

Medicare Physician Fee Schedule (PFS) Proposed Rule 2019

(As on July 23, 2018; Note: This document may be updated)

Executive Summary

Physician Fee Schedule

- The 2019 Medicare Physician Payment Schedule Conversion Factor is \$36.0463.
- Updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense (PE) inputs to be phased in over a 4-year period.
- Global Surgery Data collection suggests 010-day global period are over-valued.
- Expand access to medical care using telecommunications technology by proposing to cover many new services and start paying for virtual check-in, patient transmitted image review and inter-professional communication.
- TKA and THA are potentially mis-valued.
- Relativity adjuster for hospital outpatient departments remain at 40% of OPPS rates.
- Physicians will be allowed to choose method of E/M documentation, among the following options: (1) 1995 or 1997 Guidelines for history, physical exam and medical decision making (current framework for documentation); (2) Medical decision making only; (3) Physician time spent face-to-face with patients.
- Decreased burden: require documentation to support the medical necessity of the visit and to support a level 2 CPT visit code. Single payment rate for office-based E/M visits level 2-5 (\$135 for new patients and \$93 for established patients).
- Reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit.
- Eliminate the requirement to document medical necessity of furnishing visits in the home rather than office. The proposal also eliminates the prohibition on same-day Evaluation and Management (E/M) visits billed by physicians in the same group or medical specialty.
- RUC and HCPAC recommendations accepted at 71% and 81%, respectively.
- Reduce the new drug add-on to 3 percent (which would then be subject to the sequester cut) for certain Wholesale Acquisition Cost (WAC)-based new drug payments for a period of three months.

Quality Payment Program

- CMS is adding a third criterion to the low-volume threshold determination: providing 200 or fewer covered professional services furnished to Part B-enrolled individuals by the clinician.
- The performance threshold will be raised from 15 to 30; and the additional performance threshold for exceptional performance will be raised to 80.
- Final Score Weights: Cost will be raised to 15, while Quality will be reduced to 45, in line with expectations as the program shifts toward a more even distribution of the category weights.
- Providers will now be able choose the new facility-based scoring option for the cost and quality categories under MIPS. To qualify, a provider must perform 75% of their services in an inpatient hospital, on-campus outpatient hospital, or emergency room setting.

Detailed Summary

Evaluation and Management coding change proposals

- CMS has proposed to collapse payment for office and outpatient visits.
 - **Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).**

Table 21 (on page 31) estimates the overall impact of establishing single payment rates for level 2-5 office visits, without any of the additional coding or proposed payment adjustments. You'll notice the following:

 - +12% for Podiatry
 - +4% for Orthopaedic Surgery
 - Minimal change for Pain Management
 - Minimal change for Physical Medicine
 - -7% for Rheumatology

Factoring in the additional adjustments (e.g. HCPCS G-code add-ons, modifier -25, etc.) in Table 22 (page 33) these change to:

 - -4% for Podiatry (down from +12% above)
 - Minimal change for Orthopaedic Surgery (down from +4% above)

- 3% or less increase for Pain Management (up from “minimal change” above)
- Minimal change for Physical Medicine (same as above)
- -3% for Rheumatology (up from -7% above)

When factoring in all services (Table 94, page 36) there is a +3% increase for Pain Management; +1% for Orthopaedic Surgery; -1% for Physical Medicine and Physical/Occupational Therapy, -2% for Podiatry, and -4% for Rheumatology.

- Proposing a minimum documentation standard where, for Medicare PFS payment purposes, practitioners would only need to document the information to support a level 2 E/M visit.
 - New patient office visit (99202-99205) payments would be blended to be \$135 (compared to the current \$110 and \$167, for levels 3 and 4, respectively). Established office visits (99212-99215) would be blended to be paid at \$93 (compared to the current \$74 and \$109, for levels 3 and 4, respectively).
 - New codes would be created to provide add-on payments to office visits for specific specialties (\$9) and primary care physicians (\$5).
- To replace existing documentation guidelines, CMS proposes to allow use of (1) 1995 or 1997 documentation guidelines; (2) medical decision-making or (3) time. Documentation for history and exam will focus on interval history since last visit. Physicians will be allowed to review and verify certain information in the medical record entered by ancillary staff or the beneficiary, rather than re-entering the information. **CMS is seeking comments on how documentation guidelines for medical decision making might be changed in subsequent years.**
 - The proposal includes the creation of HCPCS G-code add-ons to account for increased resource utilization (and therefore, reimbursement) for primary care services and select specialty services, including rheumatology and interventional pain management – **but not orthopaedic surgery.**
 - When physicians report an E/M service and a procedure on the same date, CMS proposes to implement a 50% multiple procedure reduction to the lower paid of the two services (currently identified on the claim by an appended modifier -25).

- Proposes an add-on payment for a 30-minute prolonged face-to-face E/M visit as well as a technical modification to the practice expense methodology.
- Proposes to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit, and solicits public comment on potentially eliminating a policy that prevents payment for same-day E/M visits by multiple practitioners in the same specialty within a group practice.
- For E/M visits furnished by teaching physicians, CMS proposes to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.
- CMS is soliciting public comment on the implementation timeframe of these proposals, as well as how we might update E/M visit coding and documentation in other care settings in future years. CMS believes these proposals would allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.

Remote Monitoring and inter-professional consultations

- CMS will implement new CPT codes and payment for remote monitoring and interprofessional consultations.
 - Pay clinicians for virtual check-ins: brief, non-face-to-face assessments via communication technology: Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code GRAS1);
 - Pay for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit. These services would be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous 7 days or within the next 24 hours or at the soonest available appointment. RHCs and FQHCs would be able to bill a newly created

RHC/FQHC Virtual Communications G-code, with payment set at the average of the PFS national non-facility payment rates for communication technology-based services and remote evaluation services.;

- Pay clinicians for evaluation of patient-submitted photos or recorded video;
- Expand Medicare-covered telehealth services to include prolonged preventive services: For CY 2019, CMS is proposing to add the following codes to the list of telehealth services: HCPCS codes G0513 and G0514 (Prolonged preventive service(s));
- Pay separately for new coding describing Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1, and 994X9) and Inter-professional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449)
- CMS updated supplies and equipment pricing. The re-pricing of antigens has a significant impact on allergy and immunology payments, with an estimated 6% reduction for the specialty.

Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

- CMS is seeking comment on creating a bundled episode of care for management and counseling treatment for substance use disorders.
- Seeking comment for regulatory and sub-regulatory changes to help prevent opioid use disorder and improve access to treatment under the Medicare program.
- Seeking comment on methods for identifying non-opioid alternatives for pain treatment and management, along with identifying barriers that may inhibit access to these non-opioid alternatives including barriers related to payment or coverage.

Providing Practice Flexibility for Radiologist Assistants

CMS is proposing to revise the physician supervision requirements so that any diagnostic test performed by a Radiologist Assistant (RA) may be furnished under, at most, a direct level of physician supervision, when performed by an RA in accordance with state law and state scope of practice rules.

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

Since January 1, 2013 (per the Middle Class Tax Relief and Jobs Creation Act of 2012) all providers of outpatient therapy services have been required to include functional status information on claims for therapy services. The Bipartisan Budget Act of 2018 repealed the

therapy caps, while imposing protections to ensure therapy services are furnished when appropriate. As a result, we are proposing to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

Outpatient PT and OT Services Furnished by Therapy Assistants

The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022. To implement this payment reduction, CMS will establish a new modifier by January 1, 2019 and has included details on this.

CMS proposes two new therapy modifiers – one for PT Assistants (PTA) and another for OT Assistant (OTA) – when services are furnished in whole or in part by a PTA or OTA. These are to be used in conjunction with the three existing therapy modifiers that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

Conversion Factor

- The proposed 2019 PFS conversion factor is \$36.05, a slight increase above the 2018 PFS conversion factor of \$35.99. This considers the budget neutrality adjustment to account for relative value changes.
- The combined impact of Work, Practice Expense (PE) and malpractice (MP) Relative Value Unit (RVU) changes for orthopaedics is 1%.

Practice Expense (PE)¹: Market-Based Supply and Equipment Pricing Update

CMS proposes to update the PFS direct PE inputs for supply and equipment pricing for CY 2019. These supply and equipment prices were last systematically developed in 2004-2005. CMS is

¹ Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding Malpractice (MP) expenses. The PE RVUs are developed for each physicians' service by considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses.

proposing to phase in the new direct PE input pricing over a 4-year period beginning in 2019 leading to CY 2022 to ensure a smooth transition.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System (OPPS) and are instead paid under applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services. The PFS relativity adjuster in CY 2018 is 40 percent, meaning that non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. **For CY 2019, CMS is proposing to maintain the current PFS relativity adjuster at 40 percent.** CMS believes that this PFS Relativity Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

Global Surgery Data Collection

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on postoperative visits and use these data to assess the accuracy of global surgical package valuation. Beginning July 1, 2017, CMS required groups with 10 or more practitioners in nine states to use the no-pay CPT code 99024 to report postoperative visits for specified procedures. However, only 45 percent of clinicians participated — this varied substantially by specialty. Among procedures performed by “robust reporters” of 99024, only 16 percent of 010-day global services and 87 percent of 090-day global services had one or more matched visits reported (volume-weighted). CMS is soliciting comments pertaining to increased compliance and also whether visits are typically being performed in the 010-day global period. Also, they are soliciting comment on whether they should mandate the usage of modifiers -54 “for surgical care only” and -55 “post-operative management only”, regardless of whether the transfer of care is formalized.

Medicare beneficiaries with End-stage Renal Disease (ESRD) and Stroke

To implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services effective January 1, 2019, CMS proposes to add renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home

dialysis monthly ESRD-related clinical assessments. Further, CMS proposes to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Clinical Laboratory Fee Schedule

The Clinical Laboratory Fee Schedule (CLFS) final rule entitled “Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System” implemented Section 1834A of the Social Security Act (the Act), which required extensive revisions to the Medicare payment, coding, and coverage for Clinical Diagnostic Laboratory Tests (CDLTs) paid under the CLFS. Beginning January 1, 2018, the payment amount for a test on the CLFS is generally equal to the weighted median of private payer rates determined for the test, based on the data of “applicable laboratories” that is collected during a specified data collection period and reported to CMS during a specified data reporting period.

To lessen burdens, CMS proposes a change to the way Medicare Advantage payments are treated in their definition of “applicable laboratory”, whereby additional laboratories of all types serving a significant population of beneficiaries enrolled in Medicare Part C could meet the majority of Medicare revenues threshold and potentially qualify as an applicable laboratory and report data to CMS.

In addition, CMS is seeking public comments on alternative approaches for defining an applicable laboratory, for example, using the Form CMS 1450 14x bill type or CLIA certificate number to define an applicable laboratory.

CMS is seeking public comments on potential changes to the low expenditure threshold component of the definition of an applicable laboratory, they are particularly interested in receiving comments from the physician community.

Ambulance Fee Schedule (AFS) Payments

The Bipartisan Budget Act of 2018 extended the temporary add-on payments for ground ambulance services for 5 years. The 3 temporary add-on payments include: (1) a 3 percent increase to the base and mileage rate for ground ambulance transports that originate in rural areas; (2) a 2 percent increase to the base and mileage rate for ground ambulance transports that originate in urban areas; and (3) a 22.6 percent increase in the base rate for ground ambulance transports that originate in super rural areas. These provisions were set to expire on December 31, 2017, but have been extended through December 31, 2022. The Bipartisan

Budget Act also increased the reduction from 10 percent to 23 percent in payments for non-emergency basic life support transports of beneficiaries with end-stage renal disease for renal dialysis services. This provision is effective with services on or after October 1, 2018.

WAC-Based Payment² for Part B Drugs: Proposal to Alter Add-on Amount

CMS is proposing that, effective January 1, 2019, WAC-based payments for new Part B drugs during the period first quarter of sales when ASP is unavailable, the drug payment add-on would be 3 percent in place of the 6 percent add-on that is currently being used. If this proposal is finalized, CMS will also update Manual provisions in order to permit Medicare Administrative Contractors to use an add-on percentage of up to 3 percent, rather than 6 percent, when utilizing WAC for pricing new drugs.

Aligning the Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organization (ACO) with the Meaningful Measures Initiative

CMS is proposing to reduce the total number of measures in the Shared Savings Program quality measure set from 31 to 24 and focus the measure set on more outcome based measures including patient experience of care. This is aligning the proposed changes to Merit-based Incentive Payment System (MIPS). At the same time, the addition of two new patient experience of care measures and one new measure to the CMS Web Interface measures that are reported under MIPS makes the Shared Savings Program measure set more outcomes oriented.

Request for Information on Price Transparency

Under current law, hospitals are required to establish and make public a list of their standard charges. In the fiscal year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule, CMS announced it is updating its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet. However, CMS is still seeking information from the public regarding barriers preventing providers and suppliers from informing patients of their out-of-pocket costs; what changes are needed to support greater transparency around patient obligations for their out of pocket costs; what can be done to

² Some Part B drug payments are based on Average Sales Price (ASP) methodology and, by statute, include an add-on payment of 6 percent of the ASP amount. Some Part B drug payments are based on wholesale acquisition cost (WAC) such as single-source drugs without ASP data. WAC-based payment rates typically exceed rates based on ASP amounts.

better inform patients of these obligations; and what role providers of health care services and suppliers should play in this initiative.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

- For CY 2019, CMS proposes to revise the significant hardship criteria in the AUC program to include: 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances.
- Proposes to add independent diagnostic testing facilities (IDTFs) to the definition of applicable setting under this program. This will allow the AUC program to be more consistently applied to outpatient settings.
- Proposes to allow AUC consultations, when not personally performed by the ordering professional, to be performed by auxiliary personnel. This will allow the ordering professional to exercise their discretion to delegate the performance of this consultation.

QPP Year 3

Due to feedback on the performance requirements of the quality performance category, re: the effectiveness and applicability of the measures, CMS is proposing:

- (1) adding 10 new MIPS quality measures that include 4 patient reported outcome measures, 7 high priority measures, 1 measure that replaces an existing measure, and 2 other measures on important clinical topics in the Meaningful Measures framework; and
- (2) removing 34 quality measures.

They also want feedback on **what patient reported outcome measures produce better outcomes** and request accompanying supporting evidence that the measures do, in fact, improve outcomes.

Adding new types of eligible clinicians into MIPS:

- Section 1848(q)(1)(C)(II) of the Act provides the Secretary with discretion, beginning with the 2021 MIPS payment year, to specify additional eligible clinicians as MIPS eligible clinicians.

- Feedback re: beginning with the 2021 MIPS payment year, adding physical therapist, occupational therapist, clinical social worker, and clinical psychologist, and a group that includes such clinicians into the definition of eligible clinician (among a few others if certain measures proposed for removal aren't removed).
- they are proposing to automatically assign a zero percent weighting for the Promoting Interoperability performance category for these new types of MIPS eligible clinicians.

MIPS determination period changes:

Going forward, if finalized, they will consolidate the MIPS determination period requirements for low-volume threshold and to identify MIPS eligible clinicians as non-patient facing, a small practice, hospital-based, and ASC-based. The determination period requirements for virtual groups, facility-based, rural and HPSA are measured differently and won't be consolidated.

Low volume threshold: For the 2020 MIPS payment year and future years, each segment of the low-volume threshold determination period includes a 30-day claims run out.

Non-patient facing: For the 2020 MIPS payment year and future years, each segment of the non-patient facing determination period includes a 30-day claims run out.

Facility based measurement:

- CMS is proposing to specify a criterion for a clinician to be eligible for facility-based measurement. Specifically, the clinician furnishes 75% or more of his or her covered professional services in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period with a 30-days claims run out.

Feedback is requested on the proposal that beginning with the 2021 MIPS payment year, **the MIPS determination period would be a 24-month assessment period including a two-segment analysis of claims data** consisting of: (1) an initial 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period; and (2) a second 12-month segment beginning on October 1 of the calendar year preceding the applicable

performance period and ending on September 30 of the calendar year in which the applicable performance period occurs.

For purposes of the 2022 MIPS payment year and future years, the performance period for the improvement activities performance category would be a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year. For purposes of the 2022 MIPS payment year, the performance period for the Promoting Interoperability performance category would be a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

Low volume threshold:

They are proposing to add one additional criterion to the low-volume threshold determination - the minimum number of covered professional services furnished to Part B-enrolled individuals by the clinician. (1) those who have allowed charges for covered professional services less than or equal to \$90,000; (2) those who provide covered professional services to 200 or fewer Part B-enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals.

Opt-in scenarios:

Proposal: Beginning with the 2021 MIPS payment year, if an eligible clinician or group meets or exceeds at least one, but not all, of the low-volume threshold determinations, including as defined by dollar amount (less than or equal to \$90,000) or number of beneficiaries (200 or fewer), or number of covered professional services (200 or fewer), then such eligible individual or group may choose to opt-in to MIPS.

Applicable eligible clinicians who meet one or two, but not all, of the criteria to opt-in and are interested in participating in MIPS would be required to make an affirmative election to either opt-in to participate in MIPS or choose to voluntarily report before data submission or by not submitting data elect to not opt-in. Once the eligible clinician has elected to participate in MIPS, the decision to opt-in to MIPS would be irrevocable and could not be changed for the applicable performance period.

TABLE 28: Low-Volume Threshold Determination Opt-in Scenarios

Beneficiaries	Dollars	Covered Professional Services	Eligible for Opt-in
≤ 200	≤ 90K	≤ 200	Excluded not eligible to Opt-in
≤ 200	≤ 90K	> 200	Eligible to Opt-in, Voluntarily Report, or Not Participate
≤ 200	> 90K	≤ 200	Eligible to Opt-in, Voluntarily Report, or Not Participate
> 200	≤ 90K	> 200	Eligible to Opt-in, Voluntarily Report, or Not Participate
> 200	> 90K	> 200	Not eligible to Opt-in, Required to Participate

- **Virtual groups:** beginning with the 2021 MIPS payment year, a virtual group election would constitute 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 APMs:** APM Entities in MIPS APMs, which meet one or two, but not all, of the low-volume threshold elements to opt-in and are interested in participating in MIPS under the APM scoring standard, would be required to make a definitive choice at the APM Entity level to opt-in to participate in MIPS.

Partial QP participation:

Beginning with the 2021 MIPS payment year, when an eligible clinician is determined to be a Partial QP for a year at the individual eligible clinician level, the individual eligible clinician will make an election whether to report to MIPS.

- If the eligible clinician elects to report to MIPS, he or she will be subject to MIPS reporting requirements and payment adjustments.
- If the eligible clinician elects to not report to MIPS, he or she will not be subject to MIPS reporting requirements and payment adjustments.
- If the eligible clinician does not make any affirmative election to report to MIPS, he or she will not be subject to MIPS reporting requirements and payment adjustments.
- As a result, **beginning with the 2021 MIPS payment year**, for eligible clinicians who are determined to be Partial QPs individually, **CMS will not use the eligible clinician’s actual**

MIPS reporting activity to determine whether to exclude the Partial QP from MIPS in the absence of an explicit election.

- This eliminates the scenario in which affirmatively agreeing to participate in MIPS as part of a virtual group prior to the start of the applicable performance period would constitute an explicit election to report under MIPS for eligible clinicians who are determined to be Partial QPs individually and make no explicit election to either report to MIPS or be excluded from MIPS.

Virtual group election process:

To continue to apply the previously established policies regarding the virtual group election process for the 2022 MIPS payment year and future years, except that:

- election to participate as virtual group for 2018-2019 was via e-mail; going forward, it will be by a means to be specified by CMS, potentially by registering to participate in MIPS as a virtual group via a web-based system developed by CMS. TBD.
- Virtual groups: Currently, MIPS uses various determination periods to identify certain MIPS eligible clinicians for consideration for certain applicable policies. CMS is proposing in this rule to add a virtual group eligibility determination period beginning in CY 2020.
 - to establish a virtual group eligibility determination period to align with the first segment of the MIPS determination period, which includes an analysis of claims data during a 12-month assessment period (fiscal year) that would begin on October 1 of the calendar year 2 years prior to the applicable performance period and end on September 30 of the calendar year preceding the applicable performance period and include a 30-day claims run out.
- For the 2018 and 2019 performance periods, TINs could determine their status by contacting their designated TA representative; otherwise, the TIN's status would be determined at the time that the TIN's virtual group election is submitted. **Proposal is to remove this provision since the inquiry about TIN size would be for informational purposes only and may be subject to change.**

Performance category measures and activities:

- Collection type as a set of quality measures with comparable specifications and data completeness criteria, including (examples).

- Submitter type as the MIPS eligible clinician, group, or third-party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities under MIPS.
- Submission type as the mechanism by which a submitter type submits data to CMS, including (examples).
- **There are five basic submission types that CMS is proposing:** direct; log in and upload; login and attest; Medicare Part B claims; and the CMS Web Interface.
- CMS is proposing to make the Medicare Part B claims collection type available to MIPS eligible clinicians in small practices beginning with the 2021 MIPS payment year.
- The CMS Web Interface submission type would no longer be available for groups to use to submit data for the improvement activities and Promoting Interoperability performance categories.
- Proposal to allow third party intermediaries to submit data using the CMS Web Interface on behalf of groups.
- Soliciting comment on expanding the CMS Web Interface submission type to groups consisting of 16 or more eligible clinicians to inform our future rulemaking.

TABLE 29: Data Submission Types for MIPS Eligible Clinicians Reporting as Individuals

Performance Category/Submission Combinations Accepted	Submission Type	Submitter Type	Collection Type
Quality	Direct Log in and upload	Individual or Third Party Intermediary ²	eCQMs MIPS CQMs QCDR measures
	Medicare Part B claims (small practices) ¹	Individual	Medicare Part B claims measures (small practices)
Cost	No data submission required ⁴	Individual	-
Promoting Interoperability	Direct Log in and upload	Individual or Third Party Intermediary	-
	Log in and attest		
Improvement Activities	Direct Log in and upload	Individual or Third Party Intermediary	-
	Log in and attest		
Performance Category/Submission Combinations Accepted	Submission Types	Submitter Type	Collection Type
Quality	Direct Log in and upload	Group or Third Party Intermediary	eCQMs MIPS CQMs QCDR measures CMS Web Interface measures Medicare Part B claims measures (small practices) CMS approved survey vendor measure Administrative claims measures
	CMS Web Interface (groups of 25 or more eligible clinicians) Medicare Part B claims (small practices) ¹		
Cost	No data submission required ^{1,2}	Group	-
Promoting Interoperability	Direct Log in and upload	Group or Third Party Intermediary	-
	Log in and attest		
Improvement Activities	Direct Log in and upload	Group or Third Party Intermediary	-
	Log in and attest		

Data Submission Deadlines:

The data submission deadlines are as follows:

- (1) For the direct, login and upload, login and attest, and CMS Web Interface submission types, March 31 following the close of the applicable performance period or a later date as specified by CMS.
- (2) For the Medicare Part B claims submission type, data must be submitted on claims with dates of service during the applicable performance period that must be processed no later than 60 days following the close of the applicable performance period.

Meaningful Measures Initiative: CMS identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities:

TABLE 27: Meaningful Measures Framework Domains and Measure Areas

Quality Priority	Meaningful Measure Area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections
	Preventable Healthcare Harm
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals
	End of Life Care according to Preferences
	Patient's Experience of Care
	Patient Reported Functional Outcomes
Promote Effective Communication and Coordination of Care	Medication Management
	Admissions and Readmissions to Hospitals
	Transfer of Health Information and Interoperability
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care
	Management of Chronic Conditions
	Prevention, Treatment, and Management of Mental Health
	Prevention and Treatment of Opioid and Substance Use Disorders
	Risk Adjusted Mortality
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care
	Community Engagement
Make Care Affordable	Appropriate Use of Healthcare
	Patient-focused Episode of Care
	Risk Adjusted Total Cost of Care

I. Quality Performance Category:

Proposal to specify, for a MIPS payment year, CMS will use the following quality measures, as applicable, to assess performance in the quality performance category:

- measures included in the MIPS final list of quality measures established by us through rulemaking;
- QCDR measures as approved;
- facility-based measures as described in rule;
- and MIPS APM measures as described in rule.

CMS is proposing to weight **the cost performance category at 15 percent** for the 2021 MIPS payment year, and to provide that performance in **the quality performance category will comprise 50 percent of a MIPS eligible clinician's final score for the 2020 MIPS payment year,**

and that the quality performance category comprises 45 percent of a MIPS eligible clinician’s final score for the 2021 MIPS payment year.

TABLE 31: Summary of Data Completeness Requirements and Performance Period by Collection Type for the 2020 and 2021 MIPS Payment Years

Collection Type	Performance Period	Data Completeness
Medicare Part B claims measures	Jan 1- Dec 31 (or 90 days for selected measures)	60 percent of individual MIPS eligible clinician’s, or group’s (beginning with the 2021 MIPS payment year) Medicare Part B patients for the performance period.
Administrative claims measures	Jan 1- Dec 31	100 percent of individual MIPS eligible clinician’s Medicare Part B patients for the performance period.
QCDR measures, MIPS CQMs, and eCQMs	Jan 1- Dec 31 (or 90 days for selected measures)	60 percent of individual MIPS eligible clinician’s, or group’s patients across all payers for the performance period.
CMS Web Interface measures	Jan 1- Dec 31	Sampling requirements for the group’s Medicare Part B patients: populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group’s sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.
CAHPS for MIPS survey	Jan 1- Dec 31	Sampling requirements for the group’s Medicare Part B patients.

Proposed changes for Medicare Part B claims measures, MIPS CQMs, eCQMs, or QCDR measures.

(i) must submit data on at least six measures including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure. If fewer than six measures apply to the MIPS eligible clinician or group, report on each measure that is applicable.

(ii) MIPS eligible clinicians and groups that report on a specialty or subspecialty measure set, as designated in the MIPS final list of quality measures established by CMS through rulemaking, must submit data on at least six measures within that set. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician or group, report on each measure that is applicable.

Proposed changes for CMS Web Interface measures.

(i) Report on all measures included in the CMS Web Interface. The group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module.

(ii) If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries.

(iii) The group is required to report on at least one measure for which there is Medicare patient data.

Definition of a high priority measure:

Beginning with the 2019 performance period, CMS proposes to amend the definition of a high priority measure, to include quality measures that relate to opioids and to further clarify the types of outcome measures that are considered high priority.

Beginning with the 2021 MIPS payment year, they will define a high priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. Outcome measures would include intermediate-outcome and patient-reported outcome measures.

- They want comment on this proposal, specifically if stakeholders have suggestions on what aspects of opioids should be measured. For example, should they focus solely on opioid overuse?

Given that there are a limited number of CMS Web Interface measures, CMS wants feedback on **building upon the CMS Web Interface submission type** by expanding the core set of measures available for that submission type **to include other specialty specific measures (such as surgery).**

Topped Out Measures:

- CMS is proposing that once a measure has reached an extremely topped out status (for example, a measure with an average mean performance within the 98th to 100th percentile range), CMS may propose the measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped out measure lifecycle, due to the extremely high and unvarying performance where meaningful distinctions

and improvement in performance can no longer be made, after taking into account any other relevant factors.

- **But they would also consider retaining the measure if there are compelling reasons as to why it should not be removed** (for example, if the removal would impact the number of measures available to a specialist type or if the measure addresses an area of importance to the Agency).
- CMS is proposing to exclude QCDR measures from the topped-out timeline that was finalized in the CY 2018 Quality Payment Program final rule. Because QCDRs have more flexibility to develop innovative measures, CMS “believes there is limited value in maintaining topped out QCDR measures in MIPS.”

Categorizing Measures by Value:

CMS acknowledges that not all measures are created equal. Accordingly, they’re seeking comment on implementing a system where measures are classified as a particular value (gold, silver or bronze) and points are awarded based on the value of the measure. In this scenario, they could “envision awarding points for achievement as follows: up to 15 to 20 points in the top tier; up to 10 points in the next tier; and up to 5 points in the lowest tier.”

II. Cost Performance Category:

To provide for a smooth transition, CMS expects to increase the weight of the cost performance category by 5 percentage points each year until it reaches the required 30 percent weight for the 2024 MIPS payment year.

Reliability threshold for cost:

In the CY 2017 Quality Payment Program final rule, CMS finalized a reliability threshold of 0.4 for measures in the cost performance category.

CMS proposes a case minimum of 10 episodes for the procedural episode-based measures and 20 episodes for the acute inpatient medical condition episode-based measures that they have proposed beginning with the 2019 MIPS performance period.

CMS proposes to codify the previously finalized case minimum of 35 for the MSPB measure, 20 for the total per capita cost measure, and 20 for the episode-based measures specified for the 2017 MIPS performance period.

Attribution for cost measures:

CMS proposes to attribute episodes to each MIPS eligible clinician who bills inpatient (E&M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization.

CMS “believes that establishing a 30 percent threshold for the TIN would ensure that the clinician group is collectively measured across all of its clinicians who are likely responsible for the oversight of care for the patient during the trigger hospitalization.”

For procedural episode groups specified beginning in the 2019 MIPS performance period, CMS proposes to attribute episodes to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes. These trigger services are identified in the measure specifications posted at qpp.cms.gov.

III. Improvement Activities Performance Category:

IA Inventory Proposals:

(1) adopt one new criterion and remove one existing criterion for nominating new improvement activities beginning with the CY 2019 performance period and future years;

CMS is proposing to adopt an additional criterion called “Include a public health emergency as determined by the Secretary” to the criteria for nominating new improvement activities beginning with the CY 2019 performance period and future years.

To align with the new Promoting Interoperability rules, they propose to remove the criterion for selecting improvement activities for inclusion in the program entitled “Activities that may be considered for an advancing care information bonus” beginning with the CY 2019 performance period and future years.

(2) modify the timeframe for the Annual Call for Activities;

CMS has found that “processing and reviewing the volume of improvement activities nominations requires more time than originally thought.”

Beginning with the CY 2019 performance period and future years, CMS is proposing to: (1) delay the year for which nominations of prospective new and modified improvement activities would apply; and (2) expand the submission timeframe/due date for nominations.

Beginning with the CY 2019 performance period and for future years, CMS is proposing to change the performance year for which the nominations of prospective new and modified improvement activities would apply, such that 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.

Beginning with the CY 2019 performance period, CMS is proposing to change the submission timeframe for the Call for Activities from February 1st through March 1st to February 1st through June 30th, providing approximately 4 additional months for stakeholders to submit nominations.

(3) add 6 new improvement activities for the CY 2019 performance period and future years;

- Comprehensive Eye Exams
- Financial Navigation Program
- Completion of Collaborative Care Management Training Program
- Relationship-Centered Communication
- Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support
- Patient Medication Risk Education

(4) modify 5 existing improvement activities for the CY 2019 performance period and future years;

- Care transition documentation practice improvements (added "...real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications")
- Chronic Care and Preventative Care Management for Empaneled Patients (Addition of examples of evidence based, condition-specific pathways for care of chronic conditions: 'These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP).')

- Participation in MOC Part IV (Added two examples of ways in which a MIPS eligible clinician can participate in Maintenance of Certification (MOC) Part IV, incl. participation in “specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE)”)
- Use of Patient Safety Tools (Addition of “opiate risk tool (ORT), or other similar tools” as an additional example/category of an action that can be undertaken to meet the requirements of this activity.)
- Implementation of analytic capabilities to manage total cost of care for practice population (Added an example platform that uses available data to analyze opportunities to reduce cost through improved care)

In this proposed rule, CMS clarifies that an improvement activity is by default medium-weight unless it meets considerations for high-weighting. “We believe that an activity that requires significant investment of time and resources should be high-weighted. ***We invite public comment on the need for additional transparency and guidance on the weighting of improvement activities as we work to refine the Annual Call for Activities process for future years.***” CMS is also seeking comment on potentially applying high-weighting for any improvement activity employing CEHRT.

IV. Promoting Interoperability (formerly ACI):

CMS continues to believe it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019.

Scoring Methodology for 2017 and 2018 Performance Periods

This is an overhaul of the existing program requirements as it eliminates the concept of base and performance scores.

Under the proposed scoring methodology: MIPS eligible clinicians would be required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level.

- The scores for each of the individual measures would be added together to calculate the Promoting Interoperability performance category score of up to 100 possible points for each MIPS eligible clinician. In general, the Promoting Interoperability performance category score makes up 25 percent of the MIPS final score.

TABLE 36: Proposed Scoring Methodology for the MIPS Performance Period in 2019

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	<i>Bonus:</i> Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	<i>Bonus:</i> Verify Opioid Treatment Agreement	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	<u>Choose two of the following:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

TABLE 37: Proposed Scoring Methodology Beginning with MIPS Performance Period in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	5 points
	Query of Prescription Drug Monitoring Program (PDMP)	5 points
	Verify Opioid Treatment Agreement	5 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	35 points
Public Health and Clinical Data Exchange	<u>Choose two of the following:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

V. MIPS APMs

CMS is clarifying that the regulation to specify that:

A MIPS APM must be designed in such a way that participating APM Entities are incented to reduce costs of care or utilization of services, or both.

It will consider each distinct track of an APM and whether it meets the criteria in order to be a MIPS APM, and that it is possible for an APM to have tracks that are MIPS APMs and tracks that are not MIPS APMs.

Ten APMs will satisfy the criteria to be MIPS APMs in 2019, including BPCI-Advanced.

VI. MIPS Final Score Methodology

i. Scoring quality:

Beginning with the 2021 MIPS payment year, CMS proposes to establish separate benchmarks for the following collection types: eCQMs; QCDR measures; MIPS CQMs; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures. CMS would apply benchmarks based on collection type rather than submission mechanism, and would establish separate benchmarks for QCDR measures and MIPS CQMs since these measures do not have comparable specifications. CMS proposes to assign zero points for measures that do not meet data completeness starting with the CY 2020 MIPS performance period.

Measures with clinical guideline changes during the performance period: CMS is proposing to suppress a measure without rulemaking, if during the performance period a measure is significantly impacted by clinical guideline changes or other changes that CMS believes may pose patient safety concerns. CMS would rely on measure stewards for notification in changes to clinical guidelines. CMS will reduce the total available measure achievement points for the quality performance category by 10 points for MIPS eligible clinicians that submit a measure significantly impacted by clinical guideline changes or other changes that CMS believes may pose patient safety concerns.

Small Practice Bonus: Starting with the 2021 MIPS payment year, CMS proposes to add a small practice bonus of 3 points in the numerator of the quality performance category for MIPS eligible clinicians in small practices if the MIPS eligible clinician submits data to MIPS on at least 1 quality measure.

Incentives to Report High-Priority Measures: For the 2021 MIPS payment year, CMS propose to modify the policies finalized in the CY 2017 Quality Payment Program final rule to discontinue awarding measure bonus points to CMS Web Interface reporters for reporting high priority measures.

Incentives to Use CEHRT to Support Quality Performance Category Submissions: CMS invites comment on other ways that they can encourage the use of CEHRT for quality reporting.

ii. Scoring cost:

Scoring improvement for Cost: Proposal to provide that the maximum cost improvement score for the 2020, 2021, 2022, and 2023 MIPS payment years is zero percentage points (per Section 51003(a)(1)(B) of the Bipartisan Budget Act), and to modify the performance standards to reflect that the cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

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

CMS is proposing to modify our determination of a **facility-based individual** at in four ways.

- First, CMS proposes to add on-campus outpatient hospital (as identified in the POS code in the HIPAA standard transaction, that is, POS code 22) to the settings that determine whether a clinician is facility-based.
- Second, that a clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room.
- Third, that, if they are unable to identify a facility with a VBP score to attribute a clinician's performance, that clinician is not eligible for facility-based measurement.
- Fourth, they propose to align the time period for determining eligibility for facility based measurement with changes to the dates used to determine MIPS eligibility and special status.

Under CMS's proposal, they provide that a facility-based group receives a score under the facility-based measurement scoring standard derived from the VBP score for the facility at which the plurality of clinicians identified as facility-based would have had their score determined if the clinicians had been scored under facility-based measurement as individuals.

No election of facility-based measurement: After further considering the advantages and disadvantages of an opt-in or an opt-out process, CMS proposes a modified policy that does not require an election process. Instead, it proposes to automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined quality and cost performance category score.

Facility-Based Measures:

Beginning in 2019 performance period, CMS proposes to adopt for facility-based measurement, the measure set that they finalize for the fiscal year Hospital VBP program for which payment begins during the applicable MIPS performance period. Starting with the 2021 MIPS payment year, the scoring methodology applicable for MIPS eligible clinicians scored with facility-based measurement is the Total Performance Score methodology adopted for the Hospital VBP Program, for the fiscal year for which payment begins during the applicable MIPS performance period.

Among the 2020 Hospital VBP Program Measures is: THA/TKA Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Scoring facility-based measurement: CMS proposes that the quality and cost performance category percent scores would be established by determining the percentile performance of the facility in the Hospital VBP Program for the specified year, then awarding a score associated with that same percentile performance in the MIPS quality and cost performance categories for those MIPS eligible clinicians who are not eligible to be scored under facility-based measurement for the MIPS payment year.

Scoring Improvement in Facility-Based Measurement: CMS proposes to not assess improvement for MIPS-eligible clinicians who are scored in MIPS through facility-based measurement in 1 year but through another method in the following year.

Expansion of facility-based measurement to PAC: They are particularly interested in the opportunity to expand facility-based measurement into post-acute care (PAC) and the end-stage renal disease (ESRD) settings and seek comment on how to do so. They are seeking

comment on how they may attribute the quality and cost of care for patients in PAC settings to clinicians.

iii. Scoring Improvement Activities:

- Clarifying here that the improvement activities performance category score cannot exceed 100 percent.
- In response to comments received regarding patient-centered medical homes or comparable specialty practices receiving full credit for the improvement activities performance category for MIPS, CMS stated that it would like to make clear that credit is not automatically granted. MIPS eligible clinicians and groups must attest in order to receive the credit.
- Therefore, in this proposed rule, they are clearly requiring that an eligible clinician or group must attest to their status as a patient-centered medical home or comparable specialty practice in order to receive this credit.

iv. Scoring Promoting Interoperability:

- For the 2021 MIPS payment year, they propose to continue the complex patient bonus as finalized for the 2020 MIPS payment year.

Final Scores:

TABLE 50: Finalized and Proposed Weights by MIPS Performance Category and MIPS Payment Year

Performance Category	Transition Year (Previously Finalized)	2020 MIPS Payment Year (Previously Finalized)	2021 MIPS Payment Year (Proposed)
Quality	60%	50%	45%
Cost	0%	10%	15%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

Reweighting for Extreme and Uncontrollable Circumstances:

- Beginning with the 2019 MIPS performance period/2021 MIPS payment year, if a MIPS eligible clinician submits an application for reweighting based on extreme and uncontrollable circumstances, but also submits data on the measures or activities specified for the quality or improvement activities performance categories, he or she

would be scored on the submitted data like all other MIPS eligible clinicians, and the categories would not be reweighted.

- CMS also proposes to apply the policy finalized for virtual groups in the CY 2018 Quality Payment Program final rule to groups submitting reweighting applications for the quality, cost, or improvement activities performance categories based on extreme and uncontrollable circumstances.

Reweighting the Performance Categories for MIPS Eligible Clinicians Who Join a Practice in the Final 3 Months of the Performance Period Year

Beginning with the 2019 MIPS performance period:

- A MIPS eligible clinician who joins an existing practice (existing TIN) during the final 3 months of the calendar year in which the MIPS performance period occurs (the performance period year) that is not participating in MIPS as a group would not have sufficient measures applicable and available.
- A MIPS eligible clinician who joins a practice that is newly formed (new TIN) during the final 3 months of the performance period year would not have sufficient measures applicable and available, regardless of whether the clinicians in the practice report for purposes of MIPS as individuals or as a group.
- In each of these scenarios, they are proposing to reweight all four of the performance categories to zero percent for the MIPS eligible clinician and, because he or she would be scored on fewer than two performance categories, the MIPS eligible clinician would receive a final score equal to the performance threshold and a neutral MIPS payment adjustment.

Extreme and uncontrollable circumstances affecting entire regions or locales: CMS will extend and codify the interim a policy for automatically reweighting the quality, improvement activities, and Promoting Interoperability performance categories for the transition year of MIPS for MIPS eligible clinicians who are affected by extreme and uncontrollable circumstances affecting entire regions or locales.

For the 2021 MIPS payment year, with the proposal to weight cost at 15 percent, they propose to reweight the Promoting Interoperability performance category to 45 percent and the improvement activities performance category to 40 percent when the quality performance category is weighted at zero percent.

TABLE 51: Performance Category Redistribution Policies Proposed for the 2021 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	45%	15%	15%	25%
Reweight One Performance Category				
-No Cost	60%	0%	15%	25%
-No Promoting Interoperability	70%	15%	15%	0%
-No Quality	0%	15%	40%	45%
-No Improvement Activities	60%	15%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	50%	50%
-No Cost and no Improvement Activities	75%	0%	0%	25%
-No Promoting Interoperability and no Quality	0%	15%	85%	0%
-No Promoting Interoperability and no Improvement Activities	85%	15%	0%	0%
-No Quality and no Improvement Activities	0%	15%	0%	85%

VII. MIPS Payment Adjustments

Performance Threshold: CMS uses 2017 QPP performance data to estimate that the mean and median for the 2024 program year will be 63.50 and 77.83. For the purposes of estimating the 2024 performance threshold, CMS chooses the mean to work back five years and set the performance threshold for 2021 Program Year at 30 points (up from 15). Should it be 25? 35?

Should they establish a path going forward for 2022 and 2023 so that the incremental increases between now and 2024 are known in advance or determine it each rulemaking cycle until 2024?

The **Additional Performance Threshold** for exceptional performance is set at 80 points.

Application of the MIPS Payment Adjustment Factor Formula: in the case of covered professional services furnished by a MIPS eligible clinician during a MIPS payment year beginning with 2019, the amount otherwise paid under Part B with respect to such covered professional services and MIPS eligible clinician for such year, is multiplied by 1, plus the sum of: the MIPS payment adjustment factor divided by 100, and as applicable, the additional MIPS payment adjustment factor divided by 100.

Beginning 2019 payment year, the MIPS payment adjustment does not apply for non-assigned claims for non-participating physicians. They propose to apply the MIPS payment adjustment to

claims that are billed and paid on an assignment-related basis, and not to any non-assigned claims, beginning with the 2019 MIPS payment year.

Exemption for 1115A Waivers: CMS proposes that the applied MIPS payment adjustment factors would not apply to certain model specific payments as described above for the duration of a section 1115A model's testing, beginning in the 2019 MIPS payment year.

VIII. Third Party Intermediaries

Proposing new clarifying definition for third party intermediary.

Update to the Definition of a QCDR: A QCDR would be defined as an entity with clinical expertise in medicine and in quality measurement development that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

Establishment of an Entity Seeking To Qualify as a QCDR or QR: beginning with the 2022 MIPS Payment Year, the QCDR/QR must have at least 25 participants by January 1 of the year prior to the performance period. These participants do not need to use the QCDR/QR to report MIPS data to CMS; rather, they need to submit data to the QCDRQR for quality improvement.

Revising the self-nomination period for QCDR/QRs: CMS wants to allow for additional review time and measure discussions with QCDR/QRs. CMS is proposing to update the self-nomination period from September 1 of the year prior to the specific performance period until November 1 to July 1 of the calendar year prior to the specific performance period until September 1.

Measure ID: QCDRs must include their CMS-assigned QCDR measure ID number when posting their approved QCDR measure specifications, and also when submitting data on the QCDR measures to us.

Updated consideration criteria for approval of QCDR measures: CMS noted there was concern among commenters that the Call for Measures process is cumbersome, would increase burden, does not recognize the uniqueness of QCDRs and is not agile. In order "to work towards consistent standards and evaluation criteria" CMS proposes to apply eight new criteria to address help clarify and address this issue.

Update on QCDRs seeking permission from another QCDR to use an existing, approved QCDR measure: CMS talks about their interest in having QCDRs utilize other QCDR performance measures to prevent similar or duplicative measures, and preventing other QCDRs from being charged a fee for that use. CMS proposes “requiring” QCDRs as part of their measure approval process to allow any “approved QCDR to submit data on the QCDR measure” for MIPS and requiring other QCDRs “to use the same CMS assigned QCDR measure ID.”

IX. Public Reporting on Physician Compare

Quality and Cost Measure reporting: Last year, CMS finalized that they would not publicly report first year quality and cost measures, meaning any measure in its first year of use in the quality performance category, on Physician Compare. CMS here revises the law to indicate that they will not publicly report first year quality or cost measures for the first 2 years a measure is in use in the appropriate performance category.

High performance reporting: CMS requests comment on the proposal not to include the indicator for “high” performance in the Promoting Interoperability performance category beginning with year 2 of the Quality Payment Program (2018 data available for public reporting in late 2019).

EHR utilization reporting: What type of EHR utilization performance information would stakeholders like CMS to consider adding to Physician Compare?

Adding Star Ratings for QCDR measures: Proposal to further modify the existing policy to extend the use of the ABC™ methodology and equal ranges method to determine, by measure and collection type, a benchmark and 5-star rating for QCDR measures using current performance period data in year 2 of the Quality Payment Program, and using historical benchmark data when possible as proposed above, beginning with year 3 of the Quality Payment Program.

X. Overview of APM Incentive

Proposed change – beginning for CY 2019, in order to be an Advanced APM, the APM must require at least 75 percent of eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals (from current 50%).

MIPS Comparable Quality Measures:

Clarification that measures submitted in response to the annual call for quality measures or those developed using QPP funding are not automatically MIPS-comparable; the same is true for QCDR measures. If QCDR measures are endorsed by a consensus-based entity they are presumptively considered MIPS-comparable quality measures; otherwise they would have needed independent verification, or to make our own assessment and determination, that the measures are evidence based, reliable, and valid before considering them to be MIPS-comparable quality measures. **To clarify: at least one of the quality measures upon which an Advanced APM bases the payment must be finalized on the MIPS final list of measures; be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidenced-based, reliable, and valid.**

CMS explicitly requires that an outcome measure must be evidence-based, reliable, and valid (unless, as specified in the current regulation, there is no available or applicable outcome measure). This proposal would have an effective date of January 1, 2020, and would specifically require that at least one outcome measure for which measure results are included as a factor when determining payment to participants under the terms of the APM must also be a MIPS-comparable quality measure. CMS will maintain the generally applicable revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for QP Performance Periods 2021 through 2024. Should they consider increasing it?

CMS proposes that for each of the three QP determinations, they will allow for claims run-out for 60 days (approximately 2 months), before calculating the Threshold Scores so that the three QP determinations will be completed approximately 3 months after the end of that determination time period. CMS also proposes that when an eligible clinician is determined to be a Partial QP for a year at the individual eligible clinician level, the individual eligible clinician will make an election whether to report to MIPS.

If the eligible clinician elects to report to MIPS, they will be subject to the MIPS reporting requirements and payment adjustment.

If the eligible clinician elects not to report, they will be excluded from the MIPS reporting requirements and payment adjustment.

In the absence of an explicit election to report to MIPS, the eligible clinician will be excluded from the MIPS reporting requirements and payment adjustment. This means that no

XII. All-Payer Combination Option

Increasing the CEHRT Use Criterion for Other Payer Advanced APMs

CMS is proposing to change the current CEHRT use criterion for Other Payer Advanced APMs so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, the other payer arrangement must require at least 75 percent of participating eligible clinicians in each APM Entity to use CEHRT.

Evidence of CEHRT Use: A payer or eligible clinician must provide documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement by at least 50 percent of eligible clinicians in 2019, and 75 percent of the eligible clinicians in 2020 and beyond, whether or not such CEHRT use is explicitly required under the terms of the payment arrangement.

Evidence based, reliable, valid measures: For such payment arrangements that are determined to be Other Payer Advanced APMs for the 2019 performance year and did not include an outcome measure that is evidence-based, reliable, and valid, and that are resubmitted for an Other Payer Advanced APM determination for the 2020 performance, they would continue to apply the current regulation for purposes of those determinations.

Generally applicable nominal amount standard: Please provide comment on the proposal to maintain the 8 percent nominal amount standard for Other Payer Advanced APMs for QP Performance Periods through 2024.

Determination of Other Payer Advanced APMs: For Other Payer Advanced APM determinations for performance year 2020, after the first year that a payer, APM Entity, or eligible clinician submits a multi-year payment arrangement that it determines to be an Other Payer Advanced APM for that year, the requester would need to submit information only on any changes to the payment arrangement that are relevant to the Other Payer Advanced APM criteria for each successive year for the remaining duration of the payment arrangement.