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CMS Quality Payment Program Final Rule CY 2020

Key Highlights and Preliminary Insights

Since the launch of the Centers for Medicare and Medicaid Services' (CMS) Quality Payment Program (QPP) in 2017, CMS has taken steps every year to update and align both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM) tracks. The tactic for the 2020 performance period is to maintain many of the requirements from the 2019 performance period, while updating both the MIPS and Advanced APM tracks with continued focus on reducing burden, responding to feedback from clinicians and stakeholders, and putting the patient voice front and center.

Pulse8's industry experts have thoroughly reviewed the recently published 2020 CMS Quality Payment Program Final Rule and are excited to share our initial insights.

2020 QPP Final Rule Policy Highlights

Key finalized policies for the 2020 performance period:

- Maintaining the weights of the Cost (15%) and Quality (45%) performance categories
- Increasing the performance threshold from 30 points to 45 points
- Increasing the additional performance threshold for exceptional performance from 75 points to 85 points
- Increasing the data completeness threshold for the quality data that clinicians submit to 70%
- Increasing the Improvement Activity performance category participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice
- Revising the specifications for the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measure
- Updating requirements for Qualified Clinical Data Registry (QCDR) measures and the services that third-party intermediaries must provide (beginning with the 2021 performance period)
- The Promoting Interoperability performance category is weighted at 25% (no change from PY 2019)
- The Improvement Activities performance category is weighted at 15% (no change from PY 2019)

MIPS Value Pathways (MVPs)

CMS has outlined a new MIPS participation framework that they anticipate starting in the 2021 performance year. The framework is still being finalized; however, the intent is to move away from siloed performance category activities and measures – and move toward a set of measure options more relevant to a clinician's scope of practice and more meaningful to patient care.

The MIPS Value Pathways (**MVPs**) framework is intended to align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS for different specialties or conditions.

Additionally, MVPs will incorporate a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health priorities, limiting the number of required or condition-specific measures that eligible providers are required to report. The new MVPs are a means to streamlining MIPS reporting as well as reducing provider burden, improving measurement, and enhancing CMS's Patients Over Paperwork initiative.

CMS has stated that they intend to work closely with clinicians, patients, specialty societies, third parties, and others as they further establish the MVPs for the 2021 performance period.

Pulse8 Insights:

2020 MIPS eligible providers who use **Calcul8**, Pulse8's solution to assist in improving CMS-Hierarchical Condition Category (CMS-HCC) coding and documentation, have the potential to significantly increase their MIPS performance score and improve their reimbursement rate in MIPS payment year 2022. With the overall performance threshold being raised from 30 to 45 points and the additional performance threshold being raised to 85 points for exceptional performance, understanding how to take action and maximize performance points in each MIPS performance category is of the utmost importance.

CMS uses Medicare claims data to calculate cost measure performance, which means clinicians and groups do not have to submit any data for this performance category. Many MIPS-eligible clinicians and groups struggle to understand how they can directly impact and improve their cost performance category points, as these are calculated by CMS subsequent to the performance year. Measure achievement points are determined by comparing performance on a measure to a benchmark. Cost performance benchmarks are created using performance data from the same performance period, rather than historic benchmarks. CMS adjusts for clinical risk for every cost measure in the MIPS cost performance category. Risk adjustment accounts for patient characteristics that can influence spending and are outside of clinician's control, such as clinical risk factors. **As a provider, understanding how to accurately reflect the clinical risk of your patient population through accurate coding and documentation will have a positive impact on your cost performance category score.**

For each cost measure in the MIPS Cost Performance Category, CMS-HCCs are incorporated into estimated costs to produce a risk score. This risk score is then used to adjust for disease burden in your attributed patient population for each measure. If a MIPS-eligible clinician is coding and documenting HCCs accurately, they will then have the potential to score more achievement points for each scored cost measure when compared to the performance period benchmark.

Using **Pulse8** products to effectively code and document clinical risk will take the mystery out of how the MIPS cost category is scored and, in turn, will assist clinicians and groups in gaining control of their MIPS cost category score.

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Summary 2020 QPP Final Rule Highlight Table

Policy Area	CY 2019 Policy	CY 2020 Policy
Performance Category Weights	• Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	**No change:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%
Quality Performance Category	**Data Completeness Requirements:** • Medicare Part B Claims measures: 60% of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, eCQMs: 60% of clinicians or group's patients across all payers for the performance period	**Data Completeness Requirements:** • Medicare Part B Claims measures: **70%** sample of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, eCQMs: **70%** sample of clinician's or group's patients across all payers for the performance period
Improvement Activities Performance Category	**Definition of Rural Area:** Rural area means a ZIP code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available	**Definition of Rural Area:** Rural area means a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP Code file available. **Note:** this is a technical correction, as CMS had previously misidentified the source file in regulation. There is no change to how they identify rural clinicians
	Improvement Activities Inventory: • Added 1 new criterion, "Include a public health emergency as determined by the Secretary." • Removed "Activities that may be considered for a Promoting Interoperability bonus."	**Improvement Activities Inventory:** • Addition of 2 new Improvement Activities • Modification of 7 existing Improvement Activities • Removal of 15 existing Improvement Activities
	Requirement for Improvement Activity Credit for Groups: • Group or virtual group can attest to an Improvement Activity if at least one clinician in the TIN participates	**Requirement for Improvement Activity Credit for Groups:** • Group or virtual group can attest to an Improvement Activity when **at least 50% of the clinicians (in the group or virtual group) perform the same activity** during any continuous 90-day period within the same performance period
Promoting Interoperability Performance Category	**Objectives and Measures:** • One set of objectives and measures based on the 2015 Edition CEHRT • Four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange	**Objectives and Measures:** *Beginning with the 2019 performance period:* • The optional query of **PDMP measure will require a yes/no response instead of a numerator/denominator** • Redistribution of the points for the Support Electronic Referral Loops by sending Health Information measure to the Provide Patients

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	• Clinicians required to report certain measures from each of the four objectives, unless an exclusion is claimed • Two new measures for the e-Prescribing objective: Query of Prescription Monitoring Program (PDMP) and Verify Opioid Treatment Agreement as optional with bonus points available	Electronic Access to Their Health Information measure if an exclusion is claimed *Beginning with the 2019 performance period:* • Removal of the Verify Opioid Treatment Agreement Measure • Inclusion of the Query of PDMP measure as optional with a yes/no response
Cost Performance Category	**Measures:** • Total per Capita Cost (TPCC) • Medicare Spending Per Beneficiary (MSPB) • 8 episode-based measures **Case Minimums:** • 10 for procedural episodes • 20 for acute inpatient medical condition episodes	**Measures:** • TPCC measure (**revised**) • MSPB-C (MSPB Clinician) measure (**name and specification revised**) • 8 existing episode-based measures • **10 new episode-based measures:** 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair 4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation 6. Lower Gastrointestinal Hemorrhage (applies to groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment • No change for case minimums
	Measure Attribution: • All measures are attributed at the TIN/NPI level for both individuals and groups • Plurality of primary care services rendered by the clinician to determine attribution for the total per capita cost measure • Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure • For procedural episodes, episodes are attributed to each MIPS eligible clinician	**Measure Attribution:** • Measure attribution **will be different for individuals and groups and will be defined in the applicable measure specifications** • TPCC attribution will require a combination of (i) an E&M services and (ii) general primary care service or a second E&M service, from the same clinician group • TPCC attribution **will exclude certain clinicians** who primarily deliver certain non-primary care services (e.g. general surgery) or are in specialties that are unlikely to be

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	who renders a trigger service (identified by HCPCS/CPT procedure codes) • For acute inpatient medical condition episodes, episodes are attributed to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization	responsible for primary care services (e.g. dermatology) • MSPB Clinician attribution will have a different methodology for surgical and medical episodes • No changes proposed for attribution in episode-based measures (existing and new)
Final Score Calculation: Performance Category Reweighting due to Data Integrity Issues	• No policy to account for data integrity concerns • Several scenarios for reweighting have previously been finalized, including extreme and uncontrollable events (all performance categories) and hardship exemptions specific to the Promoting Interoperability performance category	• Beginning with the 2018 performance period and 2020 payment year, CMS will reweight performance categories for a MIPS eligible clinician who they determine has data for a performance category that are inaccurate, unusable, or otherwise compromised due to circumstances outside of the control of the clinician or its agents if they earn the relevant information prior to the beginning of the associated MIPS payment year. MIPS eligible clinicians or third-party intermediaries should inform CMS of such circumstances (CMS may also independently learn of qualifying circumstances) • If reweighting is determined to be appropriate, CMS will follow existing policies on reweighting
Performance Threshold / Additional Performance Threshold / Payment Adjustments	• Performance Threshold is set at **30 points**	*For the 2020 performance period (2022 payment year):* • Performance threshold is set at **45 points** • Additional performance threshold is set at **85 points** for exceptional performance • As required by statute, the maximum negative payment adjustment is **-9%** • Positive payment adjustment can be up to 9% (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9% *For the 2021 performance period:* • Performance threshold is set at **60 points** • Additional performance threshold is set at **85 points** for exceptional performance

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APM Scoring Standard: Quality Performance Category	MIPS APMs receive quality scores based on their participation in the model — if no data is available for scoring, the categories are reweighted to75% for Promoting Interoperability and 25% for Improvement Activities **Exception:** CMS will use data submitted by the Participant TIN in a Shared Savings Program ACO in the rare event that no data is submitted by the Entity	MIPS eligible clinicians participating in MIPS APMS can report on MIPS quality measures in a manner like CMS' established policy for the Promoting Interoperability performance category under the APM Scoring Standard for purposes of the MIPS Quality performance category beginning with the 2020 MIPS performance period (CMS will allow MIPS eligible clinicians in MIPS APMs to receive a score for the quality performance category through either individual or TIN-level reporting based on the general applicable MIPS reporting and scoring rules for the Quality performance category) CMS will apply a minimum score of 50%, or an "APM Quality Reporting Credit" under the MIPS Quality performance category for certain APM entities participating in MIPS, where APM quality data are not used for MIPS purposes In cases where this credit is applied, it will be added to the MIPS quality score, subject to a cap of 100 as a total score for the Quality performance category

Source: qpp.cms.gov