# 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

- o Requiring QCDRs (beginning with the 2020 performance period) to work together to harmonize their similar QCDR measures
- o 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** | <ul><li>Quality: 45%</li><li>Cost: 15%</li><li>Promoting Interoperability: 25%</li><li>Improvement Activities: 15%</li></ul> | <u>No change:</u><ul><li>Quality: 45%</li><li>Cost: 15%</li><li>Promoting Interoperability: 25%</li><li>Improvement Activities: 15%</li></ul> |
| **Quality Performance Category** | **Data Completeness Requirements:**<ul><li><u>Medicare Part B Claims measures</u>: 60% of Medicare Part B patients for the performance period</li><li><u>QCDR measures, MIPS CQMs, and eCQMs</u>: 60% of clinician's or group's patients across all payers for the performance period</li></ul> | **Data Completeness Requirements:**[1]<ul><li><u>Medicare Part B Claims measures</u>: **70%** sample of Medicare Part B patients for the performance period</li><li><u>QCDR measures, MIPS CQMs, and eCQMs</u>: **70%** sample of clinician's or group's patients across all payers for the performance period</li></ul><u>Note</u>: 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:**<br>CMS seeks measures that are:<ul><li>Applicable</li><li>Feasible</li></ul> | **Call for Measures:**<br>In addition to current requirements:<ul><li>Measures submitted in response to Call for Measures are required to demonstrate a link to existing and related cost</li></ul> |

[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<br>• Valid at the individual clinician level<br>• Different from existing measures<br><br>For complete information on current policy, review the 2019 Call for Measures and Activities. | measures and improvement activities as appropriate and feasible. |
| | **Measure Removal:**<br>• A quality measure may be considered for removal if the measure is no longer meaningful, such as measures that are topped out.<br>• A measure would be considered for removal if a measure steward is no longer able to maintain the quality measure. | **Measure Removal:**<br>In addition to current measure removal criteria:<br>• MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking for 2 consecutive years may be removed.<br>• 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:**<br>No special benchmarking policy. The general benchmarking policy for quality measures applies, where:<br>• Performance on quality measures is broken down into 10 "deciles."<br>• 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:**<br>• 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.<br>• 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:<br>   o **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.<br>• 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. |     o **MIPS #236 (NQF 0018):** Controlling High Blood Pressure<br>*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*:<br>• QCDRs and Qualified Registries are required to provide services for the entire performance period and applicable submission period.<br>• 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.<br>• QCDRs and Qualified Registries are required to submit data for each category:<br>    o Quality;<br>    o Improvement Activities; and<br>    o Promoting Interoperability performance categories.<br>• Health IT vendors are required to submit data for at least one category.<br><br>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:**<br>• 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:**<br>*Beginning with the 2021 performance period*:<br>• 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).<br>• 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.<br>• 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:**<br>• QCDR measures must be beyond the measure concept phase of development.<br>• CMS will show a preference for QCDR measures that are outcome-based rather than clinical process measures. | **QCDR Measure Requirements:**<br>*Beginning with the 2020 performance period:*<br>• 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.<br>• 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.<br><br>*Beginning with the 2021 performance period*:<br>• 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.<br>• 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**.<br>• 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.<br>• 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.<br>• 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.<br>• At CMS discretion, QCDR measures may be approved for two years, contingent on additional factors.<br>• 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:**<br>• 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:**<br>CMS has finalized the following guidelines to help QCDRs understand when a QCDR measure would likely be rejected during the annual self-nomination process:<br>• QCDR measures that are duplicative of an existing measure or one that has been removed from MIPS or legacy programs, which have been retired<br>• Existing QCDR measures that are "topped out" (though these may be resubmitted in future years)<br>• 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<br>• QCDR measures that split a single clinical practice/action into several measures or that focus on rare events<br>• Whether the previously identified areas of duplication have been addressed as requested<br>• QCDR measures that are "check-box" with no actionable quality action<br>• QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years<br>• QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years<br>• 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<br>• 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)<br>• 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:**<br>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:**<br>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.<br>(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:**<br>To be eligible for Patient-Centered Medical Home designation, the practice must meet one of the following criteria:<br>• The practice has received accreditation from one of four accreditation organizations that are nationally recognized:<br>    ○ The Accreditation Association for Ambulatory Healthcare;<br>    ○ The National Committee for Quality Assurance (NCQA);<br>    ○ The Joint Commission; or<br>    ○ The Utilization Review Accreditation Commission (URAC); OR<br>• The practice is participating in a Medicaid Medical Home Model or Medical Home Model; OR<br>• The practice is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition. | **Patient-Centered Medical Home Criteria:**<br>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:<br>To be eligible for Patient-Centered Medical Home designation, the practice must meet one of the following criteria:<br>• The practice has received accreditation from an accreditation organization that is nationally recognized (such as the four organizations specified for PY 2019);<br>• The practice is participating in a Medicaid Medical Home Model or Medical Home Model;<br>• The practice is a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; OR<br>• 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:<br>(1) Have a personal physician/clinician in a team-based practice<br>(2) Have a whole-person orientation<br>(3) Provide coordination or integrated care<br>(4) Focus on quality and safety<br>(5) Provide enhanced access |
| | **Improvement Activities Inventory:**<br>• Added 1 new criterion, "Include a public health emergency as determined by the Secretary."<br>• Removed "Activities that may be considered for a Promoting Interoperability bonus." | **Improvement Activities Inventory:**<br>• Addition of 2 new Improvement Activities.<br>• Modification of 7 existing Improvement Activities.<br>• Removal of 15 existing Improvement Activities. |
| | **CMS Study on Factors Associated with Reporting Quality Measures:**<br>• 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:**<br>• 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:**<br>• 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:**<br>An activity will be considered for removal if:<br>• 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<br>• The activity does not align with current clinical guidelines or practice<br>• The activity does not align with at least one meaningful measures area<br>• The activity does not align with Quality, Cost, or Promoting Interoperability performance categories<br>• There have been no attestations of the activity for 3 consecutive years<br>• The activity is obsolete |
| | **Requirement for Improvement Activity Credit for Groups:**<br>• 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:**<br>• 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.<br><br>No change to definition of an individual hospital-based MIPS eligible clinician. |
| **Promoting Interoperability Performance Category** | **Objectives and Measures:**<br>• One set of objectives and measures based on the 2015 Edition CEHRT<br>• Four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange<br>• Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed.<br>• 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:**<br>*Beginning with the 2019 performance period:*<br>• The optional Query of **PDMP measure** will require a **yes/no response** instead of a numerator/denominator.<br>• 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.<br><br>*Beginning with the 2020 performance period:*<br>• We will remove the Verify Opioid Treatment Agreement Measure.<br>• We will include the Query of PDMP measure as optional with a yes/no response. |
| **Cost Performance Category** | **Measures:**<br>• Total Per Capita Cost (TPCC)<br>• Medicare Spending Per Beneficiary (MSPB)<br>• 8 episode-based measures<br>**Case Minimums:**<br>• 10 for procedural episodes<br>• 20 for acute inpatient medical condition episodes | **Measures:**<br>• TPCC measure (**Revised**)<br>• MSPB-C (MSPB Clinician) measure (**Name and specification Revised**)<br>• 8 existing episode-based measures<br>• **10 new episode-based measures:**<br>  1. Acute Kidney Injury Requiring New Inpatient Dialysis<br>  2. Elective Primary Hip Arthroplasty<br>  3. Femoral or Inguinal Hernia Repair |

| Policy Area | CY 2019 Policy | CY 2020 Policy |
|---|---|---|
| | | 4. Hemodialysis Access Creation<br>5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation<br>6. Lower Gastrointestinal Hemorrhage (applies to groups only)<br>7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels<br>8. Lumpectomy Partial Mastectomy, Simple Mastectomy<br>9. Non-Emergent Coronary Artery Bypass Graft (CABG)<br>10. Renal or Ureteral Stone Surgical Treatment<br><br>No changes to case minimums |
| | **Measure Attribution:**<br>• All measures are attributed at the TIN/NPI level for both individuals and groups.<br>• Plurality of primary care services rendered by the clinician to determine attribution for the total per capita cost measure.<br>• Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure.<br>• For procedural episodes, we attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes).<br>• For acute inpatient medical condition episodes, we attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management | **Measure Attribution:**<br>• Measure attribution will be **different for individuals and groups** and will be defined in the applicable measure specifications.<br>• 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.<br>• 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).<br>• MSPB Clinician attribution will have a different methodology for surgical and medical episodes.<br>• 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.<br>• 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).<br>• 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**.<br>• Additional performance threshold set at 75 points for exceptional performance.<br>• As required by statute, the maximum negative payment adjustment is -7%.<br>• 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):_<br>• Performance Threshold is set at **45 points**.<br>• Additional performance threshold is set at **85 points** for exceptional performance.<br>• As required by statute, the maximum negative payment adjustment is **-9%**.<br>• 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%.<br><br>_For the 2021 performance period:_<br>• Performance Threshold is set at **60 points**.<br>• 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:_<br>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: <br>• 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; <br>• Empanelment of each patient to a primary clinician; and <br>• 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). <br><br> • 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:** <br> 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:** <br> 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. <br><br> 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**<br>• Low-Volume Threshold (LVT)<br>• Eligible Clinician Types<br>• Opt-in Policy<br>• MIPS Determination Period | No change |
| **Data Collection and Submission**<br>• MIPS Performance Period<br>• Collection Types<br>• Submitter Types<br>• Submission Types<br>• CEHRT Requirements | No change |
| **Quality Measures**<br>• Topped-Out Measures<br>• Measures Impacted by Clinical Guideline Changes | No change |
| **MIPS Scoring**<br>• Measure, Activity and Performance Category Scoring Methodologies<br>• 3 Point Floor for Scored Measures<br>• Improvement Scoring<br>• Bonus Points:<br>    ○ Small Practice Bonus | No change |

| | |
|---|---|
|       o  High-Priority Measures<br>      o  End-to-End Electronic Reporting | |
| **Facility-Based Clinicians**<br>• Definition and Determination<br>• Scoring Methodology and Policies | No change |

## Version History Table

| Date | Change Description |
|---|---|
| 11/1/2019 | • Original posting |