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PAI Scorecard of CY 2019 QPP Finalized Policies

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Simplify the QPP and reduce physician burden

	FINALIZED POLICY	PAI COMMENTS
MIPS Submission Mechanisms	CMS finalized 5 basic submission types: • **Direct** computer-to-computer interactions • **Login and upload** in a CMS-specified form and manner • **Login and attest** in a CMS-specified from and manner • **Medicare Part B claims** but only for small practices • **CMS Web Interface** Additionally, CMS will allow submission mechanisms for single measures as well as for measures reported by groups and virtual groups.	PAI recommended that the Agency retain the current terms and definitions to allow for greater continuity and less disruption in the program.

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Simplify the QPP and reduce physician burden

	FINALIZED POLICY	PAI COMMENTS
MIPS Promoting Interoperability Category	CMS eliminated the base, performance, and bonus scores, and finalized a new scoring methodology under which performance will be based at the individual measure level. The scores for each individual measure will be summed up to arrive at the Promoting Interoperability category score. CMS has also eliminated the bonus for completing certain Improvement Activities using CEHRT.	PAI did not support the new scoring methodology as it would further add to the complexity of the program and reduce a physician's ability to participate. PAI also opposed the proposal to eliminate the bonus points and continued to support bonuses for those improvement activities currently qualified for CEHRT reporting.
MIPS Quality Category Scoring	CMS sought input on moving towards one of the following approaches for the Quality category scoring methodology: • Establishing a pre-determined denominator (e.g., 50 points) but no specific requirements on the number of measures that must be submitted. Measures would be classified based on value tier (e.g., gold, silver, bronze) that would have different maximum points that could be earned (this would be similar to how the points are currently structured under the improvement activities category for high- and medium-weight activities). • Keeping the current requirement that 6 measures be reported, with every measure worth up to 10 points, but changing the minimum number of points that can be earned based on the classification tier (e.g., gold measures would receive at least 5 points instead of at least 3 points).	PAI did not support these proposals and had several concerns with the new proposed methodologies. PAI supported maintaining the current methodology and supported eliminating the requirement that a minimum number of measures should be reported.

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Make the QPP translatable across specialties and settings

	FINALIZED POLICY	PAI COMMENTS
MIPS Groups Creation of Sub-groups	CMS is considering a sub-group option for future years of the program and sought comments on developing such an option.	PAI supported the sub-group option and encouraged the Agency to proceed in a transparent manner. We believe this could potentially be a valuable option for multidisciplinary groups, as well as groups that span across geographic/regional areas. PAI suggested some specific policies for consideration as this option is being developed.
MIPS Cost Category	CMS added 8 episode-based measures beginning with the 2019 performance year: Elective outpatient percutaneous coronary intervention; Knee arthroplasty; Revascularization for lower extremity chronic critical limb ischemia; Routine cataract removal with intraocular lens (IOL) implantation; Screening/surveillance colonoscopy; Intracranial hemorrhage or cerebral infarction; Simple pneumonia with hospitalization; and ST-elevation myocardial infarction (STEMI) with PCI.	PAI expressed several concerns with the episode-based cost measures and emphasized the need for additional testing and experience before these measures are used for determined the Cost category score.
	CMS finalized two categories for the cost measures: • **Acute inpatient medical condition episode group** – attribution to each MIPS EC who bills inpatient E/M claim lines during trigger inpatient hospitalization under a TIN that renders at least 30% of inpatient E/M claim lines in that hospitalization. The case minimum would be 20 episodes for these measures. • **Procedural episode group** – attribution to each MIPS EC who renders a trigger services as identified by HCPCS/CPT code. The case minimum would be 10 episodes for these measures.	PAI highlighted the need for the Cost category to be further evaluated as there are many concerns with attribution and risk adjustment that need to be resolved. We encouraged the Agency to continue to engage with stakeholders and work closely on the development of this category.
MIPS Cost Category	CMS noted its desire to ensure a “smooth transition to a 30 percent weight” for the Cost category and will consider the comments received in response to this policy for future rulemaking.	PAI noted that the proposed change from 10% to 15% weight may seem modest but represents a 50% increase in the impact of the cost measure on the overall score. Depending on how the Agency accounts for changes in the distribution of scores, the cost measure could have

Make the QPP translatable across specialties and settings

	FINALIZED POLICY	PAI COMMENTS
		an outsized impact on the distribution of overall scores and payment adjustments.

Make the QPP more predictable

	FINALIZED POLICY	PAI COMMENTS
MIPS Determination Period	Beginning with the 2019 performance yea, MIPS eligibility determination will be based on a 24-month period including two-segments: (1) 12-month segment beginning October 1 two years prior to the performance period and ending on September 30 the year preceding the performance period (e.g., for the 2019 performance year this would be October 1, 2017 – September 30, 2018); and (2) 12-month segment beginning on October 1 of the year preceding the performance year and ending on September 30 of the performance year (e.g., for the 2019 performance year this would be October 1, 2018 – September 30, 2019). The first segment will also be used for the Virtual Group eligibility determinations.	While PAI understood the logic behind the use of the proposed two segments, we believe the second segment could lead to confusion and uncertainty about participation status. PAI requested that the second segment have an end date and notification date, which both occur prior to the start of the performance year, regardless of the length of the segment. This would allow physicians and practices to better prepare for participation beginning January 1 of the applicable performance year.
MIPS	CMS finalized the following category weights for the 2019 performance year / 2021 payment adjustment year:	PAI expressed concern about increasing the weight of the Cost category from 10% to 15%. PAI recommended maintaining the 10%

Make the QPP more predictable

	FINALIZED POLICY	PAI COMMENTS
Category Weights	• Quality – 45% • Promoting Interoperability – 25% • Cost – 15% • Improvement Activities – 15% CMS maintained the category reweighting policies.	cost category weight and the 50% quality category weight until concerns with the cost category are addressed.
MIPS Performance Periods	For 2022 and beyond, CMS finalized the following performance periods for each of the four categories: • Quality and Cost categories – full calendar years • Promoting Interoperability and Improvement Activities categories – minimum 90-day period Additionally, CMS will take into consideration comments it received on whether it should expand the Cost category performance period from one year to 2 or more years in future rulemaking.	PAI supported maintaining the 90-day performance period for the Promoting Interoperability and Improvement Activities performance categories and recommended similar reporting periods for the Quality and Cost categories to promote alignment across the program. PAI also noted that the proposed two or more years performance period for the cost category could potentially also be an option, but with safeguards in place to both invite and protect continued physician participation in the program. Additional details, impact analysis, and other information for stakeholder review and input would be necessary prior to moving forward with this proposal.
MIPS Quality Category	For extremely topped out measures (e.g., measures with an average mean performance within the 98th to 100th percentile range) CMS finalized a policy allowing it to propose the measure for removal in the next QPP changes rule but will consider retaining the measure for compelling reasons.	PAI opposed this policy, believing that the Agency should only propose a measure for removal during the official measure process to assist with predictability. Furthermore, PAI encourage the Agency to reconsider it's topped-out measures policies.
	CMS finalized an incremental approach for removing non-high priority process measures, which would take into consideration the impact the removal of the measure would have for a specific specialty and whether is promotes positives outcomes in patients, among other considerations.	PAI opposed this policy, believing that the Agency should only propose a measure for removal during the official measure process to assist with predictability.

Make the QPP more predictable

	FINALIZED POLICY	PAI COMMENTS
MIPS Quality Category	CMS will maintain the following minimum points policies for Quality category measures: • A minimum of 3 points for each measure that can be reliably scored against a benchmark • For small practices (15 or fewer ECs), a minimum of 3 points for measures that do not meet the minimum data-completeness criteria • For "larger" practice (greater than 15 ECs), a minimum of 1 point for measures that do not meet the minimum data completeness criteria • A minimum of 3 points for measures that do not meet the case minimum requirements • A minimum of 3 points for measures that do not have a benchmark	PAI supported this policy and encouraged the Agency to move towards greater alignment and predictability by increasing the minimum number of points to three for all reported measures. However, did not support the additional proposal beginning with the 2020 performance year to assign a score of zero points for measures that do not meet the data completeness criteria.
	CMS has eliminated the bonus points for CMS Web Interface high-priority measures, and intends to eliminate the bonus points for end-to-end reporting of high-priority measures after the 2019 performance year (but has not finalized this policy at this time).	PAI did not support these proposals eliminating the bonus points and recommended that the Agency gain additional experience and gather additional data on performance and reporting prior to making such changes in the program.
MIPS Small Practice Bonus	CMS finalized its policy to add the small practice bonus to the Quality category score but increased the value from 3 points to 6 points.	PAI urged the Agency to continue the small practice bonus as currently finalized and applied.
APMs Nominal Amount Standard	CMS will maintain the 8% nominal amount standard for the QP performance periods through 2024.	PAI reaffirmed its past comments on the need to lower the nominal amount standard for small and rural practices. PAI recommended starting with fairly low nominal amount standards and gradually increasing them as small groups get comfortable taking on more risk – similar to the approach being taken under the Medical Home Model.

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Make the QPP more predictable

	FINALIZED POLICY	PAI COMMENTS
APMs QP Determinations	CMS will allow for a claims' run-out for 60 days before calculating the scores for the QP determinations for Advanced APM participation so that the determinations will be completed approximately 3 months after the end of each determination period.	PAI supported the Agency's efforts to notify physicians of their QP determinations as soon as possible and encouraged the Agency to consider ways that also effectively communicate this information on a timely basis rather than burdening physicians with constantly checking the QP look-up portal to see that this information is available. Additionally, PAI supports bilateral opportunities for correction of errors or delays in reporting by either an APM entity or the Agency. We believe greater communication and transparency is necessary for this process.

The QPP needs to be more accessible

	FINALIZED POLICY	PAI COMMENTS
MIPS Low volume threshold	As per the Bipartisan Budget Act of 2018, the low-volume threshold for the 2021 MIPS payment year and future years will include a third criterion based on the number of covered professional services provided under the PFS. CMS proposed a third criterion: • Have < $90,000 in Part B allowed charges; OR • Provide care to < 200 beneficiaries, OR • Provide < 200 covered professional services under the PFS Additionally, CMS will allow, groups, virtual groups, and APM Entities to opt-in to MIPS participation if they meet or exceed one or two of the above criteria.	PAI supported maintaining the low-volume threshold and the addition of the third criterion. We believed that maintaining the low-volume threshold continues to help additional small and rural physicians avoid a negative payment adjustment and not be subject to participating in a program that may be too burdensome for their practice. Additionally, PAI commended the Agency for offering an opt-in option for physicians and other ECs who meet or exceed at least one of the three criteria.
MIPS	CMS expanded the definition of ECs to "a physician, physician assistant, nurse practitioner, and clinical nurse specialist, a certified	PAI did not have concerns with the new proposed definition. However, PAI believed that CMS should work with the expansion group to

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The QPP needs to be more accessible

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Definition of eligible clinician	registered nurse anesthetist; beginning with the 2021 MIPS payment year, a physical therapist, occupational therapist, clinical social worker, and clinical psychologist (as defined by the Secretary); and a group that includes such clinicians."	ensure they are well-educated on the QPP participation requirements and the importance of participation to their broader cohort of clinicians.
MIPS Performance Threshold	CMS increased the performance threshold from 15 points to 30 points and the exceptional performance threshold to 75 points for the 2019 performance year. CMS will take the comments it received in response to establishing a performance threshold for 2024 and beyond into consideration for future rulemaking.	PAI recommended a more gradual increase in the performance threshold. For example, a maximum five-point increase to the threshold each year could be reasonable. Additionally, PAI did not recommend increasing the exceptional performance threshold until additional insight is gained on how many MIPS participants by practice size have been able to meet/exceed the 70-point threshold.
All-Payer QP Determinations	CMS added a third option for QP determinations. Under this third option, when all clinicians have reassigned billing under a TIN that participates in a single entity APM, then the determination may be made at the TIN level. This would only be permitted where the entire TIN has met the Medicare threshold for the All-Payer Combination Option.	PAI continues to support proposals which enable more physicians and other ECs to receive QP/PQ credit for their participation in both Medicare and Other Payer Advanced APMs.

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MIPS Measures High Priority Measure	Beginning with the 2019 performance year CMS will define a high priority measure to be an outcome (including intermediate-outcome and patient-reported measures), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.	PAI supported the intent of the additional opioid-related quality measure; however, had some concerns that the measure may not meet the needs of patients. We believed CMS should continue working across agencies and with stakeholders to develop and present opioid-related measures to the physician community for comment prior to its inclusion in the set. Additionally, as the Agency develops these measures, it is important that the measures at the federal level align with state-level initiatives and programs.
MIPS Complex Patient Bonus	CMS retained the 5-point complex patient bonus and will continue to add this to the MIPS final score. CMS will use the second 12-month segment of the determination period (finalized above) for calculating this bonus.	PAI supported the continuation of this bonus without modifications.
MIPS Social Risk Factors	CMS sought feedback on which social risk factors provide the most valuable information and the methodology for accounting for differences in outcomes based on these disparities and differences in social risk factors.	PAI strongly supported the Agency's desire to account for social risk factors and noted that the Agency should investigate the following factors for consideration: patient demographics, race, ethnicity, health status, severity of illness, disability, comorbidities, income poverty level; as well as housing status, caregiver needs and ability, transportation, language services, among others.

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Other

	FINALIZED POLICY	PAI COMMENTS
PQs and Virtual Groups Partial QPs within Virtual Groups	CMS clarified that ECs who are determined to be Partial QPs and are in a virtual group, will not have their actual MIPS reporting activity used to determine whether the EC is participating in MIPS. The EC would need to make an explicit election to opt-in or opt-out of MIPS participation. In the absence of an explicit election, the physician would be excluded from the MIPS reporting requirements and payment adjustment.	PAI supported this option for PQs and not automatically defaulting them into the program and being subject to the payment adjustment unless they take affirmative actions to explicitly participate.
MIPS Groups Application of MIPS Adjustment	For payment adjustments that are determined and applied at the group level, beginning with the 2019 performance year / 2021 payment adjustment year, CMS will apply the adjustment for NPI/TINs that bill under the TIN during the following 15-month window: October 1 of the year prior the performance year through the end of the performance year (e.g., for the 2021 payment adjustment year this would be the October 1, 2018 – December 31, 2019).	PAI believed additional clarity and guidance is needed on this proposed policy so it does not add a new level of confusion and complexity to the program. CMS should provide examples of how this policy would be applied in different scenarios, for example, if a physician joins or leaves a practice mid-year. Additionally, the Agency should also consider the implications of these policies on physician employment and how they may negatively impact physicians' abilities to switch between practices based on their past MIPS performance scores and adjustments that might follow them going forward.
Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration	CMS finalized its proposals to implement the MAQI Demonstration in CY 2018 and related waivers for exclusions from MIPS reporting requirements and payment adjustments. Additional information on the demonstration is available here.	PAI was supportive of overall direction of the demonstration, but noted that additional focus should also be provided on equipping and helping physicians and practices better understand their options under Medicare, MA, and other value-based payment arrangements.
Physician Compare	CMS finalized policies to proceed with reporting performance data on Physician Compare, with some modifications, including provisions related to measures reported for the Quality and Cost category, among other provisions.	PAI supported transparency and publicly reporting data; however, we do not believe that there is valid or reliable data that should be posted on Physician Compare at this time. We strongly urged the Agency against proceeding with this proposal.

Other

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APMs CEHRT Criterion	Beginning with 2019 for Advanced APMs, and with 2020 for Other Payer APMs, they must require at least 75% of ECs to use CEHRT.	While PAI supports the adoption of EHRs, PAI is concerned that the CEHRT requirement for Advanced APMs is restrictive. Thus, PAI recommended that the Agency consider adopting more flexibility for the EHR adoption requirement, rather than specifying that it must be CEHRT, that may have certain capabilities and functionalities that are not applicable to or appropriate for different practices and patients.
APMs Measures Criterion	CMS amended the Advanced APM quality criteria so that at least one quality measure must be on the MIPS final list, be endorsed by a consensus-based entity, or otherwise be determined to be an evidence-based, reliable, and valid by CMS to considered MIPS-comparable. Similar criteria was finalized for at least one outcome measure in the Advanced APM.	PAI appreciated this clarification; however, urged the Agency against making independent determinations about the appropriateness and value of certain measures over other measures.