-mail a virtual group election to MIPS_VirtualGroups@cms.hhs.gov by December 31 of the calendar year prior to the start of the applicable performance period.
MIPS Performance Period	**Minimum Performance Period for each Performance Category**: • Quality: 12-months • Cost: 12-months • Improvement Activities: continuous 90-days • Promoting Interoperability: continuous 90-days	**Minimum Performance Period for each Performance Category:** • Same performance periods as in Year 2

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

	The claims submission mechanism[1] is available for clinicians participating individually.	**Medicare Part B claims measures** can only be submitted by clinicians in a **small practice** (15 or fewer eligible clinicians), whether participating **individually or as a group**.
	For individual eligible clinicians, one submission mechanism[1] must be selected: • Claims • QCDR • Qualified registry • EHR	**Individuals can use multiple collection types[1]** In Year 3, individual eligible clinicians can submit measures via multiple collection types[1] (MIPS CQM, eCQM, QCDR measures, and for small practices, Medicare Part B claims measures). • If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring.
	Groups and Virtual Groups must use one submission mechanism: • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25+)	**Groups and Virtual Groups can use multiple collection types.** In Year 3, groups and virtual groups can submit measures via multiple collection types[1] (MIPS CQM, eCQM, QCDR measures, CMS Web Interface measures for large practices, and Medicare Part B

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

	• CMS-Approved Survey Vendor for CAHPS for MIPS	claims measures for small practices). • If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring **EXCEPTION:** CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures.
	Data Completeness Requirements: • Claims: 60% of Medicare Part B patients for the performance period. • QCDR/Registry/EHR: 60% of clinician's or group's patients across all payers for the performance period. • CMS Web Interface: Sampling requirements for Medicare Part B patients. • CAHPS for MIPS Survey: Sampling requirements for Medicare part B patients.	**Data Completeness Requirements:** • The same data completeness requirements as Year 2, with the following scoring change: • For groups that submit 5 or fewer quality measures and do not meet the CAHPS for MIPS sampling requirements, the quality denominator will be reduced by 10 and the measure will receive zero points.
	Topped-Out Measures: Definition: if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. QCDR measures will not go through the comment and rulemaking process to remove topped out measures. Polices include: • Finalized 4-year lifecycle for identification and removal of topped out measures.	**Topped-Out Measures:** • The definition and lifecycle for topped out measures remain the same for Year 3, although additional factors may affect the time a topped-out measure remains such as: • <u>Extremely Topped-Out Measures</u>**:** A measure attains extremely topped out status when the average mean performance is within the 98th to 100th percentile range. Such measures may be proposed for removal in the next rule-making cycle, and will not

	• Scoring cap of 7 points for topped out measures. • Policies to identify, remove and cap scoring for topped out measures do not apply to CMS Web Interface measures. • Policy does not apply to CAHPS for MIPS Summary Survey Measures (SSMs). • 6 measures identified for scoring cap for topped out measures.	follow the 4-year lifecycle for other topped-out measures. • QCDR measures are excluded from the topped-out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped-out during the self-nomination process, it will not be approved for the applicable performance period.
	Measures Impacted by Clinical Guideline Changes: • No requirements	**Measures Impacted by Clinical Guideline Changes:** • CMS will identify measures for which following the guidelines in the existing measure specification could result in patient harm or otherwise provide misleading results as to good quality care. • Clinicians who are following the revised clinical guidelines will still need to submit the impacted measure. The total available measure achievement points in the denominator will be reduced by 10 points and the numerator of the impacted measure will result in zero points.
	Bonus Points: High-Priority Measures (after first required measure) • 2 points for outcome, patient experience • 1 point for other high priority measures which need to meet the data completeness and case minimum requirements along with having a performance rate of greater than 0.	**Bonus Points: High-Priority Measures (after first required measure)** Same as Year 2, with the following change: • Discontinue high priority measure bonus points for CMS Web Interface Reporters. **We also revised the definition of a high priority measure to include opioid-related measures.** • A high priority measure is an outcome, appropriate use, patient safety, efficiency, patient

	• Capped bonus points at 10% of the denominator of total Quality performance category.	experience, care coordination, or opioid-related quality measure. • Outcome measures would include intermediate-outcome and patient-reported outcome measures.
	Bonus Points: End-to-End Electronic Reporting: • 1 point for each measure submitted using end-to-end electronic reporting. • Capped at 10% of the denominator of total Quality performance category points.	**Bonus Points: End-to-End Electronic Reporting:** • Same as Year 2
	Improvement Scoring- Full Participation: • Eligible clinicians must fully participate (i.e., submit all required measures and meet data completeness criteria and case minimums) for the performance year. • The quality improvement percent score is 0 if the eligible clinician did not fully participate in the quality category for the current performance period. • If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we will compare 2018 performance to an assumed 2017 Quality category score of 30%.	**Improvement Scoring – Full Participation:** • Same as Year 2
	Small Practice Bonus: • 5 bonus points are added to the final score for clinicians who are in a small practice and submit data on at least one performance category for the 2018 performance period.	**Small Practice Bonus:** • The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation • 6 bonus points are added to the numerator of the Quality

		performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.
Cost Performance Category	**Weight to final score:** • 10% in Year 2	**Weight to final score:** • 15% in Year 3
	Measures: • Two measures: Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB). • Derived from Medicare claims. • Reliability threshold of 0.4 established. • Case minimum of 20 for TPCC and 35 for MSPB.	**Measures:** • The TPCC and MSPB measures remain the same in Year 3. • We are adding 8 new episode-based measures to the Cost performance category. • Case minimum of 10 for procedural episodes and 20 for acute inpatient medical condition episodes.
	Measure Attribution: • Plurality of primary care services rendered by the clinician to determine attribution for the TPCC measure. • Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure.	**Measure Attribution:** Same as Year 2 with the following changes: • For procedural episodes, we will attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes). • For acute inpatient medical condition episodes, we will attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization.
	Scoring Improvement: • Improvement scoring was added to the Cost performance category scoring methodology with a maximum cost improvement score of 1%. • The Bipartisan Budget Act of 2018 delayed consideration of	**Scoring Improvement:** • Cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

	improvement in the Cost performance category until the 2024 payment year. As a result, there will be no improvement scoring in Year 2 of the program.	
	Calculating the Cost Score: • Cost Achievement Points/Available Points= Cost Performance Category Percent Score. • The percent score cannot exceed 100%. • The Bipartisan Budget Act of 2018 delayed consideration of improvement in cost performance category scoring until the 2024 MIPS payment year. • We will not calculate a Cost performance category score if the eligible clinician is not attributed any Cost measures, because of case minimum requirements or the lack of a benchmark	**Calculating the Cost Score:** • Same as Year 2
Facility-Based Quality and Cost Performance Categories	**Measurement**: • Not Applicable	**Measurement:** • For facility-based scoring, the measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians (FY 2020 for 2019 performance period).
	Applicability – Individual: • Not Applicable	**Applicability – Individual:** • MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23),

		based on claims for a period prior to the performance period. • Clinicians must have at least a single service billed with the POS code used for the inpatient hospital (21) or emergency room (23). • The clinician can be attributed to a facility with a Hospital VBP Program score for the applicable period.
	Applicability – Group: • Not Applicable	**Applicability – Group:** • A facility-based group is one in which 75% or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals.
	Attribution: • Not Applicable	**Attribution:** • A facility-based clinician is attributed to the hospital at which they provide services to the most Medicare patients. • A facility-based group is attributed to the hospital at which a plurality of its facility-based clinicians are attributed. • If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used. • If we are unable to identify a facility with a Hospital VBP Program score to attribute a clinician's performance, that clinician is not eligible for facility-based measurement and will have to participate in MIPS via other methods.
	Election: • Not Applicable	**Election:** • Facility-based measurement is automatically applied to MIPS

		eligible clinicians and groups who are eligible for facility-based measurement and who have a higher combined Quality and Cost score. • There are no data submission requirements for the Quality and Cost performance categories for individual clinicians and groups in facility-based measurement. • In order for facility-based measurement to be applied at the group level, the group must submit data for the Improvement Activities or Promoting Interoperability performance categories in order to be recognized at the group-level for scoring purposes.
	Benchmarks: • Not Applicable	**Benchmarks:** • Benchmarks for facility-based measurement are those that are adopted under the Hospital VBP program of the facility for the year specified.
	Assigning MIPS Category Scores: • Not Applicable	**Assigning MIPS Category Scores:** • Both the Quality performance category score and Cost performance category score for facility-based measurement are reached by determining the percentile performance of the facility determined in the Hospital VBP program for the specified year and awarding a score associated with that same percentile performance in the MIPS Quality and Cost performance category scores for those clinicians who are not scored using facility-based measurement.
	Scoring Improvement:	**Scoring Improvement:**

	• Not Applicable	• Given that improvement is already captured in Hospital VBP Program Total Performance Score that is the basis of the facility-based score for the MIPS Quality and Cost performance categories, there is no additional improvement scoring for facility-based measurement for either the Quality or Cost performance category.
	Scoring - Special Rules: • Not Applicable	**Scoring - Special Rules:** • Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital IQR Program, or other reasons. In these cases, we will be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians will be required to participate in MIPS via another method.
Improvement Activities Performance Category	**Weight to final score:** • 15% in Year 2	**Weight to final score**: • 15% in Year 3
	Improvement Activities Inventory: • The initial inventory was established based on research, an environmental scan and priorities. • In Year 2 the Annual Call for submitting Improvement Activities was established.	**Improvement Activities Inventory:** • For the CY 2019 performance period and future years. Modifications include the addition of one new criterion in this category, "Include a public health emergency as determined by the Secretary," and the removal of, "Activities that may be considered for a Promoting Interoperability bonus" ○ Adding 6 new Activities ○ Modifying 5 existing Activities ○ Removing 1 existing Activity

	Improvement Activities Inventory Submission Timeline: • Submissions are collected at any time during the performance period to create an Improvement Activities Under Review (IAUR) list. Submissions received by March 1st will be considered for inclusion in the following calendar year.	**Improvement Activities Inventory Submission Timeline:** • Improvement activities nominations received in a particular year will be vetted and considered for the next year's rulemaking cycle for possible implementation in a future year. For example, an improvement activity nomination submitted during the CY 2020 Annual Call for Activities would be vetted, and if accepted by CMS, would be proposed during the CY 2021 rulemaking cycle for possible implementation starting in CY 2022. • The submission timeframe/due dates for nominations is February 1st through June 30th, providing approximately 4 additional months to submit nominations.
	CMS Study on Burdens: • Study purpose, participation credit, requirements, and study procedures updated from Year 1.	**CMS Study on Burdens:** • The CMS study title will be changed to, "CMS Study on Factors Associated with Reporting Quality Measures" ○ The sample size will be increased to 200 MIPS eligible clinicians with a focus on group requirements for only a subset of study participants. ○ For the 2019 performance period and future years, we are finalizing that focus group participation will be a requirement only for a selected subset of the study participants, using purposive sampling and random sampling methods. Those selected would be required to participate in at least one

		focus group meeting and complete survey requirement, in addition to all the other study requirements. • We are also finalizing the policy that when participating in the study, at least one of the three required quality measures must be either an outcome or a high priority measure.
	Scoring: PI Bonus • Completing certain improvement activities using CEHRT will qualify for a bonus under the PI performance category.	**Scoring: PI Bonus** • In Year 3 we are discontinuing the bonus.
Promoting Interoperability (PI) Performance Category	**Weight to final score:** • 25% in Year 2 **Note:** Performance category name changed from Advancing Care Information to Promoting Interoperability.	**Weight to final score:** • 25% in Year 3

	Reweighting:
	• Reasons to reweight the Promoting Interoperability category to 0% include:
	  ○ Nurse practitioner, physician assistant, clinical nurse specialist, or certified registered nurse anesthetist.
	  ○ Significant hardship (e.g. lack of internet, extreme and uncontrollable circumstances, small practice).
	  ○ 50% or more of patient encounters occurred in practice locations where no control over the availability of CEHRT.
	  ○ Non-patient facing.
	  ○ Hospital-based[2].
	  ○ ASC-based[3].
	• Automatic reweighting for extreme and uncontrollable circumstances.
	• MIPS eligible clinicians using decertified EHR Technology, exception.
	• For any of the above reasons, if a MIPS eligible clinician reports Promoting Interoperability (formerly ACI) measures and objectives, they will be scored like other MIPS eligible clinicians and the Promoting Interoperability performance category will not be reweighted to 0%.
		Reweighting:
		• Reweighting of the Promoting Interoperability performance category remains the same as Year 2 and extends to additional MIPS eligible clinician types added for Year 3:
		  ○ Physical Therapists,
		  ○ Occupational Therapists,
		  ○ Speech-language Pathologists,
		  ○ Audiologists,
		  ○ Clinical psychologists, and
		  ○ Registered dietitians or nutrition professionals.

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

	Certification Requirements: • Eligible clinicians may use either the 2014 or 2015 Edition CEHRT or a combination of the two. • A one-time bonus of 10 percentage points is applied to those who exclusively use only 2015 Edition CEHRT.	**Certification Requirements**: • Eligible clinicians must use 2015 Edition CEHRT in Year 3.
	Scoring: • Performance category score is comprised of the base, performance, and bonus scores. • Clinicians must complete the base score requirements in order to receive any score in the category.	**Scoring:** • Eliminating base, performance, and bonus scores. • Finalizing a new scoring methodology. • Performance-based scoring at the individual measure-level. Each measure will be scored based on the MIPS eligible clinician's performance for that measure based on the submission of a numerator or denominator, or a "yes or no" submission, where applicable. • Finalizing Security Risk Analysis measure as a required measure without points. • The scores for each of the individual measures will be added together to calculate the score of up to 100 possible points. If exclusions are claimed, the points for measures will be reallocated to other measures.
	Objectives and Measures • Two measure set options for reporting based on the clinician's CEHRT edition (either 2014 or 2015).	**Objectives and Measures** • One 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. • Finalizing adding 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.
Final Score	**General Performance Category Weights in Year 2:** • Quality: 50% • Cost: 10% • PI: 25% • IA: 15% If a MIPS eligible clinician is scored on fewer than two performance categories, a final score equal to the performance threshold will be assigned and the MIPS eligible clinician will receive an adjustment of 0%.	**General Performance Category Weights in Year 3:** • Quality: 45% • Cost: 15% • PI: 25% • IA: 15% If a MIPS eligible clinician is scored on fewer than two performance categories, the final scoring policy is the same as Year 2.
	Complex Patient Bonus: • A bonus of up to 5 points will be added to the final score for clinicians who treat medically complex patients as well as those with social risk factors. The bonus consists of two indicators: 1. The average Hierarchical Condition Category (HCC) risk scores, and 2. The proportion of patients with dual eligible status • The HCC risk scores are based on data from the calendar year preceding the performance period.	**Complex Patient Bonus:** • Retaining the 5-point bonus added to the MIPS Final Score for clinicians who treat medically complex patients. • Beginning with Year 3, the 2021 MIPS payment year, the second 12-month segment of the MIPS determination period (October 1, 2018 - September 30, 2019) would be used when calculating average HCC risk scores and the proportion of full benefit or partial benefit dual eligible beneficiaries for MIPS eligible clinicians.

MIPS Payment Adjustments	**Application of Payment Adjustment to Medicare Paid Amount:** • For each MIPS payment year, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor for exceptional performance, are applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician during the year. • The Balanced Budget Act of 2018 changed this so that the MIPS adjustment factors will apply to payments for "covered professional services" furnished by the MIPS eligible clinician, beginning with Year 1 (the 2019 MIPS payment year). • Finalized application of the payment adjustment to the Medicare paid amount.	**Application of Payment Adjustment to Medicare Paid Amount:** • Same as Year 2, MIPS adjustment factors will apply to payments for "covered professional services" furnished by the MIPS eligible clinician.
	Final Score/2020 payment adjustment: • For individual eligible clinicians, we will use the final score associated with the TIN/NPI used during the performance period. • For groups submitting data using the TIN identifier, we will apply the group final score to all the TIN/NPI combinations that bill under the TIN during the performance period. • For eligible clinicians in a MIPS APM, we will assign the APM Entity group's final score to all APM Entity Participant NPIs associated with the APM Entity	**Final Score/2021 payment adjustment:** • Remains the same as Year 2, with one change. MIPS eligible clinicians in a group practice who qualify for a group final score will have a modified determination period to include: ○ The 15-month window that starts with the second 12-month determination period (October 1 prior to the MIPS performance period through September of the current MIPS performance period) • Finalizing a policy to assign a weight of 0% to each of the four performance categories and a

	• For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, we will determine a final score using either the individual or group data submissions. • If a MIPS eligible clinician is not in an APM Entity and is in a virtual group, the MIPS eligible clinician will receive the virtual group final score over any other final score.	final score equal to the performance threshold when: ○ A MIPS eligible clinician joins an existing practice (existing TIN) in the final three months of the performance period year and the practice is not participating in MIPS as a group ○ A MIPS eligible clinician joins a practice that is a newly formed TIN in the final three months of the performance period year
Performance Threshold / Payment Adjustment	• Performance Threshold is set at 15 points. • Additional performance threshold set at 70 points for exceptional performance. • MIPS eligible clinicians receive a payment adjustment and, if applicable, an additional payment adjustment, determined by comparing final score to the performance threshold and the additional performance threshold. • A final score at or above the performance threshold receives a neutral or positive payment adjustment and a final score below the performance threshold receives a negative adjustment. • As required by statute, the maximum negative payment adjustment is -5%. • Positive payment adjustments generally can be up to 5% (but they are multiplied by a scaling factor to achieve budget neutrality, which could result in	• 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%. • A positive payment adjustment generally can be up to 7% (but they the upward payment adjustment factor is multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 7%). • The additional payment adjustment for exceptional performance will be applied in the same way as in year 2 for final scores at or above the additional performance threshold.

	an adjustment above or below 5%). • The additional payment adjustments for exceptional performance start at 0.5% and go up to 10% x scaling factor not to exceed 1.	
Public Reporting via Physician Compare		
Policy Area	**Year 2 (Final Rule CY 2018)**	**Year 3 (Final Rule CY 2019)**
Public Reporting on Physician Compare	• All measures under the MIPS Quality performance category are available for public reporting if they meet the public reporting standards and resonate to users in testing. • Codified that no first year quality measures are available for public reporting.	Remains the same in Year 3 with the following change: • First year quality measures will not be publicly reported for the first 2 years in use in the Quality performance category, starting with performance Year 2.
	Public Reporting of Cost Measures: • A subset of Cost measures is available for public reporting.	**Public Reporting of Cost Measures:** • Remains the same in Year 3 except that first year Cost measures will not be publicly reported for the first 2 years a measure is in use in the Cost performance category.
	Indicator for Promoting Interoperability: • Include an indicator on Physician Compare for any eligible clinician or group with "successful" performance under the Promoting Interoperability performance category. • Include additional information, such as objectives, activities, or measures. • Make first year objectives, activities, and measures available for public reporting, as appropriate.	**Indicator for Promoting Interoperability:** Remains the same in Year 3 with the following change: • Include an indicator on Physician Compare for any eligible clinician or group with "successful" performance under the Promoting Interoperability performance category. • A high performing indicator under the Promoting Interoperability performance category will not be publicly reported on Physician Compare.

	Benchmark Methodology: • Use the Achievable Benchmark of Care (ABC™) methodology to determine a benchmark for the Quality, Cost, Improvement Activities, and Promoting Interoperability data, as feasible and appropriate, by measure and by collection type. • Use this benchmark as the basis of a 5-star rating for each available measure, as feasible and appropriate.	**Benchmark Methodology:** Remains the same in Year 3 with the following changes: • Use the ABC™ methodology to determine benchmarks based on historical data by measure and collection type. • Extend use of the ABC™ methodology and equal ranges method to determine, by measure and collection type, a benchmark and 5-star rating for Qualified Clinician Data Registry (QCDR) measures using the current performance period data in Year 2 of the Quality Payment Program, and use historical benchmark data when possible, beginning with Year 3.
APM Policies		
Policy Area	**Year 2 (Final Rule CY 2018)**	**Year 3 (Final Rule CY 2019)**
APMs: Advanced APMs Minimum CEHRT Use Threshold	• In general, to qualify as an Advanced APM, a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM entity use CEHRT.	• We are increasing the CEHRT use threshold for Advanced APMs so that an Advanced APM must require at least 75% of eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals.
APMs: MIPS Comparable Measures	• Quality measures upon which an Advanced APM bases payment must be reliable, evidence-based, and valid. • A determination as to whether a measure is reliable, evidence-based, and valid is made based on several criteria, whether the measure is: 1. On the MIPS final list, 2. Endorsed by a consensus-based entity (NQF),	• We are amending the Advanced APM quality criteria to state that at least one of the quality measures upon which an Advanced APM bases payment must be: 1. On the MIPS final list, 2. Endorsed by a consensus-based entity, or 3. Otherwise determined by CMS to be evidence-based, reliable, and valid. This

	3. Submitted in the annual call for quality measures, 4. Developed using QPP Measure Development funds, or 5. Otherwise determined by CMS to be reliable, evidence-based, and valid	provision applies beginning in 2020
APMs: Outcome Measures	• The quality measures upon which an Advanced APM bases payment must include at least one outcome measure unless CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APM's QP Performance Period.	• We are amending the Advanced APM quality criterion to require that the outcome measure used must be evidence-based, reliable and valid. The outcome measure used in an Advance APM must be: 1. On the MIPS final list, 2. Endorsed by a consensus-based entity, or 3. Otherwise determined by CMS to be evidence-based, reliable, and valid. This provision applies beginning in 2020
APMs: Revenue-Based Nominal Amount Standard	• For performance years 2019 and 2020, we maintained the revenue-based nominal amount standard at 8% of the average estimated Parts A and B revenue of providers in participating APM Entities.	• We are maintaining the revenue-based nominal amount standard for Advanced APMs at 8% through performance year 2024.
APMs: Payer-Initiated Process for Remaining Other Payers	• We established a process to allow select payers – including Medicaid, Medicare Advantage plans, and participants in multi-payer CMMI models – to submit payment arrangements for consideration as Other Payer Advanced APMs, starting in 2018 (for the 2019 All-Payer QP Performance Period). • Finalized our intent to allow remaining other payers (i.e.,	• We are implementing the previously finalized policy without modification, and allowing all payer types to be included in the 2019 Payer Initiated Process for the 2020 QP Performance Period.

	those not incorporated in the process for 2019), including commercial and other private payers, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 (for the 2020 All-Payer QP Performance Period) and annually each year thereafter.	
APMs: Addition of TIN Level All-Payer QP Determinations	• All-Payer QP determinations are conducted at the individual eligible clinician level.	• Beginning in 2019, we will allow for QP determinations under the All-Payer Option to be requested at the TIN level, in addition to the APM Entity and individual eligible clinician levels, when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity.
APMs: Multi-Year Other Payer Advanced APM Determinations	• Payers and eligible clinicians with payment arrangements determined to be Other Payer Advanced APM must re-submit all information for CMS review and redetermination on an annual basis.	• We are maintaining annual submissions but streamlining the process for multi-year arrangements such that, at the time of the initial submission, the payer and/or eligible clinician will provide information on the length of the agreement, and attest at the outset that they will submit information about any material changes to the payment arrangement during its duration. • In subsequent years, if there were no changes to the payment arrangement, the payer and/or eligible clinician do not have to annually attest that there were no changes to the payment arrangement.
APMs: Other Payer Advanced APM Revenue-	• We established a revenue-based nominal amount standard for Other Payer Advanced APMs parallel to the revenue-based nominal	• We are maintaining the revenue-based nominal amount standard for Other Payer Advanced APMs at 8% through performance year 2024

Based Nominal Amount Standard	amount standard for Advanced APMs. • An other payer arrangement will meet the revenue-based nominal amount standard for performance years 2019 and 2020 if risk is: ○ At least 8% of the total combined revenues from the payer of providers and suppliers in participating APM Entities	
APMs: Other Payer Advanced APMs Minimum CEHRT Use Threshold	• In general, to qualify as an Other Payer Advanced APM, a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM entity use CEHRT.	• We are increasing the CEHRT use criterion threshold for Other Payer Advanced APMs so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, CEHRT must be used by 75% of eligible clinicians participating in the payment arrangement to document and communicate clinical care, whether or not CEHRT use is explicitly required under the terms of the payment arrangement.
APMs: Use of CEHRT criterion for Other Payer Advanced APMs	• We will presume that another payer arrangement satisfies the 50% CEHRT use criterion if we receive information and documentation from the eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinician information.	• We are modifying the CEHRT use criterion for Other Payer Advanced APMs to allow either payers or eligible clinicians to submit evidence demonstrating that CEHRT is actually used at the required threshold level to be an Other Payer Advanced APM.
APMs: Revising the MIPS APM criteria	• Currently, one of the MIPS APM criteria is that an APM "bases payment on cost/utilization and quality	• We are reordering the wording of this criterion to state that the APM "bases payment on quality measures and cost/utilization."

	measures." We did not intend to limit an APM's ability to meet the cost/utilization part of this criterion solely by having a cost/utilization measure.	This clarifies that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure.

Continuing the Dialogue

Continuing our user-centered approach, CMS wants to hear from the health care community on the final rule and the implications for clinicians in Year 3, as well as on our message and education delivery. To give feedback or host a listening session, please contact us at QPP@cms.hhs.gov.

Contact Us

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

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