

K. CY 2020 Updates to the Quality Payment Program

1. Executive Summary

a. Overview

This section of the final rule sets forth changes to the Quality Payment Program starting January 1, 2020, except as otherwise noted for specific provisions. The 2020 performance period of the Quality Payment Program will build upon the foundation that has been established in the first 3 years of the program, which provides a trajectory for clinicians moving to performance-based payments, and will gradually prepare clinicians for the 2022 MIPS performance period of the program and the 2024 MIPS payment year. Participation in both tracks of the Quality Payment Program – Advanced Alternative Payment Models (APMs) and Merit-based Incentive Payment System (MIPS) – has increased from 2017 to 2018.¹ The number of QPs – Qualifying APM Participations – nearly doubled from 2017 to 2018, from 99,076 to 183,306 clinicians. In MIPS, 98 percent of eligible clinicians participated in 2018, up from 95 percent in 2017. As the Quality Payment Program continues to mature, CMS recognizes additional long-term improvements will need to occur. We have taken stakeholder input into consideration to ensure that we continue to implement the Quality Payment Program as required while smoothing the transition where possible and offering targeted educational resources for program participants. For example, in an effort to get broad feedback on our MIPS Value Pathways (MVPs) participation framework we held a public webinar specifically focused on the topic, conducted 7 listening sessions with various stakeholder groups throughout the proposed rule comment period, and engaged with clinicians and others through several other public forums. We plan to continue engaging with clinicians and other stakeholders as we move forward developing the MVPs.

While we continue efforts to strengthen the Quality Payment Program, we remain interested in clinician participation and engagement in the program, particularly as initial MVPs are developed for the 2021 MIPS performance period. We have been given flexibility in establishing the cost performance category weight and performance threshold in the early years of the Quality Payment Program. The Bipartisan Budget Act of 2018 (BBA 2018) (Pub. L. 115-123, enacted February 9, 2018) extended the flexibility and transition years within the Quality Payment Program. Beginning with the 2024 MIPS payment year (2022 performance period), as required by law, the cost performance category under MIPS will be weighted at 30 percent and the performance threshold will be set at the mean or median of the final scores for all MIPS eligible clinicians with respect to a prior period specified by the Secretary. The provisions of this rule are intended to recognize our reduced flexibility beginning with the 2024 MIPS payment year and continue to put clinicians in a position to make the transition as required by statute.

¹ Quality Payment Program (QPP) Participation in 2018: Results at a Glance <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/586/2018%20QPP%20Participation%20Results%20Infographic.pdf>.



b. Summary of Major Provisions

(1) MIPS Value Pathways

We are committed to the transformation of MIPS, which will allow for: more streamlined and cohesive reporting; enhanced and timely feedback; and the creation of MVPs of integrated measures and activities that are meaningful to all clinicians from specialists to primary care clinicians and to patients. The new MVPs will remove barriers to APM participation and promote value by focusing on quality and cost measure and improvement activities built on foundational global or population quality measures calculated from claims-based quality data and promoting interoperability concepts.

In the CY 2020 PFS proposed rule (84 FR 40735), we proposed to apply a new MVP framework beginning with the 2021 MIPS performance period/2023 MIPS payment year to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. As discussed in section III.K.3.a.(2) of this final rule, we are finalizing a modified proposal to define MVPs at § 414.1305 as a subset of measures and activities established through rulemaking.

Additionally, we will work with stakeholders to develop MVPs as a cohesive and meaningful participation experience for clinicians with an aligned set of measures and activities that are more relevant to a clinician's scope of practice, while further reducing reporting burden and easing the transition to APMs. We refer readers to the CY 2020 PFS proposed rule (84 FR 40732 through 40745) for more information on the MVP framework.

(2) Other Major MIPS Provisions

In addition to the MVP framework, we are finalizing two significant proposals for the 2020 MIPS performance period:

- As discussed in section III.K.3.g.(3) of this final rule, we are finalizing the proposal 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.
- As discussed in section III.K.3.c.(2)(b)(iii) of this final rule, we are finalizing the proposed episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide. Further, we are also finalizing the revised total per capita cost and the Medicare Spending Per Beneficiary (MSPB) measures.

After consideration of public comments, we are not finalizing two significant proposals:

- As discussed in section III.K.3.c.(2)(a) of this final rule, we are not finalizing our proposal to weight the cost performance category at 20 percent for the 2022 MIPS payment year. Instead, we are continuing to weight the cost performance category at 15 percent in light of concerns noted regarding more detailed and actionable performance feedback. Hence, we are also continuing to weight the quality performance category, discussed in section III.K.3.c.(1)(b) of this final rule, at 45 percent. However, we will revisit increasing the weight

of the cost performance category in next year's rulemaking to ensure clinicians are prepared for the significant increase in category weight by the 2024 MIPS payment year.

- As discussed in section III.K.3.e.(3) of this final rule, we are not finalizing our proposal to set the additional performance threshold at 80 points for the 2022 MIPS payment year and instead are finalizing the additional performance threshold at 85 points for the 2022 MIPS payment year. We are also finalizing the additional performance threshold at 85 points for the 2023 MIPS payment year.

(3) Major APM Provisions

(a) Aligned Other Payer Medical Home Models

We are finalizing the proposal to add the defined term, Aligned Other Payer Medical Home Model, to § 414.1305. The definition of Aligned Other Payer Medical Home Model includes the same characteristics as the definitions of Medical Home Model and Medicaid Medical Home Model, but it applies to other payer payment arrangements. We believe that structuring this definition in this manner is appropriate because we recognize that other payers could have payment arrangements that may be appropriately considered medical home models under the All-Payer Combination Option.

Neither the current Medical Home Model financial risk and nominal amount standards nor the Medicaid Medical Home Model financial risk and nominal amount standards apply to other payer payment arrangements. Consistent with our decision to finalize our proposal to define the term Aligned Other Payer Medical Home Model, we are finalizing our proposal to amend § 414.1420(d)(2), (d)(4), and (d)(8) to apply the same Medicaid Medical Home Model financial risk and nominal amount standards, including the 50 eligible clinician limit, to Aligned Other Payer Medical Home Models.

(b) Marginal Risk for Other Payer Advanced APMs

We are finalizing our proposal to modify our definition of marginal risk when determining whether a payment arrangement is an Other Payer Advanced APM. We proposed that, in the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we will compare the average marginal risk rate across all possible levels of actual expenditures to the marginal risk rate specified in the Other Payer Advance APM financial risk criterion, with exceptions for large losses and small losses, as described in § 414.1420(d). When considering average marginal risk in the context of total risk, we believe that certain risk arrangements can create meaningful and significant risk-based incentives for performance and at the same time ensure that the payment arrangement has strong financial risk components.

(c) Estimated APM Incentive Payments and MIPS Payment Adjustments

As we discuss in section VII.F.10.a. of this final rule, for the 2022 payment year and based on estimated Advanced APM participation during the 2020 QP Performance Period, we estimate that between 210,000 and 270,000 clinicians will become Qualifying APM Participants (QPs). Eligible clinicians who are QPs for the 2022 payment year are excluded from the MIPS reporting

requirements and payment adjustment and will receive a lump sum APM Incentive Payment equal to 5 percent of their aggregate payment amounts for covered professional services for the year prior to the payment year. We estimate that the total lump sum APM Incentive Payments will be approximately \$535-685 million for the 2022 Quality Payment Program payment year.

We estimate that there will be approximately 879,966 MIPS eligible clinicians for the 2020 MIPS performance period in section VII.F.10.b.(1)(b) of this final rule. The final number will depend on several factors, including the number of eligible clinicians excluded from MIPS based on their status as QPs or Partial QPs, the number that report as groups, and the number that elect to opt into MIPS in accordance with § 414.1310(b)(1)(ii). In the 2022 MIPS payment year, MIPS payment adjustments, which only apply to payments for covered professional services furnished by a MIPS eligible clinician, will be applied based on a MIPS eligible clinician's performance on specified measures and activities within four integrated performance categories. We estimate that MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments (\$433 million) and positive MIPS payment adjustments (\$433 million) to MIPS eligible clinicians, as required by the statute to ensure budget neutrality. Up to an additional \$500 million is also available for the 2022 MIPS payment year for additional positive MIPS payment adjustments for exceptional performance for MIPS eligible clinicians whose final score meets or exceeds the additional performance threshold of 85 points that we are finalizing in section III.K.3.e.(3) of this final rule. However, the distribution will change based on the final population of MIPS eligible clinicians for the 2022 MIPS payment year and the distribution of final scores under the program.

2. Definitions

At § 414.1305, we are finalizing definitions of the following terms:

- Aligned Other Payer Medical Home Model.
- Hospital-based MIPS eligible clinician.
- MIPS Value Pathway.

We are also finalizing revisions to the following definition at § 414.1305:

- Rural area.

These terms and definitions are discussed in detail in relevant sections of this final rule.

3. MIPS Program Details

a. Transforming MIPS: MIPS Value Pathways

(1) Overview

In the CY 2020 PFS proposed rule, we proposed an MVP definition that would prepare us to apply a new MVP framework beginning with the 2021 MIPS performance period. This MVP framework would simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. We refer readers to the CY



2020 PFS proposed rule (84 FR 40732 through 40745) for more information on the MVP framework and the proposed MVP definition.

(2) Implementing MVPs

In the CY 2020 PFS proposed rule (84 FR 40735), we described the MVP framework and proposed to define a MIPS Value Pathway at § 414.1305 as a subset of measures and activities specified by CMS. We noted that MVPs may include, but will not be limited to, administrative claims-based population health, care coordination, patient-reported (which may include patient reported outcomes, or patient experience and satisfaction measures), and/or specialty/condition specific measures. The following is a summary of the comments we received and our responses.

Comment: Several commenters supported the MVP framework and proposed definition of an MVP because this could potentially reduce the complexity of the MIPS program and clinician burden. Many commenters agreed with the intent of the MVP framework to simplify MIPS, reduce burden, make the program more meaningful for clinicians and reduce barriers to movement into APMs.

Response: We thank commenters for their support.

Comment: Several commenters stated that the MVP framework was a positive first step and they would like to see further burden reduction beyond clinician measure selection burden, including the elimination of the siloed requirements and scoring approaches for each of the four performance categories. Several commenters suggested streamlined reporting or automatic credit for Promoting Interoperability and Improvement Activities performance categories. Several commenters recommended that participation in a specialty accreditation program earn credit as an improvement activity. Several commenters suggested the use of measures that satisfy the requirements of multiple performance categories in MVPs. A few commenters provided an example of linking measures: one example was to allow a clinician to report the quality measure, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), and the improvement activity, Glycemic Screening Services (IA_PM_19) to receive credit for a quality measure and improvement activity.

Response: We intend to develop MVPs in collaboration with stakeholders that align with guiding principles that include simplification and clinician burden reduction. We intend to work with stakeholders to develop MVPs that account for variation in specialty, size, and composition of clinician practices. We also intend that MVPs would allow for a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to a patient population, a specialty or a medical condition, reducing the siloed nature of the current MIPS participation experience. We believe it is important to develop MVPs in unison with stakeholders to create low burden, meaningful MVPs that move clinicians along the value continuum and facilitate movement into APMs. Experience with MVPs that measure quality of care and patient experience of care, cost, continuous practice improvement, and effective management and transfers of health information will help to reduce barriers to APM participation. We would like to work with stakeholders to identify specialty accreditation programs, such as the American College of Surgeons' Commission on Cancer Accreditation



program that demonstrate a commitment to quality improvement and alignment with MIPS quality measures. We intend to develop MVPs to connect measures across performance categories as indicated by the commenter's diabetes example above. We note that the MIPS statute requires the use of four performance categories now called Quality, Cost, Improvement Activities, and Promoting Interoperability in determining the MIPS composite performance score. While each performance category has its own requirements and associated list of measures or activities, it is possible that a single measure or activity may meet the respective criteria for inclusion in more than one performance category; however, we do not currently have any multicategory MIPS or QCDR measures available. We would be interested in working with stakeholders to pair the improvement activities and quality and cost measures, while leveraging foundational global or population health measures and Promoting Interoperability measures that would constitute an MVP. We are interested in the potential use of measures that could satisfy more than one of the four MIPS performance categories within our statutory constraints and welcome additional stakeholder engagement related to how to best structure and develop MVPs that entail low clinician burden. Feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: Many commenters indicated conditional support for the MVP framework, with concerns about the timeline and transition to MVPs in CY 2021. Many commenters requested a longer and more gradual timeline for MVP implementation. Several commenters suggested delaying MVP implementation by 1 year to CY 2022, while several others suggested a delay of a few years, with a few specifying a 2-year delay. Many commenters stated concerns that implementation in the 2021 MIPS performance period will not allow enough time to develop MVPs for all specialists, and several commenters indicated concerns about the time needed to educate clinicians on the use of MVPs. Many commenters supported MVPs as a voluntary reporting option in addition to the currently available options for MIPS participation. Several commenters recommended that MVPs be optional during a transition period. Several commenters supported the proposed MVP definition provided that MVPs are implemented as a voluntary gradual or multiyear pilot, allowing development and clinician MVP education time. A few commenters indicated that there is a need for stability in the Quality Payment Program and urged caution with implementation of the MVP framework.

Response: We have not made any proposals regarding whether participation in MVPs will be mandatory or optional. We appreciate that we need to work diligently with stakeholders to develop and propose policies regarding many aspects of implementation of MVPs in the 2021 MIPS performance period, including the extent of first year implementation or the feasibility of an initial pilot. Feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: A few commenters did not support implementing the MVP framework stating that the MVPs would create too much change and clinician confusion with a few commenters stating that MVPs would not serve the needs of their specialty (for example, dermatology, nurse practitioners, physician assistants, occupational therapy, audiology, speech language pathology), indicating insufficient numbers of quality measures for the specialty. A few commenters stated that certain clinician types, for example, nurse practitioners, have only a



single Medicare specialty designation but practice in diverse specialty areas and that a limited number of potentially assigned MVPs may leave some clinicians out. A few commenters indicated that specialty clinicians would need either multiple MVPs or an MVP with a wide variety of measures and activities, because of the range of services provided by a specialty. For example, surgeons provide a wide range of procedures from neurosurgery to spine care. A few commenters indicated that clinicians new to MIPS reporting should have a delayed MVP timeline. A few commenters stated that the MVPs, as described, would not be able to meet the stated goals because MVPs may reduce the burden of measure selection, but will not reduce the overall burden of participating in MIPS, which the commenters indicated would require removing separate requirements for scoring and reporting for each of the performance categories. Many commenters did not support transitioning towards MVPs because this would reduce clinician choice in the selection of measures and activities; and may rely on measures and activities, including population health measures, viewed as not relevant to the clinician's clinical practice.

Response: We believe achieving the goals of the MVP framework are worthwhile and understand the need to introduce change that is balanced against the burden required for clinicians to change workflows and participate in the program. A notable change for MIPS eligible clinicians with MVPs is that they would no longer select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a clinician specialty or a clinical condition. We welcome ideas from stakeholders for developing MVPs that provide further burden reduction to clinicians. We acknowledge that a single MVP may not fit the needs of all clinician types and all clinicians in the specialty and would like to work with stakeholders to determine, to the extent possible, the number of MVPs needed for specialists and which measures and activities should be included. We would like to engage with clinicians in the field and their societies to develop applicable MVPs and foundational population health administrative claims measures that are low burden and meaningful. We believe that holding all clinicians accountable for the same population health measures will align incentives, encourage coordination between clinicians and promote meaningful progress on measures. We seek ongoing engagement with stakeholders to identify population health measures that will drive collaborative, high-quality and timely care. We believe that ongoing engagement with stakeholders will lead to improved clinicians' experience with the Quality Payment Program and drive meaningful change in the delivery system. We will consider this feedback on how to best transition to MVPs and how to optimally include MVPs that meet the needs of all clinician specialties.

Comment: Several commenters requested additional information about how equity would be maintained between clinicians reporting on MVPs and those using the currently available MIPS participation options, as well as between clinicians reporting on different MVPs, indicating a concern that one MIPS participation option or MVP should not be 'easier' than others.

Response: We agree that equity is critical to MVP implementation and requested feedback on approaches we should take to create equity across MVPs and across clinician types (84 FR 40742). We intend to work with stakeholders to determine approaches to maintain equity between MVP and the MIPS participation option, as well as clinicians reporting on different



MVPs. This feedback will inform our process development as we further develop our MVP framework and unique MVPs and undertake future rulemaking.

Comment: Many commenters expressed concerns related to the population health claims-based performance measures that would be selected for use in MVPs. Many commenters did not support the use of population health claims-based measures in MVPs because of reliability, validity, attribution, lack of risk adjustment, actionability concerns, and/or unintended consequences concerns. Several commenters supported foundational use of population health claims-based measures, with a few commenters supporting use of administrative measures that are consistent with Advanced APM measures stating that administrative measures can assess quality across time and the delivery system without clinician reporting and can be applied to various clinician types including specialties.

Response: We intend to work in close partnership with stakeholders to identify measures and activities to include in MVPs. Our vision for MVPs is to connect the four performance categories while using a foundational layer of population health claims-based measures and interoperability on which to build quality, cost and improvement activity linkages. Please refer to the on line MVP graphic (<https://qpp-cm-prod-content.s3.amazonaws.com/uploads/587/MIPS%20Value%20Pathways%20Diagrams.zip>) that provides an overview of our vision for the MIPS future state. Implementation of a foundational population health core measure set using administrative claims-based quality measures that can be broadly applied to communities or populations can result in MVP measure tracks that provide more uniformity in the program's measures, reduce clinician reporting burden, allow focus on important public health priorities, increase the value of MIPS performance data, and reduce barriers to APM participation. Additionally, we intend to examine these concerns regarding population health measure reliability, validity, attribution and risk adjustment and the technical challenges and address them to the extent feasible by working with the measure stewards and clinician experts. We believe that interoperability is also a foundational element that would apply to all clinicians, regardless of MVP, for whom the Promoting Interoperability performance category is required. We envision an initial uniform set of Promoting Interoperability measures in each MVP and will consider customizing MVP Promoting Interoperability measures in future years. We believe that eligible clinicians could benefit from more targeted approaches that assess the meaningful use of health IT in alignment with clinically relevant MVPs. The integration of population health measures and Promoting Interoperability measures into MVPs provides a degree of standardization across all clinician types and promotes an infrastructure on which to assess and improve value-based care. Measure feedback and suggestions will be considered as we undertake further rulemaking in future years.

Comment: Many commenters indicated that a critical element of specifying the measures and activities within an MVP will be stakeholder engagement. Many commenters urged us to work in tandem with clinicians and specialty societies to develop MVPs. A few other commenters suggested that specialty societies should develop MVPs. A few commenters urged us to work with multi-stakeholder consensus-based organizations such as the Core Quality Measures Collaborative and to utilize existing specialty measure set development approaches to identify a



list of measures for each MVP. A few commenters suggested that we allow stakeholders to comment on the detailed methodologies of a future MVP design and implementation plan as they become more fully developed.

Response: We appreciate the commenters' recommendations on how the measures and activities should be specified in the MVPs and for articulating the critical importance of stakeholder engagement in MVP development. In recognition of our intention to specify MVPs with stakeholder input to the extent possible, we are modifying the proposed definition of MVP at § 414.1305, by replacing the words, "as specified by CMS" with "established through rulemaking".

After consideration of the comments, we are finalizing a modification of our proposal. Specifically, we are finalizing at § 414.1305 that MIPS Value Pathway means a subset of measures and activities established through rulemaking.

(3) Requests for Feedback on MVPs

In the CY 2020 PFS proposed rule (84 FR 40739 through 40745), we requested public comments regarding several issues involving the MVPs. We received 2,100 comments related to implementation of MVPs. While we are not summarizing and responding to comments we received in this final rule, we thank the commenters for their responses and may take them into account as we develop future policies for the MVPs. We also are interested in engaging with stakeholders on additional ways to reduce burden in the MIPS program, in addition to what we have solicited comment on for MVPs. For example, in the context of MVPs, we are interested in solutions to reduce burden across all 4 MIPS categories such as use of standards such as Fast Healthcare Interoperability Resources (FHIR), number of measures across categories, reporting timeframes and data submission methods. We intend to continue a dialogue with stakeholders on these important MVP topics and may consider convening public forum listening sessions, webinars, and office hours or using additional opportunities such as the pre-rulemaking process to further understand what is important to clinicians, patients, and stakeholders and obtain further input as we develop MVPs.