Joint Physician Fee Schedule & Quality Payment Program (QPP) Rule for 2019
Merit-based Incentive Program (MIPS) Final Rule Policy Overview
December 2018

I. DOCUMENT SCOPE

We have summarized the portion of the 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; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act,” published in the Federal Register on November 1, 2018. This summary focuses on the Merit-based Incentive Program (MIPS) and the four performance categories with a particular emphasis on the Promoting Interoperability performance category. 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. And, a score of 75 and greater is needed to be considered eligible for exceptional performance and thus additional funding.

II. KEY PERFORMANCE CATEGORY CHANGES for 2019:

• COST: CMS has developed new episode-based cost measures for inclusion in the cost performance category beginning in 2019.
  • Weight: 15% instead of 30%, as previously finalized.
  • Performance period: One year starting 2019 and all future years.
• QUALITY: Facility-based measure credit permitted. Small practice bonus added to this category.
  • Weight: 50% in 2018 and 45% in 2019.
  • Performance period: 12 months starting 2018 and all future years.
• PROMOTING INTEROPERABILITY: Fewer measures, some controversial measures removed, better synced with hospital requirements, new 100-point scoring system, and new opioid measures. Also, CMS has, “prioritized only those actions which are completed electronically using certified health IT.” CMS is, limiting bonus points to brand new measures in the Promoting Interoperability performance. They are considering but have not adopted yet chances for clinicians to earn credit across multiple MIPS performance categories.
  • Weight: 25%.
  • Performance period: A minimum of a continuous 90-day period.
• IMPROVEMENT ACTIVITIES: Removes the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT. NOTE: CMS
selected a new improvement activity which CHIME requested which will allow clinicians to get credit starting in 2020, “Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support.” See page 2,368 of the rule for details.

- **Weight**: 15%
- **Performance period**: A minimum of a continuous 90-day period.

### III. GENERAL POLICIES

- **Low Volume Definition**: A third criteria was added. For 2019 eligibility for a low-volume threshold and thus exemption from MIPS will include meeting one of the following criteria: 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) provide 200 or fewer covered professional services to Part B-enrolled individuals.

- **Eligible clinicians**: CMS is expanding the definition of eligible clinicians. For 2019 this will include, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologist, clinical psychologist, registered dieticians or nutrition professionals. Clinical social workers are not being added. These clinicians may choose to submit Promoting Interoperability performance category measures, however, if they choose to report, they would be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians. CMS will automatically assign a zero percent weighting for the Promoting Interoperability performance category which will be reweighted to the quality performance category for these new types of MIPS eligible clinicians. If a clinician chooses to report as part of a group, all of the MIPS eligible clinicians in the group must qualify for a zero percent weighting in order for the Promoting Interoperability performance category to be reweighted in the final score.

- **Low-Volume threshold opt-in**: Starting 2019 the low-volume threshold for a clinician to opt-in to MIPS is one who meets one or two (but not all three) of the following: 1) has allowed charges for covered professional services less than or equal to $90,000; 2) furnishes covered professional services to 200 or fewer Medicare Part B-enrolled individuals; or 3) furnishes 200 or fewer covered professional services to Medicare Part B-enrolled individuals.

- **Small Practitioners**: In last year’s rule CMS finalized a 5 point small practice bonus for 2018 for those qualifying as such if they submitted data on at least one performance category. For 2019 CMS is keeping the bonus but they are offering credit only under the quality performance category. It will be worth 6 points under quality if the clinician submits data on at least one quality measure.

- **Data submission deadline**: Would begin no earlier than January 2 and end no later than March 31 for the CMS Web Interface. Also aligns Web Interface submission type with all other submission type deadlines.

- **Facility-based clinician scoring**: The law allows CMS to use measures for payment systems other than for physicians, such as measures used for inpatient hospitals, for purposes of the quality and cost performance categories. Starting in 2019 individual clinicians that supply 75 percent or more of their covered professional services (for groups 75% or more of the clinicians in the TIN must meet this threshold) in an inpatient hospital,
on-campus outpatient hospital, or emergency room setting based are eligible. For a detailed discussion of this policy see pages 1328-1352.

- **Multi-category measures**: CMS says they are considering adopting multi-category measures in the future. The agency said, “One possibility we have identified is to establish several sets of new multi-category measures that would cut across the different performance categories and allow MIPS eligible clinicians to report once for credit in all three performance categories. Our goal would be to establish several of combined measures, so MIPS eligible clinicians could report once for credit across all three performance categories.”

- **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 (for groups of 25+).

**TABLE 32: Data Submission Types for MIPS Eligible Clinicians Reporting as Individuals**

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary&lt;sup&gt;1&lt;/sup&gt;</td>
<td>eCQMs, MIPS CQMs, QCDR measures, Medicare Part B claims measures (small practices)</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Part B claims (small practices)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>No data submission required&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Individual</td>
<td>-</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Third party intermediary does not apply to Medicare Part B claims submission type.

<sup>2</sup> Requires 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 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 33: Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Submission Types</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Group or Third Party Intermediary</td>
<td>cCQMs, MIPS CQMs, QCDR measures</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td>Group or Third Party Intermediary</td>
<td>CMS approved survey vendor measure</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface (groups of 25 or more eligible clinicians)</td>
<td>-</td>
<td>administered directly by CMS</td>
</tr>
</tbody>
</table>

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’ billing on Medicare claims.

IV. **Quality**

**KEY CHANGES:**

- Weight is 50% in 2018 and 45% in 2019.
- Claims reporting now allowed for small providers.
- High-priority measure set now includes opioids.
- **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:** For Medicare Part B claims measures:

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

- Clinicians and groups that report on a specialty or subspecialty measure set must submit data on at least six measures within that set, including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician or group, report on each measure that is applicable.

- For CMS Web Interface measures report on all measures included in the CMS Web Interface. The group is required to report on at least one measure for which there is Medicare patient data.

- **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. Measure specifications are available on the [Quality Payment Program resource library](#) prior to the beginning of the performance period. Table of measures is below.

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

- **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, unless for administrative or claims data in which case it only applies to Medicare Part B patients. However, for groups that submit 5 or fewer quality measures and do not meet the CAHPS for MIPS sampling requirements, the quality denominator will be reduced by 10 and the measure will receive zero points.
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 has also added opioid measures to those that are considered high-priority starting 2019.

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. **NOTE:** CMS requires use of 2015 CEHRT for eCQMs starting in 2019.

- **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. 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), CMS can remove the measure without waiting for the full 4-year removal cycle (can remove at next rulemaking).

- **Process vs Outcome measures:** CMS is trying to reduce the number of process measures and move more towards outcomes measures. Starting in 2019 CMS will implement an incremental approach to removing measures. For more details see page 1039.

### IV. Cost

**KEY CHANGES:**

1. Weight for 2019 has been changed from 30% to 15%.
2. CMS has added 8 episode-based measures starting 2019.

- **Weight of cost category:** The Bipartisan Budget Act of 2018 gave CMS increased flexibility to establish the weight of the cost performance category for the first five years of MIPS, but the weight is still required to be 30 percent beginning with the 2024 MIPS payment year. As a result, and because CMS recognizes that cost measures are still early in development, CMS is weighting the cost category for 2019 at 15% rather than 30% which is what they had previously finalized in last year’s rule for 2019.

- **Cost measures:** CMS is required to post information on cost measures annually the last day of the year starting in 2018.
  - **2018:** CMS set two cost measure for 2018:
    - Total per capita cost measure; and
    - Medicare spending per beneficiary (MSPB) measure.
  - **2019:** CMS is adding 8 episode-based measures (different from per capita cost measures) for 2019 for the cost category; they are intended to represent the total cost to Medicare for an episode of care. CMS has finalized 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. See pages 1049-1075 for more details. CMS finalized the measures proposed in Table 36 below.

### TABLE 36: Episode-Based Measures Proposed for the 2019 MIPS Performance Period and Future Performance Periods

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

7
V. Promoting Interoperability

KEY CHANGES:
1. Promoting Interoperability performance category is weighted at 25% of the total MIPS score for 2019.
2. CMS has changed the name of the category from Advancing Care Information (ACI) to Promoting Interoperability (PI).
3. A new scoring methodology in effect for 2019 which removes base vs performance measures with a total possible score of 100 points.
4. Bonus points for using CEHRT to complete certain IAs has been removed.
5. There are fewer measures and objectives.
6. There is better alignment with hospital requirements.
8. A clinician who is in active engagement with two different public health agencies or clinical data registries for purposes of the same measure would be considered to have met the reporting threshold of two.
9. MIPS eligible clinicians must report on all of the required measures across all of the objectives in order to earn any score at all. Failure to report any required measure, or reporting a “no” response on a yes/no response measure, unless an exclusion is claimed will result in a Promoting Interoperability performance category score of zero.

- **New Name**: CMS has renamed this category from Advancing Care Information to Promoting Interoperability.
- **Alignment**: Measures and objectives now align better with what is required of Medicare hospitals.
- **Scoring**: There is an entirely new scoring paradigm. The base vs performance measure construct has been removed. Each measure is scored based on the clinician’s performance for that measure, except for the measures associated with the Public Health and Clinical Data Exchange objective, which require a yes/no attestation. Each measure will contribute to the clinician’s total Promoting Interoperability performance category score. The scores for each of the individual measures are added together to calculate the total Promoting Interoperability performance category score of up to 100 possible points for each MIPS eligible clinician. To calculate the Promoting Interoperability performance category score, the measure scores are added together, and the total sum is divided by the total possible points (100).
**Bonus Scoring:** CMS has also removed the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT.

**Removed measures:** Four measures are removed altogether as CMS deemed them too burdensome for clinicians to meet:
- Patient-Specific Education;
- Secure Messaging;
- View, Download, or Transmit; and
- Patient-Generated Health Data

### TABLE 41: Scoring Methodology for the MIPS Performance Period in 2019

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td><strong>e-Prescribing</strong></td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td><strong>Bonus:</strong> Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 point bonus</td>
</tr>
<tr>
<td></td>
<td><strong>Bonus:</strong> Verify Opioid Treatment Agreement</td>
<td>5 point bonus</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Report to two different public health agencies or clinical data registries for any of the following:</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Immunization Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting**</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusion available.**

### TABLE 42: Scoring Methodology for the MIPS Performance Period in 2020

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td><strong>e-Prescribing</strong></td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td><strong>Bonus:</strong> Verify Opioid Treatment Agreement</td>
<td>5 point bonus</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information**</td>
<td>20 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Report to two different public health agencies or clinical data registries for any of the following:</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Immunization Registry Reporting**</td>
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<td>Public Health Registry Reporting**</td>
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</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting**</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusion available.**
• **Fewer measures / objectives**: 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. There would now only be four objectives:
  1. eprescribing;
  2. HIE;
  3. Provider to patient exchange; and

• **Brand new measures**: CMS has added two new measures that were not previously part of MIPS:
  • Query of PDMP (under ePrescribing objective)
  • Verify Opioid Treatment Agreement (under ePrescribing objective)

• **New / Renamed measures**: For 2019:
  • The Request/Accept Summary of Care and Clinical Information Reconciliation measures have been replaced with a new measure, “The Support Electronic Referral Loops by Receiving and Incorporating Health Information” (under HIE objective); and
  • The Send a Summary of Care measure has been renamed the, “Support Electronic Referral Loops by Sending Health Information” measure.

• **Modified measures / objectives**: CMS has:
  • Renamed the Patient Electronic Access objective to Provider to Patient Exchange and renamed the remaining measure Provide Patient Access to Provide Patients Electronic Access to Their Health Information; and
  • Renamed the Public Health and Clinical Data Registry Reporting objective to Public Health and Clinical Data Exchange.

• **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.

• **Future measures under consideration**: CMS is considering adding for future program requirements (not adopted 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.

• **Objectives and Measures for 2019 and 2020**:
  1. ePrescribing:
    • **Number of Measures**: Will contain three measures weighted differently to reflect their potential availability and applicability to the clinician community.
    • **Controlled substances**: 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.
• **Opioid measures**: For the two new measures (see below), clinicians would have to include Schedule II opioid prescriptions in the numerator and denominator or claim the applicable exclusion.

• **Exclusions**: 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: e-Prescribing**
- **Points**: Is the preexisting measure that was already in place. It will be 10 points for both 2019 and 2020.
- **Exclusion**: This measure is required for reporting unless an exemption was claimed (points then redistributed equally to HIE measures).
- **Measure description**: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.
- **Denominator**: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.
- **Numerator**: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.
- **Exclusions**: Any MIPS EP who writes fewer than 100 permissible prescriptions during the performance period.

**Measure 2 [NEW]: Query of Prescription Drug Monitoring.**
- **Optional**: It is optional for 2019.
- **Points**: If reported in 2019 a clinician would get 5 bonus points. CMS had considered making it required in 2020 but did not finalize that policy and will revisit this in the future. They have not decided on the set number of points for 2020.
- **PDMP / EHR Integration**: CMS has said, "we agree that the lack of EHR integration with PDMPs is an obstacle to widespread adoption of this measure. We will continue to work with our colleagues across HHS and with stakeholders to develop necessary standards and complementary resources to promote the advancement of PDMP functionality."
- **Manual calculations**: CMS understands that many clinician systems may not have the ability to capture the number of PDMP queries in an automated fashion, and that manual data capture may be needed.
- **Queries:**
  - **Use of HIEs**: Clinicians may query the PDMP in any fashion allowed under applicable state law, which would include the use of HIEs to access PDMP data.
  - **Timing of queries**: The query of the PDMP for prescription drug history must be conducted prior to the electronic transmission of the Schedule II opioid prescription.
  - **State law**: MIPS eligible clinicians would have flexibility to query the PDMP using CEHRT in any manner allowed under their State law.
• **Opioids definition:** CMS is defining opioids as Schedule II controlled substances.

• **Amounts prescribed:** This measure includes all permissible prescriptions and dispensing of Schedule II opioids regardless of the amount prescribed during an encounter in order for MIPS eligible 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.

• **Use of CEHRT:** Clinicians are required to use CEHRT as the sole means of creating the prescription and for transmission to the pharmacy.

• **Measure description:** 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 PDMP for prescription drug history, except where prohibited and in accordance with applicable law.

• **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:** None available.

• **Measure 3 [NEW]: Verify Opioid Treatment Agreement**
  - **Optional:** It is optional for 2019 and 2020.
  - **Points:** Clinicians can receive 5 bonus points in both 2019 and 2020.
  - **Purpose:** For clinicians to identify whether there is an existing opioid treatment agreement when they electronically prescribe a Schedule II opioid using CEHRT if the total duration of the patient’s Schedule II opioid prescriptions is at least 30 cumulative days. Also intended to clearly outline responsibility of patient and clinician.

• **NCDPD:** 2015 CEHRT must support NCPDP SCRIPT Standard v10.6 standards and associated implementation specifications for electronic prescribing. CMS proposed that the 6-month look-back period would utilize at a minimum the industry standard NCDCP SCRIPT v10.6 medication history request and response transactions codified at §170.205(b)(2)). However, CMS received comments noting neither the NCPDP 10.6 Medication History Query nor the NCPDP 2017071 Medication History Query has a required, discrete data field to capture the prescription Days. CMS says due to the technically complex and potentially burdensome nature for meeting it that they may consider modifications to the denominator in future rulemaking. CMS will consider changes to the denominator in the future. CMS will revisit policies for after 2020 in future rulemaking. ONC has stated (80 FR 62642), adoption of the requirements for NCDCP SCRIPT v10.6 does not preclude developers from incorporating and using technology standards or services not required by regulation in their health IT products.
• **Format**: CMS does not define a standardized electronic document, elements, content structure, or clinical purpose for a specific document to be considered a “treatment agreement.”

• **Use of CEHRT**: CMS requires this to meet the measure. Yet, they acknowledge that there is no capability within CEHRT that supports verification and incorporation of an agreement. Instead they point to existing certification functionality which helps support the measure including those around drug formulary checks and preferred drug check lists for a given patient and medication. They also point to the ability of clinicians to use CEHRT create a new prescription, change a prescription, cancel a prescription, refill a prescription, request fill status notifications and request and receive medication history information.

• **Definition of “incorporate”**: Comments sought clarity form CMS on what it means to incorporate into an EHR. CMS defers to clinicians on how to capture in their EHR. 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.

• **Measure description**: 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.

• **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**: None for 2019 or 2020.

2. **Health Information Exchange (HIE) objective**:

   • **Measure 1**: Support Electronic Referral Loops by Sending Health Information.

   • **Name change**: CMS renamed the existing Summary of Care measure to Support Electronic Referral Loops by Sending Health Information.

   • **Points**: 20 points in both 2019 and 2020.

   • **Measure description**: 
• **Denominator**: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.

• **Numerator**: The number of transitions of care and referrals in the denominator where the summary of care record was created using CEHRT and exchanged electronically.

• **Exclusion**: Available for 2019 and 2020; any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. 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: Support Electronic Referral Loops by Receiving and Incorporating Health Information.**
  - **NEW**: CMS has added 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. Under the new measure, for at least one electronic summary of care record received for patient encounters during the performance Request/Accept Summary of Care and Clinical Information Reconciliation measures 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. CMS has also said, “for cases in which the MIPS eligible clinician determines no update or modification is necessary within the patient record based on the electronic clinical information received, and the MIPS eligible clinician may count the reconciliation in the numerator without completing a redundant or duplicate update to the record.”
  - **Points**: 20 points for 2019 and 2020.
  - **CCDAs**: CMS allows providers to constrain the information in the summary care record to support transitions of care. Although a current
problem list must always be included, the health care provider can use their judgment in deciding which items historically present on the problem list, medical history list (if it exists in CEHRT), or surgical history list are relevant given the clinical circumstances. Clinicians may use any document template within the C-CDA standard for purposes of the measures under the Health Information Exchange objective.

- **Definition of “incorporate”**: Under the old measure, Request/Accept Summary of Care, CMS said they received feedback that providers were confused by what was meant by the word “incorporate.” CMS says they intended this to, “relate to the workflows undertaken in the process of clinical information reconciliation further defined in the Clinical Information Reconciliation measure.” Further, they noted the genesis for the removal of the Request/Accept Summary of Care and Clinical Information Reconciliation measures was to remove provider burden, redundancies, and measures that were not fully automated and which involved manual calculations. Thus, with the removal of the two old measures, CMS says they are intending clinicians would, “no longer be required to manually count each individual non-health-IT related action taken to engage with other providers of care and care team members to identify and obtain the electronic summary of care record. Instead, the proposed measure would focus on the result of these actions when an electronic summary of care record is successfully identified, received, and reconciled with the patient record.”

- **Measure description**: For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.

- **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. **NOTE**: In the event that 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 clinician.

- **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 –

- **Exclusions:** 1) Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from this measure; 2) 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 would be excluded from this 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.**

  This measure has been renamed from Provide Patient Access measure. CMS did this to, “emphasize electronic access of patient health information as opposed to use of paper-based actions and limit the focus to only health IT solutions to encourage adoption and innovation in use of CEHRT.”

- **Removed measures:** CMS has removed the remove the Patient-Specific Education measure. CMS has also removed the Coordination of Care through Patient Engagement objective and all associated measures. CMS further clarified that this new measure does not require patients to, “does not require that patients actually access their information. Patients should be able to access their health information on demand, and we encourage MIPS eligible clinicians to maintain the appropriate functionalities for patient access to their health information at all times unless the system is undergoing scheduled maintenance, which should be limited.”

- **Points:** The Provide Patients Electronic Access to Their Health Information measure will be worth up to 40 points starting 2019, not 35 points as CMS had proposed beginning in CY 2020, but they did not do that because they are not requiring the Verify Opioid Treatment Agreement measure beginning in CY 2020 as proposed, which would have been worth up to 5 points.

- **APIs:** CMS declined to take our suggestion to not require the use of APIs for three years until after the standards had been finalized. They also declined to allow providers to claim an exclusion if they felt the application did not meet provider’s security requirements. They said instead that clinicians, “should work with their health IT vendors to identify applications that meet their security needs. While we appreciate stakeholder concerns regarding security issues, we believe there are already applications available to consumers that could satisfy security requirements.” They furthermore reiterated that patients have a right to access their data, “using any application of their choice that is configured to meet the technical specifications of the application programming interfaces (API) in the MIPS eligible clinician’s CEHRT.” CHIME suggested to CMS that they work with OCR and FTC on more education for patients on rights to access their information and stated, “We appreciate commenters’ interest in additional educational materials for patients on how they can improve the privacy and security of their health information. We will take this comment into consideration as we consider what other consumer-facing materials are helpful, and we direct commenters to resources currently available from HHS (for
example, content and materials such as those available at https://www.hhs.gov/hipaa/for-individuals/right-to-access/index.html and FTC (for example, content and materials such as those available at https://www.consumer.ftc.gov/topics/online-security) websites.”

- **Measure description:** For at least one unique patient seen by the MIPS eligible clinician:
  1. The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
  2. The MIPS eligible clinician ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician’s CEHRT.

- **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period.

- **Numerator:** The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician’s CEHRT.

- **Exclusions:** None.

4. **Public Health and Clinical Data Exchange objective (renamed from Public Health and Clinical Data Registry Reporting objective):** **NOTE:** CMS is considering removing this objective and associated measures in the future possibly by CY 2022.
   - **Yes / no:** The measures under the Public Health and Clinical Data Exchange objective are reported using “yes or no” responses.
   - **Points:** 10 points in both 2019 and 2020. 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. No bonus points are available for implementing more than two public health and clinical data exchange measures.
   - **Submitting on two registries for same measure:** CMS says, “Although we proposed that a MIPS eligible clinician must report on two measures of their choice to fulfill the Public Health and Clinical Data Registry reporting objective, we agree that a MIPS eligible clinician should be able to report to two different public health agencies or clinical data registries for purposes of the same measure.” Thus, CMS will allow clinicians to get full credit for this objective if they two different public health agencies or clinical data registries for purposes of the same measure.
   - **Measures:** Clinicians will be required to report on two measures of their choice from the following list of measures (exclusions available):
     - **Immunization Registry Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
1. **Exclusions**: 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.

• **Syndromic Surveillance Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.
  o **Exclusions**: 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.

• **Electronic Case Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.
  o **Exclusions**: 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.

- **Public Health Registry Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.
  
  o **Exclusions**: 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.

- **Clinical Data Registry Reporting**: The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.
  
  o **Exclusions**: 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.

5. **Protect Patient Health Information objective**:
   
   a. **Security Risk Analysis measure**: Remains part of the requirements for the Promoting Interoperability performance category, but CMS is not assigning any points for completing it. Failure to meet it results 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

KEY CHANGES:

1. 15% of final MIPS score.
2. Adopting one new criterion and removing one existing criterion for nominating new improvement activities beginning with the CY 2019 performance period and future years.
3. Extend by one extra year the time between when a measure is nominated and subsequently accepted to when it could be effective.
4. For 2019+ CMS added six new improvement activities, modified five existing ones, and removed one.
5. Removed 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 removed bonus points for improvement activities that may be applicable to the Promoting Interoperability performance category.
- **Updated criterion**: Below are CMS’ criterion for selecting new IAs.
  - Activities that may be considered for an advancing care information bonus [Is being removed]
  - Include a public health emergency as determined by the Secretary [Is being added: NEW]
  - 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;
  - 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.

- **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. CMS is changing the Annual Call for Activities from February 1st through March 1st to February 1st through June 30th, providing approximately 4 additional months for stakeholders to submit nominations beginning with the CY 2019 performance period. Further, this would delay 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 starting page 2360.

### VII. Medicaid

- **Incentives:** December 31, 2021 is the last date that states could make Medicaid Promoting Interoperability Program payments to Medicaid EPs.

- **eCQMs:**
  - **Alignment:** CMS is aligning the eCQMs available for Medicaid EPs in 2019 with those available for MIPS eligible clinicians for 2019. Medicaid clinicians electing to submit on eCQMs would have to do so for 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. And, if no outcome or high priority measures apply to a Medicaid EP’s scope of practice and there is no data for any of the outcome or high priority measures reportable by his or her CEHRT, they may report on six non-outcome and non-high priority measures that are applicable to their scope of practice.
  - **Reporting year:** CMS has finalized a full year report period for eCQMs.

- **Promoting interoperability:** The Medicaid Meaningful Use payments will end December 31, 2021.
  - **Reporting periods:**
    - **2019:** 90-day continuous period for a first time Meaningful User (EHR and eCQM reporting); for established Meaningful Users it’s a full year.
    - **2020:** CMS says, “we will adjust future years’ requirements for reporting eCQMs in the Medicaid Promoting Interoperability Program through rulemaking, and will continue to align the quality reporting requirements, as logical and feasible, to minimize EP burden.”
- **2021**: 90 days (must end by October 31, 2021).

- **Measure Changes**: **NOTE**: CMS has acknowledged that retaining these measures under Medicaid PI will misalign with Medicare hospital and MIPS requirements and has said they will consider, “proposing further changes to the Medicaid Promoting Interoperability Program in future rulemaking, to improve alignment with the objectives and measures under the MIPS program.” Meanwhile, they have made changes to certain measures:
  - **Change Coordination of Care through Patient Engagement**:
    - **Measure 1 (View, Download, or Transmit)**: Will be 5% for 2019+ (was slated to jump to 10%).
    - **Measure 2 (Secure Electronic Messaging)**: Will be 5% for 2019+ (was slated for 25%).
    - **Measure 3 (Patient-generated data)**: There remains a third, unchanged measure in this objective, patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period. Clinicians must meet two of the three measures in this objective.

- **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 amended the language restricting the use of syndromic surveillance reporting for meaningful use only to EPs practicing in an urgent care setting. The revised objectives will:
  - Include any other setting from which ambulatory syndromic surveillance data are collected by the state or local public health agency.
  - The change does not alter the exclusion for this measure for EPs who are not in a category of health care providers from which ambulatory syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system.
  - This change does not create any requirements for syndromic surveillance registries to include all EPs.
  - It is possible that an EP could own CEHRT and submit syndromic surveillance in a format that is not accepted by the local jurisdiction. In this case, the EP may take an exclusion for syndromic surveillance.