Summary of Quality Payment Program (QPP) and MIPS Provisions Included in the Medicare Physician Fee Schedule (MPFS) Proposed Rule for CY2020

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Executive Summary

The Center for Medicare and Medicaid Services (CMS) is proposing significant changes to improve the Quality Payment Program (QPP) by streamlining the program's requirements with the goal of reducing clinician burden.

Request for Information on a new MIPS Value Pathways initiative

CMS proposes a new MIPS Value Pathways (MVP) framework that would connect measures and activities across the 4 MIPS performance categories (Quality, Cost, Improvement Activities and Promoting Interoperability). MVP would incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information provided to patients.

By 2021, CMS proposes to move from reporting on activities under the four performance categories under MIPS and transition to the new MVP framework with a unified set of measures centered around a specific condition or specialty. Under the MVP framework, clinicians would report on a smaller set of measures that are outcomes-based, specialty-specific and more closely aligned with the Advanced APMs.

Key Merit-Based Incentive Payment System (MIPS) Proposals

CMS proposes to strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS to require measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. These policies relate to CY 2020 and CY 2021 for QCDRs.

The agency proposed several changes to the measures for 2020. CMS proposes to add new specialty sets of measures for Audiology, Pulmonology and Endocrinology, among others. The agency proposes to remove several standard-care and process measures, consistent with the Meaningful Measures Initiative. CMS also proposes adding ten new episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide, and proposes changes to the interoperability measures.

Key Alternative Payment Model (APM) Proposals

The agency proposes refining the APM scoring standard to improve flexibility for participants, and requests comment on APM scoring for future years of the QPP. CMS also proposes to extend the existing uncontrollable circumstances policies to MIPS eligible clinicians participating in APMs, if they are subject to the APM scoring standard and would report on MIPS quality measures. The agency also clarifies definitions and reporting requirements for APM participants.

MIPS Program Details

Request for Information: Transforming MIPS with MIPS Value Pathways (MVP)

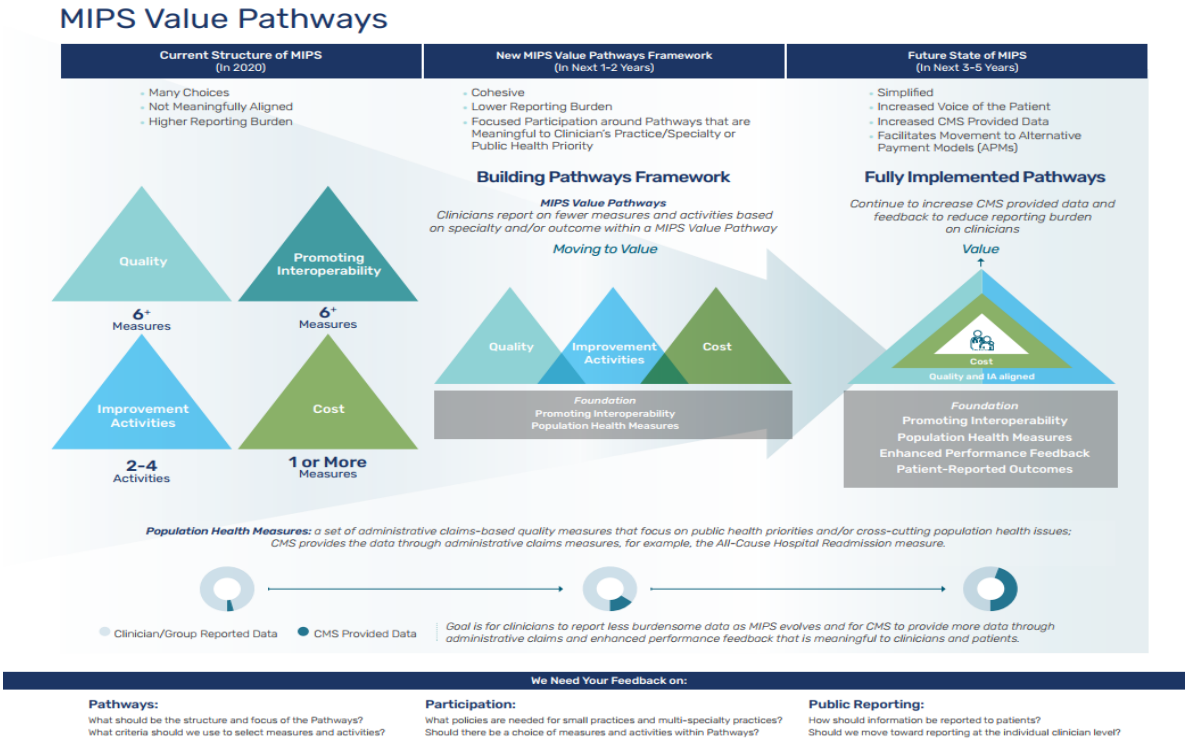
The agency seeks comment on the development and structure of MVPs, which are defined by four guiding principles:

1) MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data;
2) MVPs should include measures that encourage performance improvement in high priority areas;
3) MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers when choosing care; and
4) MVPs should reduce barriers to APM participation by including measures that are part of APMs, and by linking cost and quality measurement.

CMS envisions that MVPs would be organized around clinician specialty or health condition and will encompass a set of related measures and activities. Combining these quality and cost measures and improvement activities that are highly correlated, along with the measures from the Promoting Interoperability performance category, will strengthen clinical improvement and streamline reporting.

The following graphic[1] shows an overview of the MVP initiative.

[1] https://qpp-cm-prodcontent.s3.amazonaws.com/uploads/587/MIPS%20Value%20Pathways%20Diagrams.zip



The agency specifically requested comment on four key issues:

- How to construct MVPs, including approach, definition, development, specification, and examples;
- How to solicit measures and activities for MVPs;
- How to determine MVP assignment, for clinicians and for multispecialty groups; and
- How to transition to MVPs.

In the proposed rule, CMS provides four examples to illustrate the construction and assignment of measures and activities for MVPs. Two examples for primary care/general medicine include preventive health and diabetes prevention and treatment. For procedural specialties, the examples are for major surgery and general ophthalmology. A graphic for the Diabetes MIPS Value Pathway example is found in Appendix A of this summary.

Each example presents no more than four measures in each of the following MIPS categories: quality, cost and improvement activities. CMS would prioritize outcome and patient reported measures, non-topped out measures, and eCQMs. Population health measures and the measures in the Promoting interoperability performance category would initially apply to all MVPs, unless an exception applies. The agency requests feedback on the examples of possible MVPs, set out for illustrative purposes in the **below table**, as well as options to promote interoperability.

MVP Example	Quality Measures	Cost Measures	Improvement Activities	Promoting Interoperability

Preventive Health	• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID: 226) • Osteoarthritis: Function and Pain Assessment (Quality ID: 109) • Adult Immunization Status, proposed (Quality ID: TBD) • Controlling High Blood Pressure (Quality ID: 236) • +: population health administrative claims quality measures (e.g., all cause hospital readmission)	• Total Per Capita Cost (TPCC_1) • Medicare Spending Per Beneficiary (MSPB_1)	• Chronic Care and Preventive Care for Empaneled Patients (IA_PM_13) • Engage patients and families to guide improvement in the system of care (IA_BE_14) • Collection and use of patient experience and satisfaction data on access (IA_EPA_3)	All measures in Promoting Interoperability
Diabetes Prevention and Treatment	• Hemoglobin A1c (HbA1c) Poor Care Control (>9%) (Quality ID:001) • Diabetes: Medical Attention for Nephropathy (Quality ID: 119) • Evaluation Controlling High Blood Pressure (Quality ID: 236): • + population health administrative claims quality measures	• Total Per Capita Cost (TPCC_1) • Medicare Spending Per Beneficiary (MSPB_1)	• Glycemic Management Services (IA_PM_4) • Chronic Care and Preventative Care Management for Empaneled Patients (IA_PM_13)	All measures in Promoting Interoperability
Major Surgery	• Unplanned Reoperation within the 30-Day Postoperative Period (Quality ID: 355) • Surgical Site Infection (SSI) (Quality ID: 357) • Patient-Centered Surgical Risk Assessment and Communication (Quality ID: 358) • + population health administrative claims quality measures	• Medicare Spending Per Beneficiary (MSPB_1) • Revascularization for Lower Extremity Chronic Critical Limb Ischemia (COST_CCLI_1) • Knee arthroplasty (COST_KA_1)	• Use of patient safety tools (IA_PSPA_8) • Implementing the use of specialist reports back to referring clinician or group to close referral loop (IA_CC_1) OR • Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)	All measures in Promoting Interoperability
General Ophthalmology	• Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (Quality ID: 012)	• Medicare Spending Per Beneficiary (MSPB_1)	• Implementation of improvements that contribute to more timely communication of test results (IA_CC_2)	All measures in Promoting Interoperability

	• Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetes Care (Quality ID: 019) • Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery (Quality ID: 191) • + population health administrative claims quality measures	• Routine Cataract Removal with Intraocular Lens Implantation (COST_IOL_1)	• Comprehensive eye exam (IA_AHE_7)	

Adjusting MVPs for Different Practice Characteristics

Small and Rural Practice Participation in MVPs

Under current MIPS quality performance category submission requirements, the same number of measures and activities are reported regardless of group size, which may be a burden on small and rural practices. These practices also may lack a sufficient case mix to report measures that can be reliably scored. CMS is also interested in adopting policies to help small practices transition into APMs.

The agency requests public comment on policies to support small and rural practices:

- How to structure MVPs to provide flexibility for small and rural practices and reduce participation burden?
- How to mitigate challenges small and/or rural practices have in reporting, including what types of technical assistance would be most useful?
- How to reduce barriers to small and/or rural practices transitioning into APMs, such as lack of information on performance, quality and cost measures and limited resources?

Multispecialty Practice Participation in MVPs

CMS is considering requiring that multispecialty practices report the relevant MVP for each specialty to provide more comprehensive information for patients. The agency specifically requests public comment on the following questions on MVP policies for multispecialty practices:

- Can the agency use the MVP approach as an alternative to sub-group reporting to more comprehensively capture the range of the items and services furnished by the group practice?
- Would it better for multispecialty groups to report and be scored on multiple MVPs to offer patients a more comprehensive picture of group practice performance or for multispecialty groups to create sub-groups, which would break the overall group into smaller units that would independently report MVPs?
- How should the agency balance the need for information for patients on clinicians within the multispecialty practice with the clinician burden of reporting?
- What criteria should be used to identify which MVPs are applicable to multispecialty groups?

    - For example, should it be based on the number or percentage of clinicians from the same specialty in the group?
    - Should a group be able to identify which clinicians will report which MVP?
- Should there be a limit on the number of MVPs that could be reported by a multispecialty group?
- What mechanisms should be used to assess a group's specialty composition to determine which MVPs are applicable?
    - For example, would groups need to submit identifying information to assure that measure MVPs aligned with the number or percent of clinicians of different specialties within a group?
    - Is there information (such as specialty as identified in PECOS or the specialty reported on claims) that the agency could leverage to ensure the appropriateness of MVPs for groups?

Incorporating QCDR Measures into MVPs

While proposals related to QCDR measures are included in a separate section of the rule (III.K.3.g(2)(C)), clinicians can choose from either QCDR or MIPS measures to fulfill the requirements of the quality performance category. The agency is concerned that the abundance and duplication of measures has caused to clinician confusion and lack of consistency, and is seeking feedback on how best to incorporate QCDRs into the MVP framework.

Scoring MVP Performance

The agency specifically requests comment on scoring MVP performance:

- What scoring policies can be simplified or eliminated under the MVP framework?
- What scoring policies will help to create level comparability across MVPs?
- How should CMS score multispecialty groups reporting multiple MVPs?

MVP Population Health Quality Measure Set

CMS is planning to increase utilization of global and population based administrative claims-based quality measures as they develop a population health quality measure set and include a proposal to add at least one additional administrative claims-based quality measure starting in the 2021 MIPS performance period. The agency specifically requests feedback on the following questions:

- In addition to the quality measures described above, are there specific administrative claims-based quality measures we should consider, including, but not limited to, any that assess specialty care that are specified and/or tested at the clinician/group practice level?

- Should administrative claims-based quality measures be used to replace some of the reporting requirements in the quality performance category?
    - For example, if two additional administrative claims-based quality measures were added to MVPs, should the agency reduce the required quality measures by 1 measure for each of the MVPs?
- In addition to testing, what other information or methods should be used to mitigate concerns about administrative claims-based quality measure reliability, applicability, and degree of actionable feedback for clinician performance improvement? What concerns should be prioritized?

Clinician Data Feedback

CMS aims to provide meaningful feedback to clinicians on administrative claims-based quality and cost measures, and is seeking comment on data feedback and timing needs:

- As clinicians and groups move towards joining APMs, is there particular data from quality and cost measures that would be helpful?
- Would it be useful to clinicians to have feedback based on an analysis of administrative claims data that includes outlier analysis or other types of actionable data feedback?
    - What type of information about practice variation, such as the number of procedures performed compared to other clinicians within the same specialty or clinicians treating the same type of patients, would be most useful?
    - What level of granularity (for example, individual clinician or group performance) would be appropriate?

Enhanced Information for Patients

Patient Reported Measures

CMS aims to enhance the patient voice in MVPs. The agency specifically requests feedback on the following questions:

- What patient experience/satisfaction measurement tools or approaches to capturing information would be appropriate for inclusion in MVPs?
    - How could current commercial approaches for measuring the customer experience outside of the health care sector (for example, single measures of satisfaction or experience) be developed and incorporated into MVPs to capture patient experience and satisfaction information?
- What approaches should be taken to get reliable performance information for patients using patient reported data, in particular at the individual clinician level?
    - Given the current TIN reporting structure, are there recommendations for ensuring clinician level specific information in MVPs?

  - Should clinicians be incentivized to report patient experience measures at the individual clinician level to facilitate patients making informed decisions when selecting a clinician, and, if so, how?
- How should patient-reported measures be included in MVPs?
  - How can the patient voice be better incorporated into public reporting under the MVP framework, in particular at the individual clinician level?

Publicly Reporting MVP Performance Information

As CMS considers publicly reporting MVP performance information, the agency wants to ensure that patients have information that is important and useful, including information on clinician performance, cost, quality, patient experience, and satisfaction with care. The agency specifically requests feedback on the following questions:

- What considerations should be taken into account if the agency publicly report a value indicator, as well as corresponding measures and activities included in the MVPs?
- What data elements should be included in a value indicator? For example, should all reported measures and activities be aggregated into the value indicator?
- How would a value indicator, based on information from MVPs, be useful for patients making health care decisions?
- What methods of displaying MVP performance information should be considered, other than the current approach of using star ratings for quality measure information on clinician profile pages?
- What factors should be considered to ensure publicly reported MVP information is comparable across relevant clinicians and groups?

Group Reporting

CMS is proposing to revise existing policies on group reporting related to the Promoting Interoperability performance category. The proposed revision would state that "individual eligible clinicians that elect to participate in MIPS as a group must aggregate their performance data across the group's TIN, and for the Promoting Interoperability performance category, must aggregate the performance data of all of the MIPS eligible clinicians in the group's TIN for whom the group has data in CEHRT."

The agency is also proposing to revise existing policies to state that solo practitioners and groups of 10 or fewer eligible clinicians that elect to participate in MIPS as a virtual group must aggregate their performance data across the virtual group's TINs. For the Promoting Interoperability performance category, they must aggregate the performance data of all of the MIPS eligible clinicians in the virtual group's TINs for whom the virtual group has data in CEHRT.

MIPS Performance Category Measures and Activities

CMS proposes to increase the performance threshold from 30 points in 2019 to 45 points in 2020 and 60 points in 2021. In order to meet the requirements, set out by Congress to be met by the sixth year of the program, the agency also proposed to increase the additional performance threshold for exceptional performance to 80 points in 2020 and to 85 points in 2021.

Proposals for the MIPS performance categories:

- Reduce the Quality performance category weight to 40 percent in 2020, 35 percent in 2021, and 30 percent in 2022
- Increase the Cost performance category weight to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022

Proposals for the Quality performance category: the agency proposes to continue to focus on high-priority outcome measures and add new specialty sets for the following specialties: Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology.

Table 43 shows proposed scoring policies for the quality performance category for the 2020 MIPS performance period.

Measure Type	Description	Scoring Rules
Class 1	Measures that are submitted or calculated that meet all the following criteria: 1) Has a benchmark; 2) Has at least 20 cases; and 3) Meets the data completeness standard (generally 70 percent for 2020).	3 to 10 points based on performance compared to the benchmark
Class 2	Measures that are submitted and meet data completeness, but do not have either of the following: 1) A benchmark 2) At least 20 cases	3 points
Class 3	Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum.	MIPS eligible clinicians other than small practices will receive zero measure achievement points. Small practices will continue to receive 3 points.

For the Cost performance category, CMS is proposing to add 10 new episode-based cost measures, and to revise two current measures (Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost). Episode-based measures, set out in the below table, are developed to represent the cost to Medicare for items and services furnished during an episode of care.

Measure Topic	Episode Measure Type

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

The agency also proposes to modify the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and seeks comment on including additional episode-based measures in future rulemaking.

For the Improvement Activities performance category, CMS is proposing the following changes:

- Modify the definition of a rural area at §414.1305 to mean "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," which corrects the Health Resources and Services Administration (HRSA) Area Health Resource file name;
- Remove the criteria for patient-centered medical home designation that a practice must have received accreditation from one of four accreditation organizations that are nationally recognized or comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition;
- Increase the participation threshold for group reporting from a single clinician to 50 percent of the clinicians in the practice;
- Remove 15 improvement activities from the Inventory beginning with the 2020 performance period; modify seven existing improvement activities for 2020 performance period and future years; and add two new improvement activities for 2020 performance period and future years (See Appendix II of the Proposed Rule).
- Conclude the CMS Study on Factors Associated with Reporting Quality Measures at the end of the CY 19 Performance Period, complete the data analysis, and make recommendations to improve outcomes, reduce burden, and enhance clinical care.
    - This 3-year study was created in the CY17 QPP final rule to examine whether there were improved outcomes, reduced burden in reporting, and enhancements in clinical care by selected MIPS eligible clinicians that focused on a data driven approach to quality measurement. As an incentive, MIPS eligible clinicians who successfully participated in the study received full credit in the Improvement Activities performance category.
- Update the Improvement Activity Inventory and establishing criteria for removal in the future.

The below table shows the proposed criteria for removal of measures.

Factor 1	Activity is duplicative of another activity

Factor 2	There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice
Factor 3	Activity does not align with current clinical guidelines or practice
Factor 4	Activity does not align with at least one meaningful measure area
Factor 5	Activity does not align with the quality, cost or Promoting Interoperability performance categories
Factor 6	There have been no attestations of the activity for three consecutive years
Factor 7	Activity is obsolete.

For the Promoting Interoperability performance category, the agency requested comment on several areas. Table 41 in the proposed rule sets out the objectives and measures for the promoting interoperability performance category in 2020 (particularly relevant to opioids, prescription drug prescribing and monitoring, and EHRs).

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APM

The agency expects that 10 APMs will satisfy the requirements to be MIPS APMs for the 2020 MIPS Performance Period:

- Comprehensive ESRD Care Model (all tracks)
- Comprehensive Primary Care Plus Model (all tracks)
- Next Generation ACO Model
- Oncology Care Model (all tracks)
- Medicare Shared Savings Model (all tracks)
- Medicare ACO Track +1 Model
- Bundled Payments for Care Improvement Advanced
- Maryland Total Cost of Care Model (Maryland Primary Care Model)
- Vermont All-Payer ACO Model
- Primary Care First (al tracks)

Calculating MIPS APM Performance Category Scores

The APM scoring standard is intended to reduce the reporting burden for MIPS eligible clinicians participating in MIPS APMS. In order to achieve this goal, CMS proposes new approaches to quality performance category scoring, which include:

- Allowing MIPS eligible clinicians participating in APMS to report on MIPS quality measures in the same manner as set out in the policy for the Promoting Interoperability performance category;
- Applying a minimum score of 50 percent, called an “APM Quality Reporting Credit” for certain APM entities where APM quality data cannot be used;
- Using quality data to calculate an APM Entity group level score when an APM Entity has reported quality measures to MIPS on behalf of the APM Entity group;
- Applying any bonuses or adjustments available to MIPS groups for measures reported by the APM Entity, as applicable; and

- Applying both the application-based and the automatic extreme and uncontrollable circumstances policies to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standards and report on MIPS quality measures.

MIPS Final Score Methodology

Performance Category Scores

CMS includes several proposals for scoring policies that will assist in the transition from MIPS to MVPs. Specifically, the agency proposes to:

- Maintain the 3-point floor for measures that can be scored for performance;
- Develop benchmarks based on flat percentages in specific cases where the agency determines that otherwise applicable benchmarks could incentivize inappropriate treatment;
- Continue the scoring policies for measures that do not meet the case-minimum requirement, do not have a benchmark, or do not meet the data-completeness criteria;
- Maintain cap on measure bonus points for high-priority measures & end-to-end reporting; and
- Continue the improvement scoring policy.

Calculating the Final Score

CMS is proposing to continue the complex patient bonus for the 2022 MIPS payment year and to establish performance category reweighting policies for the 2022, 2023, and 2024 MIPS payment years.

Table 46, transcribed from the proposed rule, summarizes the proposed weights for each performance category for the final score.

Performance Category	2022 MIPS Payment Year	2023 MIPS Payment Year	2024 MIPS Payment Year
Quality	40%	35%	30%
Cost	20%	25%	30%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

MIPS Payment Adjustments

CMS requests feedback on two proposed policies regarding the final score used in MIPS payment adjustment calculations for the 2022 and 2023 MIPS payment years:

- Set the performance threshold at 45 points and 60 points respectively;
- Set the additional performance threshold for exceptional performance at 80 points and 85 points respectively.

Targeted Review, Data Validation and Auditing

A targeted review is a process where MIPS eligible clinicians or groups can request that CMS review the calculation of their 2019 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. CMS proposes several policies related to targeted review:

1) Identify who is eligible to request a targeted review;
2) Revise the timeline for submitting a targeted review request;
3) Add criteria for denial of a targeted review request;
4) Update requirements for requesting additional information;
5) State who will be notified of targeted review decisions and require retention of documentation submitted; and
6) Codify the policy on scoring recalculations.

Proposed Requirements for MIPS Performance Categories that Must be Supported by Third Party Intermediaries

CMS utilizes third party intermediaries as a useful way to fulfill MIPS requirements while reducing clinician reporting burden. The agency proposes to modify the criteria for approval as a third party intermediary, and to establish new requirements to promote continuity of services for clinicians that use third party intermediaries.

CMS proposes several changes related to QCDR measures, which include:

- Updates to QCDR approval criteria, including requirements to engage in activities to foster improvement in the quality of care and enhance performance feedback requirements
- Updates to QCDR measures, including consideration for measure approval, requirements for measure approval, considerations for measure rejection, the approval process, and measures that have failed to reach benchmarking thresholds.

CMS proposes to update qualified registry required services, including requiring qualified registries to support all three performance categories when data submission is required. The agency also proposes to require qualified registries to provide performance feedback to clinicians at least four times per year.

The agency also sets out proposals to clarify remedial action and termination provisions for third party intermediaries.

<u>Public Reporting on Physician Compare</u>

In order to more completely and accurately reference the data available, CMS is proposing to publicly report the following information on the Physician Compare Initiative website:

- Aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians; and
- An indicator either on the profile page or in the database that displays if a MIPS eligible clinician is scored using facility-based measurement.

The agency also seeks feedback relating to publicly reporting Quality Performance category information and Promoting Interoperability category information, although there are no specific proposals for these two categories.

Key APM Proposals

CMS is required to make an incentive payment to Qualifying APM Participants (QPs) for achieving threshold levels of participation in Advanced APMs. The agency included several proposals, discussed below, related to the APM Incentive.

CMS estimates the following participation and payment rates for the 2022 payment year:

- Between 175,000-250,000 clinicians will become Qualifying APM Participants (AP), which means they are excluded from the MIPS reporting requirements and qualify for a lump sum APM Incentive Payment.
- Total lump sum APM Incentive payment: $500-600 million.
- MIPS payment adjustments, which only apply to payments for covered professional services provided by MIPS eligible clinicians, will be equally distributed between:
    - Negative MIPS payment adjustments ($584 million); and
    - Positive MIPS payment adjustments ($584 million).
- An additional $500 million is available for exceptional performance by MIPS eligible clinicians.

Provisions Related to APM Requirements

Bearing Financial Risks for Monetary Losses

CMS includes several policies in the proposed rule related to the Advanced APM criterion bearing financial risk for monetary losses. The agency is proposing to modify the definition of marginal risk when determining whether a payment arrangement is an Other Payer Advanced APM. The proposed computation would be: adding the marginal risk rate at each percentage level to determine participants' losses, and then dividing it by the percentage above the benchmark to get the average marginal risk.

QP and Partial QP Determinations

CMS is proposing that beginning with the 2020 QP Performance Period, Partial QP status will apply only to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status. The agency also proposes that an eligible clinician will not be considered a QP or a Partial QP for the year when an APM Entity terminates from an Advanced APM.

All-Payer Combination Options---Aligned Other Payer Medical Home Models

CMS is proposing to add the term "Aligned Other Payer Medical Home Model" to the definitions section for the MIPS and APM program. This term would have the same characteristics as the terms "Medical Home Model" and "Medicaid Medical Home Model," but would apply to other payment arrangements. This term would apply to an arrangement that the agency determines to have the following characteristics:

- The other payer payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.

- For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;
- Empanelment of each patient to a primary clinician; and
- At least four of the following:
  - Planned coordination of chronic and preventive care;
  - Patient access and continuity of care;
  - Risk-stratified care management;
  - Coordination of care across the medical neighborhood;
  - Patient and caregiver engagement;
  - Shared decision-making; and/or
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

The agency also proposes changes to the marginal risk rate and expected expenditures for Advanced APMs.

MIPS Measures

Each year CMS proposes changes to the MIPS measures set. The changes below apply to endocrinologists.

Proposed MIPS Quality Measures for 2022 MIPS Payment Year and Future Payment Years

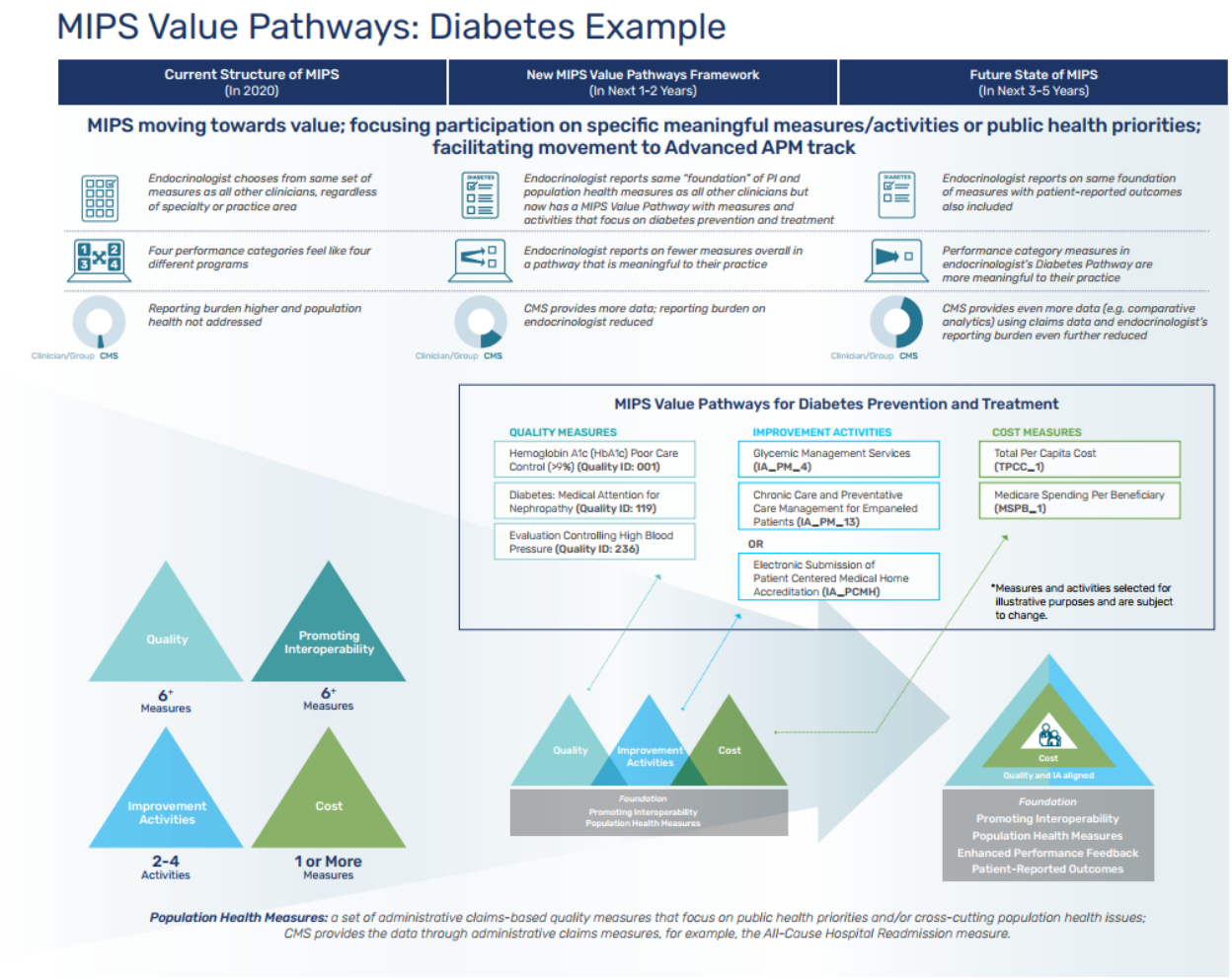
- All-Cause Unplanned Admission for Patients with Multiple Chronic Diseases

Proposed Changes to Specialty Measure Sets for 2022 MIPS Payment Year and Future Payment Years

Endocrinology---Proposed Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had HbA1c > 9.0% during the measurement period.	Intermediate Outcome/Effective Clinical Care	NCQA
Screening for Osteoporosis for *Women Aged 65-85 Years of Age:* Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis	Process/Effective Clinical Care	NCQA
Diabetes Eye Exam	Process/Effective Clinical Care	NCQA
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -Diabetes or Left Ventricular Systolic D	Process/Effective Clinical Care	American Heart Association
Diabetes: Medical Attention for Nephropathy	Process/Effective Clinical Care	NCQA
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Examination	Process/Effective Clinical Care	American Podiatric Medical Association
Preventive Care and Screening—BMI Screening and Follow-up Plan	Process/Community + Population Health	CMS
Documentation of Current Medications in the Medical Record	Process/Patient Safety	CMS
Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process/Community + Population Health	CMS

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/Community + Population Health	PCPI
Controlling High Blood Pressure	Intermediate Outcome/Effective Clinical Care	NCQA
Closing the Referral Loop: Receipt of Specialist Report	Process/Communication + Care Coordination	CMS
Osteoporosis Management in Women who Had a Fracture	Process/Effective Clinical Care	NCQA
Station Therapy for the Prevention and Treatment of Cardiovascular Disease	Process/Effective Clinical Care	CMS
Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Process/Effective Clinical Care	Oregon Urology Institute
Adult Immunization Status	Process/Community + Population Health	NCQA

Appendix A


MIPS Value Pathways: Diabetes Example
Current Structure of MIPS (In 2020)
New MIPS Value Pathways Framework (In Next 1-2 Years)
Future State of MIPS (In Next 3-5 Years)
MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track
Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area
Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment
Endocrinologist reports on same foundation of measures with patient-reported outcomes also included
Four performance categories feel like four different programs
Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice
Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice
Reporting burden higher and population health not addressed
CMS provides more data; reporting burden on endocrinologist reduced
CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced
Clinician/Group CMS
MIPS Value Pathways for Diabetes Prevention and Treatment
QUALITY MEASURES
Hemoglobin A1c (HbA1c) Poor Care Control (>9%) (Quality ID: 001)
Diabetes: Medical Attention for Nephropathy (Quality ID: 119)
Evaluation Controlling High Blood Pressure (Quality ID: 236)
IMPROVEMENT ACTIVITIES
Glycemic Management Services (IA_PM_4)
Chronic Care and Preventative Care Management for Empaneled Patients (IA_PM_13)
OR
Electronic Submission of Patient Centered Medical Home Accreditation (IA_PCMH)
COST MEASURES
Total Per Capita Cost (TPCC_1)
Medicare Spending Per Beneficiary (MSPB_1)
*Measures and activities selected for illustrative purposes and are subject to change.
Quality
6+ Measures
Promoting Interoperability
6+ Measures
Improvement Activities
2-4 Activities
Cost
1 or More Measures
Quality
Improvement Activities
Cost
Foundation
Promoting Interoperability
Population Health Measures
Cost
Quality and IA aligned
Foundation
Promoting Interoperability
Population Health Measures
Enhanced Performance Feedback
Patient-Reported Outcomes
Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.