



Summary of 2020 changes to the Medicare Physician Fee Schedule, Quality Payment Program, and other federal programs

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Introduction

On July 29, 2019 the Centers for Medicare & Medicaid Services (CMS) [published](#) Proposed Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies for Calendar Year 2020, including revisions to the Quality Payment Program (QPP). The provisions contained in this rule would apply to payment rates and policies for services supplied under the PFS on or after January 1, 2020 and are only proposed at this point. A final rule is expected in late fall 2019. Below is a summary of the major provisions of this proposed rule compiled by ACP Regulatory Affairs staff. Access the CMS [press release](#), [PFS fact sheet](#), and [QPP fact sheet](#) for more information.

I. Payment and Coding Changes

2020 Conversion Factor

The estimated 2020 PFS Conversion Factor is 36.09, up from 36.04 in 2019. This reflects the budget neutrality adjustment and first year of the 0 percent update adjustment factor under the Medicare Access and CHIP Reauthorization Act (MACRA).

CY 2019 Conversion Factor		36.0391
Statutory Update Factor	0.00% (1.0000)	
CY 2020 RVU Budget Neutrality Adjustment	0.14% (1.0014)	
CY 2020 Conversion Factor		36.0896

Practice Expense, Malpractice, and Geographic Pricing Cost Index Relative Value Units

CMS (“The Agency”) proposes updates to the direct practice expense inputs for individual codes based on recommendations from the Relative Value Unit (RVU) Update Committee (RUC). The Agency proposes to use invoices supplied by specialty societies to update practice expense for supplies and equipment as they continue to transition to updated pricing for medical supplies and equipment. For CY 2020, CMS is conducting a statutorily required three-year review of Geographic Pricing Cost Index (GPCI) RVUs. The proposal does not include the 1.0 work GPCI floor, which the Balanced Budget Act of 2018 (BBA) only extended through 2019. Additionally, CMS proposes to align the malpractice premium data update with the malpractice GPCI RVUs update. The Agency proposes to review, and if necessary update, malpractice RVUs at least every three years, similar to GPCI RVUs.

Evaluation and Management (E/M) Office Visits

In the final PFS for CY 2019, CMS finalized a bold strategy for 2021 to reduce the administrative burden in documenting and auditing Evaluation and Management (E/M) services. However, in this proposed rule, CMS is making significant changes to the previously finalized policy.

Therefore, effective January 1, 2021, CMS proposes to adopt Current Procedural Terminology (CPT) Editorial Panel-recommended revisions to office/outpatient E/M code descriptors,

prefatory language, and accompanying interpretive guidelines, which would govern what determines different levels of medical decision making (MDM) for office/outpatient E/M visits. Some changes parallel previously finalized policies for 2021, including the ability to choose time or MDM-based billing. However, several key aspects differ, including:

- *The number of code levels* – CMS proposes to retain 4 levels of E/M codes for new patient (99202 – 99205) and 5 levels of codes for established patients (99211 – 99215). CMS previously finalized paying a single flat fee for E/M levels 2-4 and retaining separate payment for Level 5 visits.
- *Times* – The current CMS proposal adjusts the time and work RVUs for office visit codes. For most codes, the time it takes to perform these services is 23-38 percent longer than what is currently reflected in the Medicare Physician Fee Schedule. Consistent with the time increase, these services are proposed with increased values of 13-34 percent.
 - Importantly, there is no required minimum time for services 99202-99215 as long as MDM supports the required documentation for the level of service.
 - Time is also an option for code selection.
- *Including all time spent on the day of the visit* – The rationale for increased time was in part due to the increased non-face-to-face time spent reviewing additional patient data available within electronic health records (EHRs). Physician practices are encouraging more follow up non-face-to-face care to preclude additional visits and are also spending more time on asynchronous communication (e.g., email or phone calls) with patients.
- *The elimination of certain coding level options such as use of history and exam or time in combination with MDM* – History and Exam are no longer used for code selection or a deciding factor in program integrity reviews but are performed and documented as medically appropriate. MDM or Total Time on the Date of the Encounter may be used for code selection (without regard to whether counseling and coordination of care dominate the service).
 - MDM is based on the number and complexity of problems addressed, the amount and/or complexity of data to be reviewed and analyzed, and the risk of complications and/or morbidity or mortality of patient management. Four levels remain (straightforward, low complexity, moderate complexity and, high complexity). Two of three of the MDM elements must be met:
 - Number of Diagnoses or Management Options;
 - Amount and/or Complexity of Data to be Reviewed; and/or
 - Risk of Complications and/or Morbidity or Mortality.
- *Add-on code* – In addition to the CPT and RUC recommended changes, CMS proposes to implement a Medicare-specific add-on code for E/M office visits to acknowledge the complexity associated with visits serving as a focal point for all medical care or for ongoing care related to a patient's single, serious, or complex chronic condition. CMS impact tables indicate that more than \$1.5 billion will be redistributed between specialties if this code is implemented.

CMS would adopt RUC-recommended values, times, and practice costs for E/M office visits (summarized below), which would result in an approximate 5 percent redistribution of PFS payments to physicians and other health professionals who routinely provide office visits from those who do not. CMS seeks comments on whether it is necessary to: 1) make systematic adjustments to other services to maintain relativity between these services and E/M office visits; and 2) make corresponding adjustments to E/M codes describing visits in other settings.

RUC-Recommended Pre-, Intra-, Post-Service and Total Times and Actual Total Time

HCPCS	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Actual Total Time	RUC-Rec Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

Office/Outpatient E/M Services Code Set, and the New Prolonged Services Code

HCPCS Code	Current Total Time	Current Work RVU	CY 2021 Total Time	CY 2021 Work RVU	RUC-rec Total Time	RUC-rec Work RVU
99201	17	0.48	17	0.48	N/A	N/A
99202	22	0.93	22	1.76	22	0.93
99203	29	1.42	29	1.76	40	1.6
99204	45	2.43	45	1.76	60	2.6
99205	67	3.17	67	3.17	85	3.5
99211	7	0.18	7	0.18	7	0.18
99212	16	0.48	16	1.18	18	0.7
99213	23	0.97	23	1.18	30	1.3
99214	40	1.5	40	1.18	49	1.92
99215	55	2.11	55	2.11	70	2.8
99XXX	N/A	N/A	N/A	N/A	15	0.61

E/M Documentation Requirements

CMS proposes to amend existing regulation and specify that, when furnishing their professional services, clinicians in all settings, not just teaching, may review and verify (sign/date) notes in a patient's medical record made by other physicians, residents, nurses, students, or other members of the medical team, rather than fully re-documenting the information. This proposal expands on previous burden reduction proposals and is intended to apply more broadly to documentation requirements for professional services furnished by physicians, Physician Assistants (PAs), and Advance Practice Registered Nurses (APRNs) in all settings, regardless of

whether they are acting in a teaching capacity. In previous rulemaking, CMS eliminated the requirement to document medical necessity of furnishing visits in the home and re-record elements of history and physician exam when there is evidence the information has been reviewed and updated. Physicians must now only document that they reviewed and verified information regarding the chief complaint and history recorded by ancillary staff or the patient.

Effective 2021, the Agency proposes to eliminate the use of history and/or physical exam for purposes of determining the level of E/M code. While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam would contribute to both the time and medical decision making (MDM), these elements alone would not determine the appropriate code level. E/M code descriptors would be updated to reflect modified CPT Editorial Panel language that clinicians perform a "medically appropriate history and/or examination." Level 1 new patient code 99201 would also be eliminated because it is only differentiated from 99202 by history and exam elements.

CMS proposes to allow the choice of MDM or time to decide the level of office/outpatient E/M visit, along with updated guidelines for both. These updates are based on the recommendations of the AMA Workgroup, of which ACP was an active participant. The MDM sub-components were not materially changed, but extensive edits were made to the elements for code selection and numerous definitional revisions and clarifications were made. For example, ambiguous terms and concepts (e.g. "mild") would be clarified (e.g. "acute or chronic illness with systemic symptoms"), and important terms like "Independent historian" would be formally defined. Data elements were also redefined to focus on tasks that affect the management of the patient (e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/qualified health provider). To minimize disruption, the current CMS Table of Risk was used as a foundation for the MDM requirements and current CMS Contractor audit tools were consulted. The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and not MDM.

Physician Supervision for Physicians Assistant (PA) Services

CMS proposes to loosen Medicare physician supervision requirements for PA services by deferring to state law and state scope of practice rules, which would align with physician supervision physician collaboration requirements for NP and CNS services. This would apply in states where their services are provided with medical direction and supervision as provided by state law in which the services are performed. In states where this is not the case, the requirement would be reported by documentation in the medical record.

Chronic Care Management (CCM) Services

To improve payment accuracy for non-complex chronic care management (CCM) services, CMS proposes to adopt two new G-codes with new increments of clinical staff time instead of the

existing single CPT code. The first G-code would describe the initial 20 minutes of clinical staff time and the second G-code would describe each additional 20 minutes thereafter. CMS proposes a work RVU of 0.61 for the first G-code, and 0.54 for the second G-code. The Agency requests comment on whether to implement these G-codes in 2020 or wait for anticipated changes to CPT in 2021. CMS also proposes to clarify the language describing the comprehensive care plan required for CCM codes. The new codes are as follows:

- *Healthcare Common Procedure Coding System (HCPCS) code GCCC1:* CCM services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- *HCPCS code GCCC2:* CCM services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (Use GCCC2 in conjunction with GCCC1).

Complex Chronic Care Management Services

The Agency proposes to adopt two G-codes for complex CCM services in place of the two existing CPT codes. They are proposing a work RVU of 1.00 for the initial 60 minutes of clinical staff time directed by a physician or other qualified health care professional and 0.50 for each additional 30 minutes. These G-codes would be temporary until the CPT Editorial Panel can consider revising the current code descriptors for complex CCM services. The new codes are:

- *HCPCS code GCCC3:* Complex CCM services, with the following required elements: 1) multiple (2+) chronic conditions expected to last at least 12 months, or until the death of the patient; 2) chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 3) comprehensive care plan established, implemented, revised, or monitored; 4) moderate or high complexity medical decision making; and 5) 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.
- *HCPCS code GCCC4:* Complex CCM services, each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (Report GCCC4 in conjunction with GCCC3).

To clarify what a CCM care plan typically includes, CMS proposes that a comprehensive care plan would typically include, but is not limited to, the following elements:

- A problem list
- Expected outcome and prognosis
- Measurable treatment goals
- A cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Requirements for periodic review

- Revision of the care plan (if applicable)
- Interaction and coordination with outside resources and practitioners

Feedback is sought on the proposal, including language that would best guide clinicians as they decide what to include in their CCM comprehensive care plans.

Principle Care Management (PCM) Services

CCM codes currently require patients to have two or more chronic conditions so CMS proposes to create two new payable codes for Principle Care Management (PCM) services that would entail providing care management services to patients with a single serious, high-risk condition. HCPCS code GPPP1 has a proposed work RVU of 1.28 and could be reported for each calendar month at least 30 minutes of physician or other qualified health care provider time is spent on comprehensive care management for a single high-risk disease or complex chronic condition. HCPCS code GPPP2 has a proposed work RVU of 0.61 and could be reported for each calendar month at least 30 minutes of clinical staff time is spent on comprehensive management for a single high-risk disease or complex chronic condition.

- *HCPCS code GPPP1: CCM services for a single high-risk disease, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: 1) one complex chronic condition lasting at least 3 months, which is the focus of the care plan; 2) the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization; 3) the condition requires development or revision of disease-specific care plan; and 4) the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities.*
- *HCPCS code GPPP2: CCM for a single high-risk disease services, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: 1) one complex chronic condition lasting at least 3 months, which is the focus of the care plan; 2) the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization; 3) the condition requires development or revision of disease-specific care plan; and 4) the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities.*

Opioid Use Disorder Telehealth Services

CMS proposes to add the new payment codes for opioid treatment services to the Category 1 list of telehealth services, which entails services similar to professional consultations, office visits, and office psychiatry services on the list of currently covered telehealth services. The addition of the codes aims to expand the reach of opioid use disorder treatment, particularly in rural areas experiencing high rates of opioid use or overdose. The new codes are as follows:

- *HCPCS code GYYY1*: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- *HCPCS code GYYY2*: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- *HCPCS code GYYY3*: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes.

Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

The Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) directed CMS to establish a new Part B benefit category for opioid use disorder (OUD) treatment services delivered by opioid treatment programs (OTP, also known as methadone clinics). Under this proposal, CMS would establish a bundled payment for OTPs for the delivery of medication assisted treatment (MAT) for OUD. The bundle would include FDA-approved medications for OUD (methadone, buprenorphine, naltrexone), dispensing and administration of such medication, substance use counseling, individual and group therapy, and toxicology testing, and other items and services that the Secretary determines are appropriate, which the Agency also seeks suggestions on (but specifically notes no meals or transportation). The Agency requests information on other OUD treatment medications in the development pipeline and how they could be incorporated into the benefit in the future. Certain services, specifically substance use counseling and therapy would be delivered via telecommunication. Under past regulations, telemedicine may not expand scope of practice or permit practice in a jurisdiction where the clinician is not licensed to practice. CMS would define a single episode of care as one week.

Under statute, OTPs must be: 1) accredited by a SAMHSA-approved accrediting body; 2) certified by SAMHSA; and 3) enrolled in Medicare. The rule establishes special requirements OTPs must meet in addition to standard Medicare enrollment requirements, including but not limited to: 1) maintaining and submitting a list of all eligible professionals legally authorized to prescribe, order, or dispense controlled substances on behalf of the OTP; 2) satisfying risk screening requirements (including site visits and background checks), and 3) not employing or contracting with any individual who within the preceding 10 years have been convicted of a related federal or state felony, been revoked from Medicare, are on the Medicare preclusions list, or have a current or prior adverse action imposed by a state oversight board. CMS intends to maintain program integrity and patient safety through monitoring billing patterns and quality of care, performing audits, and revoking/terminating Medicare enrollment and provider agreements for abusive or dangerous prescribing patterns or non-compliance with Medicare requirements. Enrollment revocations or terminations may be appealed.

Remote Patient Monitoring (RPM)

CMS proposes a new CPT code to report time spent beyond the initial 20 minutes for evaluating patient generated health data obtained through remote patient monitoring (RPM). For all RPM services, CMS also proposes to downgrade supervision requirements from direct to general supervision, which would allow clinical staff to monitor patient data and interact with patients remotely. CMS also proposes to create six new codes to reimburse for non-face-to-face patient-initiated digital communications that require a clinical decision, listed below.

- *CPT codes 98X00, 98X01, 98X02* – Qualified non-physician healthcare professional online digital evaluation and management service for an established patient, up to 7 days, cumulative time 5–10 minutes, 11-20 minutes, and 21+ minutes respectively.
- *HCPCS codes GNPP1, GNPP2, GNPP3* – Qualified non-physician healthcare professional online assessment for an established patient, up to 7 days, cumulative time 5-10 minutes, 11-20 minutes, and 21+ minutes respectively.

Coinurance for Colorectal Cancer Screening Tests

CMS seeks comment on whether the physician, or their staff, should be required to notify patients of the cost-sharing implications and Medicare coverage rules prior to performing a screening colonoscopy. Specifically, whether physicians should be required to provide a verbal notice with a notation in the medical record, or whether CMS should consider a different approach to informing patients of the copayment implications, such as a written notice with standard language that CMS would require the physician, or their staff, to provide to patients prior to a colorectal cancer screening. CMS also seeks comments on what mechanism, if any, should be considered to monitor compliance.

Therapy Services

To codify provisions in the BBA, CMS proposes to repeal Medicare outpatient therapy caps and the therapy cap exceptions process while retaining the cap amounts as thresholds and requiring medical review to ensure therapy services are furnished when appropriate, as justified by appropriate documentation in the patient's medical record. After expenses incurred for the beneficiary's outpatient therapy services for the year have exceeded one or both of the previous therapy cap amounts, all therapy suppliers and providers would continue to use an appropriate modifier on claims (KX modifier). There would be one cap for combined physical therapy and speech language pathology services and a separate cap for occupational therapy services, indexed annually. The medical review threshold would also be lowered to \$3,000.

Opportunities for Bundled Payments under the Physician Fee Schedule

CMS is requesting comment on opportunities to expand the concept of bundled payments to services within the PFS architecture. Options could include a per-beneficiary payment for multiple covered services or condition-specific episodes.

Open Payments

CMS proposes to codify statutory changes to expand the definition of eligible clinician to include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives in addition to the previously covered physicians and teaching hospitals. CMS also proposes to revise the “nature of payment” categories by consolidating separate categories for serving as faculty and a speaker for both accredited/certified and unaccredited/non-certified continuing education programs, and to add three new categories: debt forgiveness, long-term medical supply or device loans (longer than 90 days), and acquisitions. Finally, CMS proposes to require applicable manufacturers and group purchasing organizations to report the device identifier (fixed portion of the unique device identifier).

New Beneficiary Notification Requirements Related to Infusion Therapy Options

The 21st Century Cures Act created a Part B benefit to cover home infusion therapy-associated professional services for certain drugs and biologicals administered intravenously or subcutaneously through a pump that is an item of durable medical equipment in the beneficiary’s home. The Act requires notification of the available options of infusion therapy to the patient, which could include verbal discussion with EHR annotation or in writing with written patient attestation. CMS seeks input on the appropriate form, manner, and frequency for physicians to satisfy the requirement of notifying beneficiaries with their infusion therapy options under Part B.

Deferring to State Scope of Practice Requirements

CMS proposes to allow an anesthetist or a physician to examine and evaluate the patient before surgery for anesthetist and planned procedure risk, which would allow for pre- and post-procedure anesthesia evaluations to be performed by the same clinician. CMS also proposes to allow hospice staff to accept drug orders from physicians, NPs, or PAs, provided the PA is acting within his/her state scope of practice requirements and hospice rules, is the patient’s attending physician, and is not employed by or has a contractual agreement with the hospice.

Advisory Opinions on the Application of the Physician Self-Referral (“Stark”) Law

CMS proposes several changes to the Stark Law advisory opinion process, including the logistics of requesting and receiving an advisory opinion, as well as updating their scope, applicability, and permissible subject matter. Under current law, the Secretary is required, upon request and when requirements are met, to issue written advisory opinions regarding whether an arrangement involving a designated health service referral is prohibited under Stark Law. These advisory opinions are binding to the party or parties requesting the opinion and OIG is prohibited from opining on questions of interpretation, hypothetical situations, or those involving the activities of third parties. The proposed changes to the Stark Law advisory opinion process is outlined below:

- *Scope and Applicability* – CMS proposes that favorable advisory opinions would prevent penalties from being assessed on parties specific to the arrangement described in the request, regardless of whether they were a requestor of the opinion. Further, the Agency proposes that it would not pursue penalties for those parties specific to an arrangement that CMS determines is indistinguishable to the specific arrangement of an existing favorable advisory opinion. Finally, CMS proposes codifying that individuals and entities may reasonably rely on advisory opinions as non-binding guidance that illustrates the application of Stark Law to specific facts and circumstances.
- *Subject Matter* – CMS proposes relaxing existing restrictions that would allow the Agency to consider fulfilling requests in which they are aware of other investigations or proceedings that are substantially similar to the circumstances of the requestor. The Agency would also be permitted to deny a request that does not provide adequate information or does not respond to requests for additional information.
- *Timeline* – CMS proposes reducing the timeframe for fulfilling an advisory opinion request from 90 days to 60 days. The Agency is also considering offering an expedited option that would provide an advisory opinion within 30 days.
- *Fees* – CMS proposes replacing the current \$250 processing and issuing fee with a \$220 hourly fee, which potentially would have a cap. Should the Agency pursue an expedited pathway, they are considering a \$440 hourly fee.

II. Quality Payment Program

MIPS Value Pathways (MVP)

CMS proposes to overhaul the Merit-based Incentive Payment System (MIPS) with a new, mandatory reporting pathway called the MIPS Value Pathway (MVP) that would be effective in 2021. It aims to reduce burden on physicians and other clinicians and increase alignment with alternative payment models (APMs) by featuring a set of measures and activities that would align around a certain condition and/or specialty, thereby streamlining reporting across the four performance categories while reducing the overall number of individual measures and activities reported. CMS envisions that the number of required measures or activities per performance category would vary by MVP, though illustrative examples from the rule (which can be found in Table 34 starting on page 256) include no more than four measures or activities per performance category. Specifically, CMS is looking to integrate credit for the Promoting Interoperability (PI) and Improvement Activities Categories through the data it already collects for the Cost and Quality Categories. MVPs may include, but would not be limited to, population health measures; specialty and condition-specific measures; and measures that promote care coordination, patient engagement, and team-based care. CMS would prioritize outcomes measures, patient-reported measures, high priority clinical area measures, and measures that are calculated from administrative claims to reduce burden where feasible.

The MVP was largely based off of a similar proposal by the American Medical Association but differs notably in that the AMA proposed an optional pathway that would be offered in addition to, but would not outright replace, the traditional MIPS Program. In addition, under the AMA proposal, the PI Category would be satisfied with a simple attestation of using Certified EHR Technology (CEHRT). In contrast, CMS states that it is “not considering making modifications to the PI performance category as it becomes incorporated into the MVP framework at this time... [but is] seeking comment on how the PI category could evolve in the future to [create] greater cohesion between the MIPS performance categories,” such as measuring the use of health information technology (IT) in conducting improvement activities, while quality measures assess relevant quality outcomes.

Relatively little detail is provided in the rule; the Agency seeks stakeholder input in multiple areas related to design and implementation, including:

- How MVPS should be structured including which specialties and conditions MVPs should be designed around;
- What types of measures should be prioritized and which specific measures would be best and most appropriate, including whether measures calculated from administrative claims data would be preferred to measures that require active reporting;
- How CMS should engage specialty societies and other stakeholders in developing MVPs, including possibly establishing an open call for MVPs;
- Whether MVPs should be assigned to clinicians or groups by CMS or self-selected and how that would work for multispecialty practices (possibly through sub-TIN reporting);
- Whether clinicians and groups should choose between a small selection of related measures, or have a mandatory set of measures to report within each MVP;
- What should be the Agency’s strategies for implementation, including a possible trial or transition period;
- How patient assignment should be defined;
- How to support and accommodate rural and small practices;
- How to score MVPs;
- How to leverage MVPs to reduce barriers to participating in APMs;
- Performance feedback or data that would be useful for clinicians and patients, including access to timely claims and/or registry data and comparative performance; and

- How data should be displayed on Physician Compare.

Performance Category Weighting and Reweighting

The table below overviews the proposed MIPS performance category weights for the 2020 performance year onward. Compared to 2019, Quality would be reduced by 5 percent and Cost would increase by 5 percent. This would occur twice more in 2021 and 2022 to achieve final statutory MIPS performance category weights of 30 percent Quality, 30 percent Cost, 25 percent PI, and 15 percent Improvement Activities by 2022.

	2020	2021	2022 onward
Quality	40%	35%	30%
Cost	20%	25%	30%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

Reweighting for the 2020, 2021, and 2022 performance years are summarized in Tables 47-49 on pages 317-319. A few key points to note about category reweighting are as follows:

- As in the past, weight would generally be re-distributed to the PI and Quality Categories. However, CMS proposes to no longer weight the Improvement Activities Category above 15 percent in any circumstance.
- Because of substantial changes to the Cost Category, CMS would avoid redistributing weight to the Cost Category in 2020, except when both the PI and Quality Categories are reweighted to zero, in which case Cost would be weighted 85 percent.
- CMS would begin re-distributing weight to the Cost Category starting with the 2021 performance year.
- CMS proposes to allow reweighting for any performance category if it determines that data was inaccurate, unusable, or otherwise compromised due to circumstances outside of the clinician's control.
 - MIPS eligible clinicians are asked to self-identify if they believe they have compromised data and to not rely solely on a third party intermediary to do so.
- CMS would inform clinicians of applicable reweighting through performance feedback, as well as through routine QPP communication channels.

MIPS APM Scoring Standard

Final MIPS APM determinations will be announced via the CMS QPP website. However, CMS expects the following 10 APMs to qualify for the MIPS APM Scoring Standard for 2020:

- Comprehensive ESRD Care Model
- Primary Care First

- Next Generation Accountable Care Organization (ACO) Model
- Oncology Care Model
- Medicare Shared Savings Program
- Medicare ACO Track 1+ Model
- Maryland Total Cost of Care Model
- Vermont All-Payer ACO Model
- Comprehensive Primary Care Plus
- BPCI Advanced

CMS proposes granting APM Entity groups participating in a MIPS APM half automatic credit towards the Quality Category. However, certain limitations are being considered, including a set number of years and/or whether the APM is a two-sided risk model. Any data reported by a MIPS APM Entity would add to this base score. APM Entities required to report MIPS applicable quality data under the terms of their APM would be excluded, because it is assumed they would inherently reach half credit. CMS would look at individual and tax identification number (TIN)-level data and would use the highest reported score for each clinician, then average these together to determine the APM Entity's final score. Clinicians for which no data were reported would contribute a score of zero to the average APM Entity score. Bonus points would be added to the APM Entity level score only if not already accounted for in the individual scores. Virtual group data would not count under the MIPS APM scoring standard.

CMS would extend extreme and uncontrollable policies to clinicians under the APM scoring standard for the Quality Category, which includes possible reweighting to zero. However, if any quality data is submitted on behalf of the APM Entity, the Quality Category would not be reweighted to zero. While the TIN would not need to report data for clinicians that qualify for an exception, all clinicians in the TIN would count towards the TIN's weight when calculating the APM Entity score for the quality category.

Quality Category

CMS proposes the following measure-specific changes:

- CMS proposes to add, delete, and modify several measures and specialty measure sets, as summarized in Appendix 1 starting on page 452.
- CMS proposes to not score the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Web Interface Measure for the 2018 performance year due to previously inconsistent measure guidance, but would score the measure in 2019.
- CMS proposes to add an All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions claims-based measure. Measure specifications can be found in Table AA.1 on pages 458-459 of the rule. To allow for stakeholder input and consideration by the Measures Application Partnership (MAP), it would not be implemented until 2021.
- CMS is considering a new opioid measure entitled Potential Opioid Overuse, which would capture the proportion of adult patients who receive opioid therapy for 90 or more days with no more than a 7-day gap between prescriptions and a daily dosage of 90 morphine milligram equivalents or higher. Several EHR vendors have cited concerns

capturing several medication-specific data elements. CMS seeks further comment.

- The Agency requests feedback on several changes to the CAHPS for MIPS survey, including a new question on overall patient experience and satisfaction, open-ended narrative questions, collecting data at the clinician level, and collecting data via the web and email, in addition to phone and paper surveys.

CMS proposes to modify the measure development and removal process in the following ways:

- CMS is considering aligning the MIPS quality measure update cycle with the electronic clinical quality measure (eCQM) annual update cycle and seeks comment on this proposal.
- CMS proposes to remove measures in cases where the measure steward/owner refuses to enter into a user agreement with CMS.
- CMS proposes to remove measures that do not meet case minimum and reporting volumes for two consecutive performance periods, though CMS may retain measures that cover a key clinical priority area if the measure steward has a planned education/communication strategy to encourage reporting. Table Group C of Appendix 1 starting on page 673 summarizes the measures previously finalized for removal in 2020. However, CMS may delay removing certain measures pending public comment.

CMS proposes the following changes to data completeness requirements:

- CMS proposes to increase data completeness requirement for Part B claims, Quality Clinical Data Registry (QCDR), clinical quality measures (CQM), and eCQM measures from 60 percent to 70 percent. In addition, CMS is considering increasing data completeness thresholds specifically for topped out measures.
- CMS proposes to clarify that measures would not be required to have a benchmark in order to qualify for “high priority” bonus points, though they must meet case minimum and data completeness requirements and have a performance rate greater than 0 percent.

CMS proposes the following changes to the way it would score individual quality measures:

- CMS proposes to establish benchmarks based on flat percentages in cases where the standard benchmark could result in adverse treatment, patient harm, or unintended consequences. Flat benchmarks would be applied where the top decile exceeds 90% and would be proposed through formal rulemaking. For 2020, CMS has identified MIPS #1 Diabetes: Hemoglobin A1c Poor Control and MIPS #236 Controlling High Blood Pressure.
- CMS proposes to extend the 3-point floor for measures that meet case minimum and data completeness requirements and can be scored against a benchmark, 1-point floor

for measures that meet data completeness requirements but do not have a benchmark or fail to meet case minimum requirements, and 6-point cap on bonus points.

Cost Category

Final measures specifications and attribution methodologies for the MIPS cost measures will be made available at the MIPS resource library following publication of the final rule. Proposed measures and methodologies are summarized below.

Episode-based measures

CMS proposes to add the following episode-based cost measures:

- 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 (acute inpatient medical condition)*
- Lumbar spine fusion for degenerative disease, 1-3 Levels (procedural)
- Lumpectomy partial mastectomy, simple (procedural)
- Non-emergent coronary artery bypass graft (procedural)
- Renal or ureteral stone surgical treatment (procedural)

** The lower gastrointestinal hemorrhage measure is only being proposed for groups.*

Previously finalized attribution rules would apply. For acute inpatient medical condition-based measures, episodes would be attributed to the clinician who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN rendering at least 30 percent of inpatient E/M claim lines in that hospitalization. For procedural-based measures, episodes would be attributed to the clinician who renders a trigger service as identified by HCPCS/CPT codes. Previously established case minimums of 10 episodes for procedural measures and 20 episodes for acute inpatient medication condition measures would also

apply. CMS additionally seeks comment on whether it should create episode-based measures for the treatment of inpatient psychoses and related conditions in the future.

Redeveloped Total Per Capital Cost (TPCC) Measure

Based on concerns raised by ACP and other stakeholders related to the former Total Per Capita Cost (TPCC) Measure, which was continued from the Value-Based Payment Modifier, CMS proposes a completely redeveloped TPCC Measure, which includes these key changes:

- The proposed new attribution methodology would be triggered by a primary care E/M service that must be subsequently paired with either: 1) one or more additional services that are indicative of general primary care, such as an electrocardiogram or routine chest x-ray, or 2) a second E/M service at a later date. The goal is to establish a pattern of care. The first primary care service would trigger a one year-long risk window during which a clinician or group could be held responsible for the beneficiary's treatment costs. However, they would only be held responsible for costs that occur after this initial triggering service. The one-year risk window would be divided into four-week blocks. Only those that occur within the performance year would be scored. Any subsequent triggering events would re-start the one-year risk window.
- Within a single TIN, only the clinician performing the highest number of qualifying services would be attributed the beneficiary. However, costs for the same beneficiary could be attributed to multiple TINs within the same performance year.
- Qualifying services performed by clinicians who frequently perform non-primary care services or are in certain non-primary care focused specialties would be excluded.
- Beneficiary risk scores would be calculated on a rolling basis using diagnostic data from the year prior to that month, rather than using a set risk score for the performance year.
- A case minimum of 20 beneficiaries would continue to apply.

Redeveloped Medicare Spending Per Beneficiary (MSPB) Measure

CMS also introduces a completely redeveloped Medicare Spending Per Beneficiary (MSPB) Measure, including the following major changes:

- The proposed attribution methodology would distinguish between medical and surgical episodes and allow for attribution to multiple clinicians. Medical episodes would be attributed first to the TIN billing at least 30 percent of the inpatient E/M services during an inpatient stay, then to any clinician in the TIN who billed at least one inpatient service used for attribution. Surgical episodes would be attributed to any surgeon(s) who performs a related surgical procedure during the inpatient stay, as well as their TIN.

- Costs for certain services that are unlikely to be influenced by a clinician’s care decision would be excluded.
- A case minimum of 35 beneficiaries would continue to apply.

Improvement Activities Category

CMS proposes to remove the specific accrediting organizations previously listed for patient-centered medical homes and comparable specialty practice designations so as not to restrict to only these groups. The previously listed organizations include the Accreditation Association for Ambulatory Health care, the National Committee for Quality Assurance (NCQA), the Joint Commission Designation, and the Utilization Review Accreditation Commission (URAC). The Agency proposes to substantially increase the threshold from at least one clinician in the group to at least 50 percent of the group’s NPIs who must perform the same activity for the same continuous 90-day period. In addition, CMS specifies criteria that would be used when considering to remove activities, including whether a measure is outdated, duplicative, seldom reported, or does not align with current clinical guidelines or priority areas. Based on this new criteria, the Agency proposes to add two, modify seven, and remove 15 activities. The full inventory of proposed 2020 Improvement Activities can be found in Appendix 2.

Promoting Interoperability (PI) Category

For the PI Category, CMS proposes to maintain the minimum 90-day (up to a full year) reporting period, which aligns with the PI program for hospitals and crucial access hospitals. The Agency proposes to keep the “Query of Prescription Drug Monitoring Program (PDMP)” measure optional and available for five bonus points and would convert it from a numerator/denominator format to a “yes/no” attestation starting in 2019. CMS proposes to remove the “Verify Opioid Treatment Agreement” measure and seeks feedback on adding new, more effective opioid-related Health IT measures. Points for the “Support Electronic Referral Loops by Sending Health Information” measure would be redistributed to the “Provide Patients Access to Their Health Information” measure if an exclusion¹ is claimed. The Agency also proposes to revise the description of the “Support Electronic Referral Loops by Receiving and Incorporating Health Information” measure exclusion² to address concerns that the language in the previously finalized exclusion was unclear and seemed to create two different sets of exclusion criteria, making it more difficult for participants to claim. Both of these changes would take effect starting with the 2019 performance year. Below is a table summarizing the proposed PI objectives and measures for the 2020 performance year.

¹ The exclusion for “Support Electronic Referral Loops by Sending Health Information” is: Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

² The proposed updated exclusion criteria: Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period. For example, during the performance period, if a MIPS eligible clinician received 50 transitions of care, 50 referrals, and 50 patient encounters in which they have never before encountered the patient, the total sum of 150 would be above the threshold of fewer than 100 times, and therefore the MIPS eligible clinician would not be eligible for this exclusion.

Proposed Objectives, Measures, and Scoring Methodology for the 2020 PI Performance Period

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing**	10 points
	Query of PDMP	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 Info	40 points
Public Health and Clinical Data Exchange	Report to 2 different public health agencies / clinical data registries for any of the following: Immunization Registry Reporting** Electronic Case Reporting** Public Health Registry Reporting** Clinical Data Registry Reporting** Syndromic Surveillance Reporting**	10 points

**Exclusion available.

Because CMS does not yet have sufficient data to determine which PI measures are applicable to certain types of non-physician MIPS eligible clinicians (ECs), they propose to continue their existing policy of automatically reweighting the PI Category to zero and redistributing those points to other performance categories for non-physician ECs. However, as is currently the case, these clinicians can voluntarily choose to report on the PI category, and if they do, will be scored as any other EC would. CMS proposes to lower the threshold for groups to qualify for reweighting of the PI Category as hospital-based or non-patient-facing. Previously, every EC in the group must have independently qualified for reweighting in order for the group to qualify. Based on stakeholder feedback that this was too restrictive, CMS proposes to modify the requirement to state that a group may qualify for reweighting of the PI Category based on hospital-based or non-patient-facing status if more than 75 percent of the NPIs billing under the group's TIN meet the definition of hospital-based or non-patient-facing EC.

CMS seeks comment on several topics regarding the future of the PI Category which can be found starting on page 296 of the proposed rule and include the following:

- Potential new opioid-related measures;
- Efficiency metrics (such as duplicate labs or imaging);
- More specific requirements regarding how and when patients can access their health data, including how it relates to application programming interface (API);

- How to promote bi-directional exchange of health information with community partners;
- How CMS can facilitate and support private sector efforts to develop a workable and scalable patient matching strategy so that the lack of a specific uniform patient identifier (UPI) does not impede the free flow of information;
- How to integrate patient-generated health data into EHRs; and
- How to promote the safety of EHRs, including awarding points for attesting to performing an assessment based on Office of the National Coordinator (ONC) Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guides.

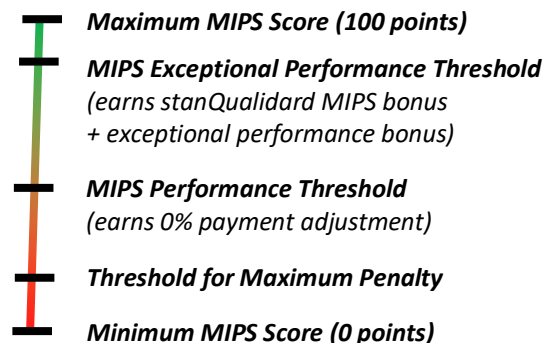
Medicaid Promoting Interoperability Program (outside of QPP)

Participation in the Medicaid PI program is separate from the MIPS PI performance category; however CMS proposes to align certain aspects of the two programs (in addition to further aligning the hospitals and critical access hospital programs). CMS proposes to align the eQMs for the Medicaid PI Program with those for the MIPS PI Category starting with the 2020 performance period. The Agency also proposes to require the same number of eQMs (six), along with the requirement that one must be an outcome measure, or alternatively a high-priority measure if one is not available. CMS would apply the same criteria to determine high-priority measures. While many of the Medicaid PI proposals align with MIPS requirements, one notable difference is a proposal to increase the minimum reporting period for the Medicaid PI Program to 274 consecutive days, as opposed to 90 days.

MIPS Payment Adjustments

CMS proposes to continue adding five bonus points to a final MIPS score for treating complex patient bonus, but reiterates it is intended to be a “short-term solution” and that it is actively working on long-term solutions to improve risk adjustment. Under MACRA, the maximum MIPS payment adjustment will increase to 9 percent and will remain there indefinitely. Payment adjustments will continue to apply on a sliding scale based on the MIPS score relative to the MIPS performance threshold. CMS proposes to set the MIPS performance threshold for 2020 at 45 points, a 15-point increase, followed by another 15-point increase for 2021. CMS proposes to increase the exceptional performance threshold by five points each of the next two years, to 80 in 2020 and 85 in 2021. Under MACRA, both thresholds must be based on either the average or median MIPS score from two years prior starting in 2022.

Performance Year	2019	2020	2021
Maximum MIPS Payment Adjustment	7%	9%	9%
Threshold for Maximum Penalty	7.5	11.25	15
MIPS Performance Threshold	30	45	60
MIPS Exceptional Performance Threshold	75	80	85



Targeted Review and Data Validation and Auditing

Third party intermediaries may submit a request for a targeted review on behalf of a clinician or group (or multiple). CMS proposes to limit the targeted review period to 60 days, which would begin on the day CMS makes available the MIPS payment adjustment factors and extend to a date specified by CMS, which may be extended. Requests for targeted reviews may be denied if: 1) they are duplicative of another request; 2) they are not submitted within the submission period; 3) they are outside the scope of targeted reviews, which is limited to MIPS payment adjustment calculations; or 4) requested supporting documentation is not provided within 30 days. CMS will notify all submitters of the final decision and reiterates in the rule that targeted review decisions are final and not subject to review or appeal. Submitters would be required to retain all related documentation for a minimum of six years from the end of the MIPS performance period. If CMS suspects a clinician, group, or third party intermediary is selectively using data to misrepresent their performance, they could be subject to remedial action and the resulting payment adjustment would be subject to auditing and adjustment.

Third Party Intermediaries

To prevent data reporting disruptions, CMS proposes all third party intermediaries must agree to provide services for the duration of the entire performance period and applicable data submission period as a precondition of their approval. In the event that the intermediary discontinues services prior to this point, it would be required to support the transition of clinicians and/or groups to an alternative vendor or data submission mechanism according to a CMS approved transition plan.

CMS proposes to require all QCDRs and qualified registries have the capability to submit data for the Quality, PI, and Improvement Activities Categories starting in 2021, with a limited exclusion for those only representing clinicians that are eligible for reweighting under the PI Category, such as physical therapists. CMS also proposes starting in 2021 that QCDR and qualified registry vendors would have to engage in activities that foster improvement in quality of care and enhance performance feedback. Specifically, vendors would have to provide performance feedback at least four times per year (provided it is reported by clinicians/groups in a manner that supports this) and feedback must include comparative data that shows performance relative to other clinicians or groups. CMS is seeking feedback on whether

clinicians and groups who utilize a QCDR or qualified registry should be required to submit data throughout the performance period to facilitate more frequent feedback.

CMS proposes that at the time of nomination, all QCDR measures must be fully developed with completed testing results at the individual level and any concerns over validity, reliability, or feasibility, including any significant variations in performance already addressed. Measures that are outcome-based, address patient safety and adverse health effects, identify appropriate use of diagnosis and therapeutics, are related to care coordination or patient and caregiver experience, and address efficiency, cost, and resource use would be prioritized for approval. The Agency also proposes to reject any measures that are not available for reporting through other QCDRs, following a policy finalized last year that vendors must agree to enter into licensing agreements with CMS permitting any approved QCDR to submit data on the measure for purposes of MIPS. CMS also proposes to create a new two-year, sub-regulatory measure review and approval process for QCDR measures that would include a one-year “probationary period” for measures identified for possible removal. CMS would consider QCDR measures for removal based on similar criteria previously finalized for other quality measures, including but not limited to measures that are duplicative, “topped out,” have low reporting rates, are process-based, have highly variant performance, cause unintended consequences, or are not actionable.

Physician Compare

CMS proposes to publicly post individual MIPS performance data, including final MIPS scores and individual performance category scores, in addition to aggregate MIPS data with minimum, average, and maximum scores, starting with 2018 performance data. It would post this information as soon as feasible. Clinicians would be indicated if scored using facility-based scoring with a link to facility-based measure-level information and Advanced APMs would have clinicians listed and link to information about that APM, including relevant performance information, as feasible. In a separate rule, CMS proposes to indicate whether clinicians successfully completed CEHRT compatibility/interoperability attestations. CMS seeks comment on adding additional data to Physician Compare in the future, including patient narratives, patient reported outcomes measures, and a single “value indicator” that would aggregate cost, quality, patient experience, and patient satisfaction data.

Medicare Shared Savings Program (MSSP) Quality Changes

CMS proposes to eliminate ACO quality measure #140 Preventive Care and Screening Influenza Immunization and replace it with ACO #47- Adult Immunization Status. CMS would also eliminate dehydration from ACO #43, the Ambulatory Sensitive Condition Acute Composite. Because these represent substantial changes, these measures would be pay for reporting in 2020-2021 and would shift to pay for performance starting in 2022. The numerator guidance for ACO #17, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention would be updated to be consistent with changes finalized to the Web Interface measure in 2018. Because this measure does not represent a substantive change, it would

remain pay-for-performance in 2020. The complete list of proposed 2020 MSSP quality measures can be found in Table 32 starting on page 227.

CMS solicits comment on how to align MSSP quality reporting requirements and scoring methodologies more closely with MIPS, including how to use MIPS quality scores to adjust shared savings and losses. Specifically, the Agency will explore replacing the MSSP quality score with the MIPS quality performance score (which was slightly higher than the MSSP quality score based on 2017 performance data). This would entail: 1) scoring measures as it does for non-ACO Web Interface reporters (whereby ACOs would receive a score for reported measures and zero points for non-reported measures but would not be required to report all measures in order to be considered reporting completely); 2) evaluating the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey based on the CAHPS for MIPS methodology (assigning points to every measure and averaging all of the measures together); 3) applying the MIPS quality improvement scoring methodology in lieu of the MSSP Quality Improvement Award; and 4) counting all MIPS claims-based measures toward the quality score for MSSP ACOs, including the Multiple Chronic Conditions (MCC) Measure, All-Cause Readmissions Measure, and (if finalized) MIPS All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions Measure. The methodology for the MIPS MCC Measure differs slightly from the current ACO MCC Measure in that it includes an additional condition (diabetes) and adjusts for two social risk factors (Agency for Healthcare Research and Quality (AHRQ) socioeconomic status index and specialist density).

In addition, CMS is considering changing the minimum quality threshold used to determine if an ACO is eligible to share in savings so that the overall MIPS quality score must meet or exceed the fourth decile across all MIPS quality measures (rather than meet the 30th percentile on one measure per quality domain). The Agency is also considering raising this threshold to the median or mean quality score and no longer exempting ACOs in their first performance year from minimum quality requirements.

Advanced APMs – Qualifying Payment Arrangements

To qualify as an Advanced APM, payment arrangements must meet certain criteria. At least 75 percent of practices within the model must use CEHRT, the model must base payment on quality criteria that is comparable to MIPS, and the model must either be a medical home model (MHM) or require a certain level of financial risk. Payers submit arrangements to CMS, who then determines which arrangements meet these qualifications and publishes lists of qualifying models prior to each performance year on the QPP website. Clinicians and groups can qualify under the Medicare Threshold based on strictly their participation in Medicare Advanced APMs, or the All Payer Combination Threshold based on their joint participation in Medicare, Medicare Advantage, Medicaid, and private payer Advanced APMs. 2020 will be the first performance year in which private payer models will count as Other Payer Advanced APMs. CMS proposes to coin the term “Aligned Other Payer MHM” to refer to a private payer payment arrangement that formally partners with CMS in a Multi-Payer Model that has been designated by CMS to qualify as a MHM under the All-Payer Combination Option. Criteria would mirror that for Medicare and Medicaid MHMs, including the 50 eligible clinician limit.

For non-MHM models, the Agency proposes to make several changes to the definition of risk that could impact which models qualify as Advanced APMs. CMS is concerned that payers may inflate benchmarks so that the risk of actual expenditures reasonably exceeding it is artificially low. Therefore, the Agency proposes to modify the definition of marginal risk so that any expected expenditures under the APM that exceed what an APM Entity would expect to incur in the absence of that APM would not count toward the benchmark for purposes of evaluating financial risk. Risk adjustment expenditures would still count regardless. CMS also proposes that for models in which marginal risk varies based on the level of losses, the average marginal risk rate would be used, with exceptions for small and large losses. Finally, CMS seeks comment on categories of items and services that should be excluded from a capitation arrangement and what percentage of total cost should constitute a “full capitation” arrangement.

Advanced APMs - Qualified Advanced APM Participant (QP) Status

Clinicians who significantly participant in Advanced APMs are eligible for a 5 percent bonus to their Medicare Part B payments and are exempt from MIPS for an applicable performance year, in addition to any financial rewards they may receive through the APM itself. These clinicians are called QPs. In order to achieve QP status, clinicians must receive a certain amount of their payments or see a certain amount of their patients through payment arrangements that qualify as Advanced APMs. Clinicians may qualify as QPs through based on their participation in Medicare Advanced APMs alone (i.e. the Medicare Option), or through a combination of their participation in Medicare, MA, Medicaid, and private payer Advanced APMs (i.e. the All Payer Combination Option). Clinicians who fall shy of these thresholds may still achieve Partial QP status, which means they have the option to be excluded from MIPS, but would not receive the 5 percent bonus. The QP and Partial QP thresholds for the 2020 and future performance years are provided below. Note that clinicians qualifying under the All-Payer Combination Option are still required to have a certain amount of their Medicare payments or patients come from an Advanced APM.

		2020		2021+	
		Medicare Option	All-Payer Combination Option	Medicare Option	All-Payer Combination Option
QP	Payments	50%	50% (25% of Medicare)	75%	75% (25% of Medicare)
	Patients	35%	35% (20% of Medicare)	50%	50% (20% of Medicare)
Partial QP	Payments	40%	40% (20% of Medicare)	50%	50% (20% of Medicare)
	Patients	25%	25% (10% of Medicare)	35%	35% (10% of Medicare)

CMS proposes several changes to the way these thresholds would be calculated moving forward. Currently, elections to participate or not participate in MIPS based on Partial QP status are often made at the APM Entity level. Partial QP elections are then applied at the National Provider Identifier (NPI) level, across all TIN/NPI combinations. Moving forward, CMS proposes to only apply Partial QP status to the TINs through which a clinician achieves partial QP status. This would allow individual clinicians to participate in MIPS and be eligible for a payment adjustment under other TINs even if an APM Entity in which they participate elects to opt out,

but would also mean clinicians would still be expected to participate in MIPS or face a penalty for any non-APM TINs. In addition, Advanced APM Entities would not count towards a clinician's QP status if it terminates (voluntarily or involuntarily) before: 1) the end of a performance period; or 2) prior to bearing responsibility for financial risk under the terms of the APM.