Proposed Joint Physician Fee Schedule & Quality Payment Program (QPP) Rule for 2019

Merit-based Incentive Program (MIPS) Proposed Policy Overview

August 2018

I. DOCUMENT SCOPE

We have summarized the portion of the proposed rule for 2019, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program" published in the *Federal Register* on July 27, 2018. This summary focuses on the Merit-based Incentive Program (MIPS) and the four performance categories. For a more detailed discussion of the overall rule please contact us. A score of at least 30 points is required to avert a penalty in the 2021 payment year.

II. KEY CHANGES:

1. **COST:** Weight of cost category in 2019 would be 15% instead of 30%.
2. **QUALITY:** Facility-based measure credit permitted, weight 50% in 2018 and 45% in 2019. Small practice bonus added to this category.
3. **PROMOTING INTEROPERABILITY:** Fewer measures, some controversial measures removed, better synced with hospital requirements, new 100-point scoring system, and new opioid measures.
4. **IMPROVEMENT ACTIVITIES:** Removes the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT
5. **Low Volume Definition:** Third criteria added. Qualifications include: 1) those with $90,000 or less in allowed charges for covered professional services; or 2) 200 or fewer Part B-enrolled individuals who are furnished Medicare physician fee schedule services; or 3) 200 or fewer covered professional services.

III. GENERAL POLICIES

- **MIPS Determination Period:** Would align the varying determination period policies into a single MIPS determination period that would be used for purposes of determining the low-volume threshold and to identify MIPS eligible clinicians as non-patient facing, a small practice, hospital-based, and ASC-based. The new determination period for all would be a 24-month assessment period beginning on October 1 of the calendar year 2 years prior to the applicable performance period.
- **Low-Volume Threshold:** For 2018 the low volume threshold was set at Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B–enrolled Medicare beneficiaries. The Bipartisan Budget Act of 2018 created some new flexibilities thus CMS has called for adding a third criterion, the minimum number of covered

professional services furnished to Part B-enrolled individuals by the clinician, starting in 2019.

- **Low-Volume threshold opt-in**: If an eligible clinician or group meets or exceeds at least one, but not all, of the low-volume threshold determinations, then they could opt-in to MIPS.

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

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

- **Data Submission and CMS Web Interface:** There are five basic submission types in MIPS: direct; log in and upload; login and attest; Medicare Part B claims; and the CMS Web Interface. CMS previously said groups may submit their MIPS data using the CMS Web Interface (for groups of 25+ eligible clinicians) for the quality, improvement activities, and promoting interoperability performance categories. CMS is now proposing:
  - CMS Web Interface submission type would no longer be available for groups to use to submit data for the improvement activities and Promoting Interoperability performance categories.
  - Third party intermediaries would be allowed to submit data using the CMS Web Interface on behalf of groups.
  - Expanding the CMS Web Interface submission type to groups consisting of 16 or more eligible clinicians to inform our future rulemaking.

  CMS clarifies:

  - Individual clinicians may submit their MIPS data for the quality using the direct, login and upload, and Medicare Part B claims submission types. And, they may submit their MIPS data for the improvement activities or Promoting Interoperability performance categories using the direct, login and upload, or login and attest submission types.
  - Groups can submit their MIPS data for the quality performance category using the direct, login and upload, and CMS Web Interface (for groups of 25+ eligible clinicians) submission types. Also clarify groups may submit their MIPS data for the improvement activities or Promoting Interoperability performance categories using the direct, login and upload, or login and attest submission types.

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

Performance Category/Submission Combinations Accepted	Submission Type	Submitter Type	Collection Type
Quality	Direct Log in and upload Medicare Part B claims (small practices)[1]	Individual or Third Party Intermediary[2] Individual	eCQMs MIPS CQMs QCDR measures Medicare Part B claims measures (small practices)
Cost	No data submission required[2]	Individual	-
Promoting Interoperability	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-
Improvement Activities	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-

[1] Third party intermediary does not apply to Medicare Part B claims submission type.
[2] Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare claims. NOTE: As used in this proposed rule, the term "Medicare Part B claims" differs from "administrative claims" in that "Medicare Part B claims" require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.

TABLE 30: Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

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

[1] Third party intermediary does not apply to Medicare Part B claims submission type.
[2] Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare claims. NOTE: As used in this proposed rule, the term "Medicare Part B claims" differs from "administrative claims" in that "Medicare Part B claims" require MIPS eligible clinicians to append

- **Definition of a MIPS eligible clinician:** Proposal to modify the definition of a MIPS eligible clinician to include starting 2019 - in addition to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists – physical therapists, occupational therapists, clinical social workers, and clinical psychologists. Also requesting comment on adding qualified speech-language pathologists, qualified audiologists, certified nurse-midwives, and registered dietitians or nutrition professionals as MIPS eligible clinicians.
- **Small Practitioners:** CMS calls for retaining the small practice bonus under MIPS but moving it to the quality performance category and allowing small practices to continue using the Medicare Part B claims collection type of data, and letting small providers participate as virtual groups. It would be worth 3 points.
- **Reporting Periods:** Starting in reporting year 2020 CMS has proposed the following:
    - **Quality:** Full year
    - **Cost:** Full year
    - **Improvement Activities**: Continuous 90 days
    - **Promoting Interoperability:** Continuous 90 days

- **Data submission deadline:** Would begin no earlier than January 2 and end no later than March 31 for the CMS Web Interface.
- **Facility-based clinician scoring:** In last year's final rule the agency established facility-base scoring starting in 2019 for the inpatient setting in the hospital value based program. CMS is not calling for expanding this now but seeks comments on how to do so for the future. CMS has proposed no data submission would be required for cost or quality categories when scoring is facility-based.

IV. Quality [Represents 50% of a clinician's MIPS score in 2018]

KEY CHANGES:

1. Weight would be 50% in 2018 and 45% in 2019.
2. Claims reporting now allowed for small providers.
3. High-priority measure set now includes opioids.
4. Meaningful Measures Initiative aims to identify the core quality of care issues that improve patient outcomes. CMS categorizes quality measures by the 19 Meaningful Measure areas.

- **Measures:** MIPS eligible clinicians who elect to submit electronic clinical quality measures (eCQMs) must submit data on at least six quality measures, including at least one outcome measure (or, if an applicable outcome measure is not available, one other high priority measure). If fewer than six measures apply to the MIPS eligible clinician or group, report on each measure that is applicable.
- **Data submission and completeness criteria:** No changes proposed for 2019, but clarifies that clinicians submitting quality measure data must submit 60% of all patient data, not just Medicare.

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

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

TABLE 32: Summary of Quality Data Submission Criteria for MIPS Payment Year 2021 for Individual Clinicians and Groups

Clinician Type	Submission Criteria	Measure Collection Types (or Measure Sets) Available
Individual Clinicians	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Individual MIPS eligible clinicians select their measures from the following collection types: Medicare Part B claims measures (individual clinicians in small practices only), MIPS CQMs, QCDR measures, eCQMs, or reports on one of the specialty measure sets if applicable.
Groups (non- CMS Web Interface)	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Groups select their measures from the following collection types: Medicare Part B claims measures (small practices only), MIPS CQMs, QCDR measures, eCQMs, or the CAHPS for MIPS survey - or reports on one of the specialty measure sets if applicable. Groups of 16 or more clinicians who meet the case minimum of 200 will also be automatically scored on the administrative claims based all-cause hospital readmission measure.
Groups (CMS Web Interface for group of at least 25 clinicians)	Report on all measures includes in the CMS Web Interface collection type and optionally the CAHPS for MIPS survey. Clinicians would need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Groups report on all measures included in the CMS Web Interface measures collection type and optionally the CAHPS for MIPS survey. Groups of 16 or more clinicians who meet the case minimum of 200 will also be automatically scored on the administrative claims based all-cause hospital readmission measure.

- **Streamlining measures:** To streamline quality measures, reduce regulatory burden, and promote innovation, CMS developed the Meaningful Measures Initiative. It aims to identify the core quality of care issues that improve patient outcomes. CMS categorizes quality measures by the 19 Meaningful Measure areas. The categorization of quality measures by Meaningful Measure area would provide MIPS eligible clinicians and groups with guidance as to how each measure fits into the framework of the Meaningful Measure Initiative.
- **High-priority measures:** A high priority measure is defined as an outcome, appropriate use, patient safety, efficiency, patient experience or care coordination quality measure. CMS calls for adding opioid measures to those that are considered high-priority staring 2019. The new MIPS quality measures proposed for inclusion in MIPS for the 2019 performance period and future years are found in Table A of Appendix 1: Proposed MIPS Quality Measures of this proposed rule.
- **eCQMs:** CMS will not accept an older version of an eCQM as a submission for the MIPS program for the quality performance category or the end-to-end electronic reporting bonus. MIPS eligible clinicians and groups reporting on the quality performance category are required to use the most recent version of the eCQM specifications. Annual updates to the eCQMs specifications can be found here.
- **Topped Out Measures:** Last year CMS finalized a four-year timeline to identify and remove topped out measures. Go here to see which measures are topped out. CMS is proposing once a measure has reached an extremely topped out status (i.e. a measure with an average mean performance within the 98th to 100th percentile range), they could remove the measure regardless of whether or not it is in the midst of the topped-out measure lifecycle, since the agency says non-high priority process measures require data collection

burden without added value for eligible clinicians and groups participating in MIPS. CMS is also calling for excluding from the four-year phase timeline to phase out topped out measures to exclude QCDRs from this.

- **Process vs Outcome measures:** For 2018 102 of the 275 quality measures are process measures that are not considered high priority. Starting in 2019 CMS proposes an incremental approach to removing measures. Before removal CMS would consider the following:
    - Whether the removal of the process measure impacts the number of measures available for a specific specialty.
    - Whether the measure addresses a priority area highlighted in the Measure
    - Development Plan: https://www.cms.gov/Medicare/Quality-Payment-Program/Measure
    - Development/Measure-development.html.
    - Whether the measure promotes positive outcomes in patients.
    - Considerations and evaluation of the measure's performance data.
    - Whether the measure is designated as high priority or not.
    - Whether the measure has reached a topped-out status within the 98th to 100th percentile range.

IV. Cost [Represents 15% of a clinician's MIPS score in 2019]

KEY CHANGES:

1. Weight for 2018 was previously set at 10% but CMS and 30% starting in 2019.
2. CMS is calling for adding 8 episode-based measures starting 2019.

- **Weight of cost category:** CMS has proposed weighting the cost category for 2019 at 15% rather than 30% because CMS recognizes that cost measures are still early in development. CMS says they will consider there are an insufficient number of measures under the cost category and before increasing the weight of the category to 30%. They anticipate the weight of the cost category will increase by 5% per year until they reach the 30% mark required in 2024. CMS invites comments on this approach.
- **Cost criteria:** CMS set two cost measure for 2018 (total per capita cost measure and Medicare spending per beneficiary (MSPB) measure). CMS will evaluate future cost measures according to the measure reevaluation and maintenance processes outlined in the "Blueprint for the CMS Measures Management System."
- **Episode-based measures:** CMS is calling for adding 8 episode-based measures for 2019 for the cost category, which can be categorized into two types of episode groups: acute inpatient medical condition episode groups, and procedural episode groups. CMS field test episode-based measures last year and report can be found here. CMS has proposed a case minimum of 10 episodes for the procedural episode-based measures and 20 episodes for the acute inpatient medical condition episode-based measures for 2019.

TABLE 33: Episode-Based Measures Proposed for the 2019 MIPS Performance Period and Future Performance Periods

Measure Topic	Measure Type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition
Simple Pneumonia with Hospitalization	Acute inpatient medical condition
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition

V. Promoting Interoperability [25% of total MIPS score]

KEY CHANGES:

1. Name change from Advancing Care Information (ACI) to Promoting Interoperability (PI)
2. New scoring methodology removing base vs performance measures with total possible score of 100 points, and removes bonus points for using CEHRT to complete certain IAs.
3. Fewer measures and objectives.
4. Better alignment with hospital requirements.

- **New Name:** CMS has renamed this category from Advancing Care Information to Promoting Interoperability.
- **CEHRT:** 2015 Edition CEHRT is required for use starting January 1, 2019.
- **New Measure / Objective Paradigm:**
  - **Alignment**: Measures and objectives now align better with what is required of Medicare hospitals (as proposed under the IPPS rule in April and expected to be finalized in August)
  - **Medicaid**: CMS will allow states to use the new measure / objective construct but it is not required (see later in the document for a longer discussion on Medicaid).
  - **Base / performance measures removed**: Under the new paradigm, there would no longer be a distinction between base and performance measures; this piece of the former construct has been removed. Also, CMS calls for removing the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT.
  - **Fewer measures / objectives**: There would now only be four objectives: 1) eprescribing; 2) HIE; 3) provider to patient exchange; and 4) public health and clinical data exchange. CMS is removing six measures (2 completely removed and 2 are renamed into a new measure) from the Promoting Interoperability objectives and measures beginning with the performance period in 2019.

- **Removed measures**: Four measures are removed altogether as CMS deemed them too burdensome for clinicians to meet:
    1. Patient-Specific Education;
    2. Secure Messaging;
    3. View, Download, or Transmit; and
    4. Patient-Generated Health Data
- **Brand new measures:** CMS has added three new measures that were not previously part of MIPS:
    1. Query of PDMP (under ePrescribing objective)
    2. Verify Opioid Treatment Agreement (under ePrescribing objective)
- **New / Renamed measure:** The Support Electronic Referral Loops by Receiving and Incorporating Health Information (under HIE objective) measure builds upon and replaces the existing measures Request/Accept Summary of Care and Clinical Information Reconciliation measures. Previously, the SoC transition measure for 2018 afforded up to 20 percentage points under the base score requiring clinicians to create and send on SoC for at least one patient. Adopted for 2019 the SoC measure was also base and counted for up to 10 percentage points requiring clinicians for at least one patient to create a SoC in CEHRT, exchange it electronically, and reconcile meds, allergies and problem list.
- **Modified measures / objectives**: CMS has renamed:
    1. Summary of Care measure to the Support Electronic Referral Loops by Sending Health Information measure;
    2. Patient Electronic Access objective to Provider to Patient Exchange and renaming the remaining measure Provide Patient Access to Provide Patients Electronic Access to Their Health Information; and
    3. Public Health and Clinical Data Registry Reporting objective to Public Health and Clinical Data Exchange.

TABLE 39: Summary of Proposals for the Promoting Interoperability Performance Category Objectives and Measures for the MIPS Performance Period in 2019

Measure Status	Measure
Measures retained – no modifications*	• e-Prescribing
Measures retained with modifications	• Send a Summary of Care (name proposal -Support Electronic Referral Loops by Sending Health Information) • Provide Patient Access (name proposal – Provide Patients Electronic Access to Their Health Information) • Immunization Registry Reporting • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting
Removed measures	• Request/Accept Summary of Care • Clinical Information Reconciliation • Patient-Specific Education • Secure Messaging • View, Download or Transmit • Patient-Generated Health Data
New measures	• Query of Prescription Drug Monitoring Program (PDMP) • Verify Opioid Treatment Agreement • Support Electronic Referral Loops – Receiving and Incorporating Health Information

*Security Risk Analysis is retained, but not included as a measure under the proposed scoring methodology.

  - **Future measures under consideration:** CMS is considering adding for future program requirements (not proposed for 2019 – just under consideration), the Health Information Exchange Across the Care Continuum (under HIE objective) whereby a clinician would send an electronic summary of care record, or receive and incorporate an electronic summary of care record, for transitions of care and referrals with health care provider other than a MIPS eligible clinician. The measure would include health care providers in care settings including but not limited to long term care facilities and post-acute care providers such as skilled nursing facilities, home health, and behavioral health settings.
- **New scoring construct:**
  - **Points:** Starting 2019, there would be a total of 100 possible points available for each clinician.
  - **Scoring by measure:** Scoring would be based on performance on each measure the Each measure would be scored based on the clinician's performance for that measure, based on the submission of a numerator and denominator, except for the measures associated with the Public Health and Clinical Data Exchange objective, which require "yes or no" submissions. Each measure would contribute to clinician's total Promoting Interoperability performance category score. The scores for each of the individual measures would be added together to calculate the Promoting Interoperability performance category score of up to 100 possible points for each clinician.

- **Meeting every measure**: If a clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category.
- **If new scoring system not adopted:** If CMS does not adopt their proposed new scoring system along with the objectives and measures they have outlined, they will maintain the existing construct with one exception; they would discontinue the 2018 Promoting Interoperability Transition Objectives and Measures. If CMS does not move to the new scoring system, they still plan on adopting the two, new measures under the eprescribing objective related to opioids as optional bonus points for 2019.

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

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

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

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

- **Objectives:**
  1. **ePrescribing**: Would contain three measures weighted differently to reflect their potential availability and applicability to the clinician community. Clinicians have the option to include or exclude controlled substances in the e-Prescribing measure

denominator as long as they are treated uniformly across patients and all available schedules and in accordance with applicable law. For the two new measures, clinicians would have to include Schedule II opioid prescriptions in the numerator and denominator or claim the applicable exclusion. Clinicians who claim the exclusion under the existing e-Prescribing measure would automatically receive an exclusion for all three of the measures under the e-Prescribing objective.

- **Measure 1:** Is the preexisting measure that was already in place (10 points). This measure would be required for reporting unless an exemption was claimed (points then redistributed equally to HIE measures).
- **Measure 2 [NEW]:** Query of Prescription Drug Monitoring is a new measure. It would be option for 2019 and mandatory after that. If reported in 2019 would get 5 bonus points. CMS proposes that for at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law. Query of the PDMP for prescription drug history must be conducted prior to the electronic transmission of the Schedule II opioid prescription. CMS is proposing to include all permissible prescriptions and dispensing of Schedule II opioids regardless of the amount prescribed during an encounter in this measure in order for clinicians to identify multiple health care provider episodes (physician shopping), prescriptions of dangerous combinations of drugs, prescribing rates and controlled substances prescribed in high quantities.
    - **Denominator**: Number of Schedule II opioids electronically prescribed using CEHRT by the MIPS eligible clinician during the performance period.
    - **Numerator:** The number of Schedule II opioid prescriptions in the denominator for which data from CEHRT is used to conduct a query of a PDMP for prescription drug history except where prohibited and in accordance with applicable law. A numerator of at least one is required to fulfill this measure.
    - **Exclusion (beginning in 2020):** Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids in accordance with applicable law during the performance period. The exclusion criteria would be limited to prescriptions of Schedule II opioids as the measure action is limited to prescriptions of Schedule II opioids only and does not include any other types of electronic prescriptions.
- **Measure 3 [NEW]:** Verify Opioid Treatment Agreement is also a new measure. It would be option for 2019 and mandatory after that. If reported in 2019 would get 5 bonus points. CMS has proposed that for at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a 6-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and

incorporates it into the patient's electronic health record using CEHRT. CMS calls for this measure to include all Schedule II opioids prescribed for a patient electronically using CEHRT by the MIPS eligible clinician during the performance period, as well as any Schedule II opioid prescriptions identified in the patient's medication history request and response transactions during a 6-month look-back period, where the total number of days for which a Schedule II opioid was prescribed for the patient is at least 30 days. Example: All of the following prescriptions would be counted for this measure: a Schedule II opioid electronically prescribed for a patient for a duration of five days by the MIPS eligible clinician using CEHRT during the performance period, and four prior prescriptions for any Schedule II opioid prescribed by another health care provider (each for a duration of seven days) as identified in the patient's medication history request and response transactions during the 6-month period preceding the date on which the MIPS eligible clinician electronically transmits their Schedule II opioid prescription using CEHRT. CMS did not propose to define an opioid treatment agreement as a standardized electronic document; nor are they proposing to define the data elements, content structure, or clinical purpose for a specific document to be considered a "treatment agreement."

  - **Denominator:** Number of unique patients for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period and the total duration of Schedule II opioid prescriptions is at least 30 cumulative days as identified in the patient's medication history request and response transactions during a 6-month look-back period.
  - **Numerator:** The number of unique patients in the denominator for whom the MIPS eligible clinician seeks to identify a signed opioid treatment agreement and, if identified, incorporates the agreement in CEHRT. A numerator of at least one is required to fulfill this measure.
  - **Exclusion (beginning in 2020):** Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids in accordance with applicable law during the performance period.

- **Scoring after 2019:** Once measures 2 and 3 become required starting 2020 all three ePrescribing measures would be weighted at 5 points each. This would add 10 points to the overall possible PI score and thus CMS is calling for reweighting the Provide Patients Electronic Access to Their Health Information measure from 40 points (2019) down to 35 points (2020+).
- **Exclusions:** If a clinician qualifies for an exclusion for Measure 1 they are automatically excluded from Measures 2 and 3. Points would be evenly redistributed among the two HIE measures.

2. **Health Information Exchange (HIE) objective:**
   - **Measure 1 (name change):** CMS has proposed changing the name of the existing Summary of Care measure to **Support Electronic Referral Loops by Sending Health Information** (20 points). Exclusion available for 2019. If

a clinician claims an exemption on the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, points would be redistributed to the Support Electronic Referral Loops by Sending Health Information measure. If a clinician is the recipient of a transition of care or referral, and subsequent to providing care the clinician transitions or refers the patient back to the referring provider of care, this transition of care should be included in the denominator of the measure for the MIPS eligible clinician. CMS allows providers to constrain the information in the summary care record to support transitions of care and to use the CCDA template that is most relevant.

- **Measure 2 (NEW):** CMS has called for a new measure, **Support Electronic Referral Loops by Receiving and Incorporating Health Information**, which combines the preexisting measures, Request/Accept Summary of Care and Clinical Information Reconciliation measures (20 points). Under the new measure, for at least one electronic summary of care record received for patient encounters during the performance period for which a clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the clinician has never before encountered the patient, the clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list. In cases when the clinician determines no update or modification is necessary within the patient record based on the electronic clinical information received, and the clinician may count the reconciliation in the numerator without completing a redundant or duplicate update to the record.
    - **Denominator:** Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.
    - **Numerator:** The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: (1) Medication – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy – Review of the patient's known medication allergies; and (3) Current Problem List – Review of the patient’s current and active diagnoses.
    - **Exclusion**: Any MIPS eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period.
- **Reporting:** Clinicians would be required to report on both measures.
- **Scoring:** 20 points per measure.

3. **Provider to Patient Exchange objective (renamed from the Patient Electronic Access objective):**

- **Measure 1:** There is only one measure in this objective, **Provide Patients Electronic Access to Their Health Information** (40 points in 2019, and 35 points thereafter), renamed from Provide Patient Access measure. As discussed above

4. **Public Health and Clinical Data Exchange objective (renamed from Public Health and Clinical Data Registry Reporting objective):**
   - **Yes / no**: The measures under the Public Health and Clinical Data Exchange objective are reported using "yes or no" responses.
     Measures: Clinicians would be required to report on two measures of their choice from the following list of measures (exclusions available):
     i. **Immunization Registry Reporting**
        1. **Exclusions**: CMS has proposed that any MIPS eligible clinician meeting one or more of the following criteria may be excluded from the Immunization Registry Reporting measure if the MIPS eligible clinician:
           a. Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period.
           b. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period.
           c. Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.

     ii. **Syndromic Surveillance Reporting**
        - **Exclusions:** CMS has proposed that a clinician meeting one or more of the following criteria be excluded:
           a. Is not in a category of health care providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.
           b. Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the performance period.
           c. Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from MIPS eligible clinicians as of 6 months prior to the start of the performance period.

     iii. **Electronic Case Reporting**
        - **Exclusions:** CMS has proposed that a clinician meeting one or more of the following criteria may be excluded:

a. Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period.
b. Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period.
c. Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.

iv. **Public Health Registry Reporting:**
- **Exclusions:** CMS has proposed that a clinician meeting one or more of the following criteria may be excluded:
  a. Does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS eligible clinician's jurisdiction during the performance period.
  b. Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period.
  c. Operates in a jurisdiction where no public health registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.

v. **Clinical Data Registry Reporting:**
- **Exclusions:** CMS has proposed that a clinician meeting one or more of the following criteria may be excluded:
  a. Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period.
  b. Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period.
  c. Operates in a jurisdiction where no clinical data registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.

vi. **Reweighting:** If there are no "yes" responses and two exclusions are claimed, the 10 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

vii. **Future rulemaking:** CMS intends to propose in future rulemaking to remove the Public Health and Clinical Data Exchange objective and measures no later than CY 2022.

5. **Protect Patient Health Information objective:**
   a. **Security Risk Analysis measure:** Would remain part of the requirements for the Promoting Interoperability performance category, but would have no points associated with it. Failure to meet it would result in zero points for the entire PI performance category. Clinicians would have to report that they completed the actions included in the Security Risk Analysis measure at some point during the calendar year in which the performance period occurs.

VI. Improvement Activities [Set at 15% of final MIPS score]

KEY CHANGES:

1. Adopting one new criterion and removing one existing criterion for nominating new improvement activities beginning with the CY 2019 performance period and future years
2. Modifying timeframe for the Annual Call for Activities
3. For 2019+ adds 6 new improvement activities, modifies 5 existing improvement activities for the CY 2019+
4. Removing 1 existing improvement activity for the CY 2019+
5. Remove the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT.

- **Bonus Scores for using CEHRT:** CMS has proposed to remove bonus points for improvement activities that may be applicable to the Promoting Interoperability performance category. However, the agency says they recognize the need to continue incentives for CEHRT and therefore, are seeking comment for future consideration on potentially applying high-weighting for any improvement activity using CEHRT.
- **Updated criterion:** CMS has proposed to add one new criterion and remove a previously adopted criterion from the improvement activities nomination criteria. CMS clarified process for selecting IAs; stakeholders would apply one or more of the below criteria when submitting nominations for improvement activities:
  - Relevance to an existing improvement activities subcategory (or a proposed new subcategory);
  - Importance of an activity toward achieving improved beneficiary health outcome;
  - Importance of an activity that could lead to improvement in practice to reduce health care disparities;
  - Aligned with patient-centered medical homes;
  - Focus on meaningful actions from the person and family's point of view;
  - Support the patient's family or personal caregiver;
  - Activities that may be considered for an advancing care information bonus **[Proposed for removal]**
  - Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care);

- Feasible to implement, recognizing importance in minimizing burden, especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA;
- Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; or
- CMS is able to validate the activity
- Include a public health emergency as determined by the Secretary **[NEW]**

- **Medium vs High-weight activities:** CMS deems high-weighed activities to be those that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being and require significant investment of time and resources should be high-weighted. Medium-weighted improvement activities they state are simpler to complete and require less time and resources as compared to high-weighted improvement activities.
- **High-weighted activities**: CMS deems high-weighted activities to be:
    - the patient-centered medical home
    - Those requiring performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI),
    - Participation in a MIPS eligible clinician's state Medicaid program, or an activity identified as a public health priority (such as emphasis on anticoagulation management or utilization of prescription drug monitoring programs)
    - Those that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being
    - Successful participation in the CMS Study on Factors Associated with Reporting Quality Measures
- **Medium-weighted activities:** All other activities that do not meet the above criteria are considered medium weight.
- **Annual call for submission of new IAs:** Until now stakeholders have had until March 1 to submit IAs for consideration for the next year. Given the volume of activities CMS is calling for extending the timeline to June 30th and delaying by a year when the IAs would be considered in rulemaking (i.e. submit by June 30th 2020 would be considered in 2021 rulemaking for possible inclusion in 2022).
- **New, revised and removed IAs:** CMS calls for 6 new improvement activities; modifying 5 existing activities; and removing 1 existing activity. See Improvement Activities Inventory in Tables A and B of Appendix 2 of the rule.

VII. Medicaid

- **eCQMs:** eCQMs under Medicaid for 2019 would be aligned with those under MIPS for 2019. We also propose that for 2019 the Medicaid Promoting Interoperability Program would adopt the MIPS requirement that EPs report on at least one outcome measure (or, if an applicable outcome measure is not available or relevant, one other high priority measure).
- **Promoting interoperability:**
    - **Reporting period:** The reporting period would be a year in 2019. Since incentive payments under Medicaid end for the PI program under statute end by 2021, CMS is calling for a 90--day reporting period in 2021 ending October 31.

- **Proposed Change to Objective 6 (Coordination of Care through Patient Engagement):**
    - **Measure 1 (View, Download, or Transmit):** Will be 5% for 2019+(had been slated to jump to 10%).
    - **Measure 2 (Secure Electronic Messaging)**: Will be 5% for 2019+ (was slated for 25%)
- **Proposed Change to the Syndromic Surveillance Reporting Measure**: For EP Objective 8 (Public health and clinical data registry reporting), Measure 2 (Syndromic surveillance reporting measure), CMS plans to amend the language restricting the use of syndromic surveillance reporting for meaningful use only to EPs practicing in an urgent care setting.