Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this presentation.
POLICIES FOR E/M
OFFICE/OUTPATIENT VISITS
FINALIZED FOR CY 2021
Policies for E/M Office/Outpatient Visits Finalized for CY 2021

• We are largely aligning our Evaluation and Management (E/M) coding with changes laid out by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/outpatient E/M visits, which:
  • Retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions
  • Revise the times and medical decision making guidelines for all of the codes and requires performance of history and exam only as medically appropriate
  • Allow clinicians to choose the E/M visit level based on either medical decision making or time

• Visit the AMA [CPT E/M](https://www.ama.org) webpage for more details

• We believe this approach reflects CMS’ goals of reducing documentation burden
AMA Summary of Revisions

1. Eliminate history and physical as elements for code selection
2. Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time
3. Modifications to the criteria for MDM
4. Deletion of CPT code 99201
5. Creation of a shorter prolonged services code
Policies for E/M Office/Outpatient Visits
Finalized for CY 2021

• We are adopting the Relative Value Scale Update Committee (RUC) recommended values for the office/outpatient E/M visit codes and the new add-on CPT code for prolonged service time. The AMA RUC-recommended values will increase payment for office/outpatient E/M visits.

• We are also consolidating and increasing payment for the Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. This is not intended to reflect a difference in payment by enrollment specialty, but rather a better recognition of differences between kinds of visits.

• We are not adopting changes to the global surgery codes, as we continue to evaluate data about post-operative visits.
### Approximate Payments for Office/Outpatient Based E/M Visits

<table>
<thead>
<tr>
<th>Level</th>
<th>Current Payment* (new patient)</th>
<th>Approximate Finalized Payment**</th>
<th>Current Payment* (established patient)</th>
<th>Approximate Finalized Payment**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$45</td>
<td>N/A</td>
<td>$22</td>
<td>$24</td>
</tr>
<tr>
<td>2</td>
<td>$76</td>
<td>$77</td>
<td>$45</td>
<td>$60</td>
</tr>
<tr>
<td>3</td>
<td>$110</td>
<td>$119</td>
<td>$74</td>
<td>$96</td>
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<tr>
<td>4</td>
<td>$167</td>
<td>$177</td>
<td>$109</td>
<td>$136</td>
</tr>
<tr>
<td>5</td>
<td>$211</td>
<td>$232</td>
<td>$148</td>
<td>$190</td>
</tr>
</tbody>
</table>

* Current Payment for CY 2019
** Finalized Payment based on the CY 2020 finalized relative value units and the CY 2019 payment rate

CY 2021 Payments may change based on CY 2021 rulemaking

- The new prolonged services code will have a payment of approximately $22
- The HCPCS G-code add-on for primary care or medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition will have a payment of approximately $15
QUALITY PAYMENT PROGRAM 2018 PERFORMANCE DATA

Overview
The 2018 performance year for the Quality Payment Program:

- **HELPED CLINICIANS GAIN FURTHER EXPERIENCE IN THE PROGRAM**: 84%
- **INCREASED OVERALL PARTICIPATION NUMBERS IN MIPS AND APMS**: 13%
- **98% OF MIPS ELIGIBLE CLINICIANS PARTICIPATED**: 0%

Snapshot of 2020 Payment Adjustments for MIPS Eligible Clinicians:

- **84%** will receive an additional adjustment for exceptional performance.
- **13%** will receive a positive payment adjustment.
- **0%** will receive a neutral adjustment (no increase or decrease).
- **2%** will receive a negative payment adjustment.

**Payment Adjustment Highlights**

- **Percent of clinicians who will receive that relevant payment adjustment**: 2% Negative*, 0% Neutral, 13% Positive, 84% Positive and Exceptional Performance Adjustment.

- **Min Adjustment**: -0.01%, 0.00%, 0.00%, 0.21%
- **Max Adjustment**: -5.00%, 0.00%, 0.20%, 1.68%
- **Min Final Score**: 0.00, 15.00, 15.01, 70.00
- **Max Final Score**: 14.99, 15.00, 69.99, 100

*For negative payment adjustments only: The Minimum Final Score is associated with the Maximum Payment Adjustment.

**These percentages have been rounded to whole numbers for this infographic.**
General Participation Numbers in 2018

Total MIPS eligible clinicians that will receive a MIPS payment adjustment (positive, neutral, or negative) 889,995

Total MIPS eligible clinicians that will receive a neutral or positive payment adjustment 872,148

Total number of Qualifying APM Participants (QPs) 183,306

Total number of Partial QPs 47
# Quality Payment Program 2018 Performance Data

## Mean and Median National Final Scores for MIPS

<table>
<thead>
<tr>
<th>MEAN</th>
<th>MEDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>86.96</strong> points (out of 100 points) was the overall national mean score for the MIPS 2018 performance year</td>
<td><strong>99.63</strong> points (out of 100 points) was the overall national median score for the MIPS 2018 performance year</td>
</tr>
<tr>
<td><strong>79.07</strong> points was the mean score for clinicians participating in MIPS as individuals or groups (not through an APM)</td>
<td><strong>93.45</strong> points was the median score for clinicians for clinicians participating in MIPS as individuals or groups (not through an APM)</td>
</tr>
<tr>
<td><strong>98.77</strong> points was the mean score for clinicians participating in MIPS through an APM</td>
<td><strong>100</strong> points was the median score for clinicians participating in MIPS through an APM</td>
</tr>
</tbody>
</table>

*Note: Mean is the sum of all Final Scores divided by count of Final Scores by unique TIN/NPI; Median is the midpoint in distribution of all Final Scores.*

## Mean and Median Final Scores bySubmitter Type*

<table>
<thead>
<tr>
<th>INDIVIDUALS</th>
<th>GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEAN</td>
<td>MEDIAN</td>
</tr>
<tr>
<td><strong>68.29</strong> points</td>
<td><strong>79.55</strong> points</td>
</tr>
<tr>
<td><strong>80.22</strong> points</td>
<td><strong>94.69</strong> points</td>
</tr>
</tbody>
</table>

*An individual is a single TIN/NPI; a group is two or more NPIs billing under a single TIN or as an APM Entity.
Quality Payment Program 2018 Performance Data

Mean and Median Final Scores for Large, Small, and Rural Practices

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Practices</td>
<td>92.32 points</td>
<td>100 points</td>
</tr>
<tr>
<td>Rural Practices</td>
<td>85.99 points</td>
<td>99.45 points</td>
</tr>
<tr>
<td>Small Practices</td>
<td>65.69 points</td>
<td>81.16 points</td>
</tr>
<tr>
<td>Small &amp; Rural Practices</td>
<td>67.25 points</td>
<td>81.36 points</td>
</tr>
</tbody>
</table>
Quality Payment Program 2018 Performance Data

Additional Breakout of Payment Adjustments Based on Special Status

**RURAL PRACTICES**
- 2.05% will receive a negative payment adjustment
- 0.61% will receive a neutral adjustment
- 14.42% will receive a positive payment adjustment
- 82.91% will receive an additional adjustment for exceptional performance

**SMALL PRACTICES**
- 13.20% will receive a negative payment adjustment
- 2.89% will receive a neutral adjustment
- 26.00% will receive a positive payment adjustment
- 57.91% will receive an additional adjustment for exceptional performance
Getting Started

Accessing the System

**PERFORMANCE YEAR 2019**

Submission Window is Open

You can now sign in to submit your PY 2019 data. Data can be submitted and updated any time until March 31, 2020, 8 pm EDT when the submission window closes.

You can also opt-in to participate in MIPS if you meet certain criteria, check out this toolkit for more details.

Sign In

**PERFORMANCE YEAR 2020**

Preliminary MIPS Eligibility is available. You can now view your preliminary eligibility. Final eligibility will be available by December 2020. Check Your Participation Status

Explore the 4 Phases of Participation

1. Collect Data
2. Report Data
3. Feedback Available
4. Payment Adjustment
In order to sign in to qpp.cms.gov and submit Performance Year 2019 data and/or view data submitted on your behalf, you need

- An account (user ID and password)
- Access to an organization (a role)

Make sure you sign in during the submission period to review data submitted on your behalf.

You cannot submit new or corrected data after the submission period closes.

If you don’t already have an account or access, review the following documentation in the QPP Access User Guide so you can sign in to submit, or view, data:

- QPP Access at a Glance
- Register for a HARP Account
- Connect to an Organization

Once you sign in, you can select Start Reporting on the main page or Eligibility & Reporting from the left-hand navigation bar.

Disclaimer: The screenshots included in this user guide were current at the time of publication. Because we are always working to incorporate feedback and improve experience, you may notice some differences between these screenshots and what you see when you’re signed in to qpp.cms.gov.

Before You Begin
Make sure you are using the most recent version of your browser:

- Chrome: 71.0
- Firefox: 64.0
- Safari: 11.0
- Edge: 44.0

Note: Internet Explorer is not fully supported by QPP.
Resources

- **2019 QPP Data Submission User Guide**
- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 AM-8:00 PM ET or by e-mail at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).
  - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.
- Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the QPP Resource Library.

<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 Data Submission FAQs</td>
<td>Answers to frequently asked submission questions relevant for PY 2019.</td>
</tr>
<tr>
<td>2019 MIPS Data Submission Videos</td>
<td>Video series about reporting PY 2019 data and making opt-in elections.</td>
</tr>
<tr>
<td>2019 CMS Web Interface Videos</td>
<td>Video series about reporting PY 2019 data through the CMS Web Interface.</td>
</tr>
<tr>
<td>2019 MIPS Scoring Guide</td>
<td>Comprehensive information about scoring measures and calculating performance category scores and final scores.</td>
</tr>
<tr>
<td>2019 EMA Resources</td>
<td>An overview of the Eligible Measures Applicability (EMA) process and identifies the MIPS CQMs and Medicare Part B Claims measures that are clinically related.</td>
</tr>
</tbody>
</table>
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  • Accessing the System 6
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• Viewing Clinician and Eligibility Information 8
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MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
Overview for 2020 (Year 4)
Comprised of four performance categories.

So what? The points from each performance category are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
Merit-based Incentive Payment System (MIPS)

Timelines

Performance period opens January 1, 2020
- Ends December 31, 2020
- Clinicians care for patients and record data during the year

Deadline for submitting data is March 31, 2021
- Clinicians are encouraged to submit data early

Feedback available
- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

MIPS payment adjustments are applied to each claim beginning January 1, 2022
MIPS VALUE PATHWAYS (MVPS)
Overview
Current Participation in MIPS

*What we’ve been hearing from clinicians:*

- The current structure of MIPS and the reporting requirements are confusing
- There is too much choice and complexity when it comes to selecting and reporting measures and activities
- The measures and activities aren’t always relevant to a clinician’s specialty
- It’s hard for patients to compare performance across clinicians

While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS’ goal to develop a meaningful program for every clinician, regardless of practice size or specialty.
MIPS Value Pathways

Overview

CMS is committed to the transformation of the Merit-based Incentive Payment System (MIPS) through the **MIPS Value Pathways (MVPs)**, a new participation framework beginning in the 2021 performance year. This new framework will:

- Remove barriers to Alternative Payment Model (APM) participation
- Move away from siloed activities and towards an aligned set of measure options more relevant to a clinician’s scope of practice that is meaningful to patient care
- Promote value by focusing on **Quality** and **Cost** measures and **Improvement Activities** built on a foundation of population health measures calculated from administrative claims-based quality measures and **Promoting Interoperability** concepts
- Further reduce reporting burden
- Keep the patient at the center of our work

After consideration of the comments submitted to the MVPs Request for Information, CMS is finalizing a modified proposal to define MVPs as a **subset** of measures and activities established through rulemaking.
MIPS Value Pathways

Overview

Through this new framework, CMS intends to:

• Provide enhanced data and feedback to clinicians

• Analyze existing Medicare information to provide clinicians and patients with more information to improve health outcomes

• Reduce reporting burden by limiting the number of required specialty or condition-specific measures
  
  - Note: All clinicians or groups reporting on a clinical area would be reporting the same measures sets

CMS recognizes concerns about the implementation timeline of MVPs and will establish an incremental implementation that does not eliminate the current MIPS framework.

CMS is committed to working with stakeholders to develop this new framework, as well as develop additional ways to reduce burden in the MIPS program. We encourage the health care community to review the MIPS Value Pathways video and our illustrative diagram. You can find more information available on the QPP website at: https://qpp.cms.gov/mips/mips-value-pathways.
MIPS Value Pathways

Current Structure of MIPS (In 2020)
- Many Choices
- Not Meaningfully Aligned
- Higher Reporting Burden

New MIPS Value Pathways Framework (In Next 1-2 Years)
- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician’s Practice/Specialty or Public Health Priority

Future State of MIPS (In Next 3-5 Years)
- Simplified
- Increased Voice of the Patient
- Increased CMS Provided Data
- Facilitates Movement to Alternative Payment Models (APMs)

Building Pathways Framework

- MIPS Value Pathways
  - Clinicians report on fewer measures and activities base on specialty and/or outcome within a MIPS Value Pathway

Moving to Value

Implementation to begin in 2021

- Quality
- Improvement Activities
- Cost

- 6+ Measures
- 6+ Measures
- 1 or More Measures

Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

Clinician/Group Reported Data  CMS Provided Data

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.
MIPS Value Pathways: Surgical Example

**Current Structure of MIPS**
(In 2020)

- Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area
- Four performance categories feel like four different programs
- Reporting burden higher and population health not addressed

**New MIPS Value Pathways Framework**
(In Next 1-2 Years)

- Surgeon reports same “foundation” of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty
- Surgeon reports on fewer measures overall in a pathway that is meaningful to their practice
- CMS provides more data; reporting burden on surgeon reduced

**Future State of MIPS**
(In Next 3-5 Years)

- Surgeon reports on same foundation of measures with patient-reported outcomes also included
- Performance category measures in Surgical Pathway are more meaningful to the practice
- CMS provides even more data (e.g. comparative analytics) using claims data and surgeon’s reporting burden even further reduced

### MIPS Value Pathways for Surgeons

**QUALITY MEASURES**
- Unplanned Reoperation within the 30-Day Postoperative Period *(Quality ID: 355)*
- Surgical Site Infection (SSI) *(Quality ID: 357)*
- Patient-Centered Surgical Risk Assessment and Communication *(Quality ID: 358)*

**IMPROVEMENT ACTIVITIES**
- Use of Patient Safety Tools *(IA_PSPA_1)*
- Implementing the Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop *(IA_CC_1)*
- Completion of an Accredited Safety or Quality Improvement Program *(IA_PSPA_28)*

**COST MEASURES**
- Medicare Spending Per Beneficiary *(MSPB_1)*
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia *(COST_CCLI_1)*
- Knee Arthroplasty *(COST_KA_1)*

*Measures and activities selected for illustrative purposes and are subject to change.

### Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.
MIPS Value Pathways: Diabetes Example

MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area

Four performance categories feel like four different programs

Reporting burden higher and population health not addressed

Endocrinologist reports same “foundation” of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment

Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice

Endocrinologist reports on same foundation of measures with patient-reported outcomes also included

Performance category measures in endocrinologist’s Diabetes Pathway are more meaningful to their practice

CMS provides more data; reporting burden on endocrinologist reduced

CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist’s reporting burden even further reduced

**Quality Measures**
- Hemoglobin A1c (HbA1c) Poor Care Control (>9%) (Quality ID: 001)
- Diabetes: Medical Attention for Nephropathy (Quality ID: 119)
- Evaluation Controlling High Blood Pressure (Quality ID: 236)

**Improvement Activities**
- Glycemic Management Services (IA_PM_4)
- Chronic Care and Preventative Care Management for Empaneled Patients (IA_PM_13)
- OR
- Electronic Submission of Patient Centered Medical Home Accreditation (IA_PCMH)

**Cost Measures**
- Total Per Capita Cost (TPCC_1)
- Medicare Spending Per Beneficiary (MSPB_1)

*Measures and activities selected for illustrative purposes and are subject to change.
2020 FINAL RULE - MIPS

Eligibility
2020 Final Rule- MIPS

MIPS Eligible Clinician Types

No changes to the MIPS eligible clinician types in the 2020 performance period; they are the same as in the 2019 performance period:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Audiologists
- Speech-language pathologists
- Registered Dietitians and other nutrition professionals
- Groups of such clinicians
No changes to low-volume threshold criteria in the 2020 performance period.

The low-volume threshold includes MIPS eligible clinicians who:

• Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

  AND

• Furnish covered professional services to more than 200 Medicare beneficiaries

  AND

• Provide more than 200 covered professional services under the PFS.

To be included in MIPS, a clinician must exceed all three criteria.

Note: For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.
No changes in the 2020 performance period to the opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

### MIPS Opt-in Scenarios

<table>
<thead>
<tr>
<th>Dollars</th>
<th>Beneficiaries</th>
<th>Professional Services (New-proposed)</th>
<th>Eligible for Opt-in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>No – excluded</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>No – required to participate</td>
</tr>
</tbody>
</table>
Is There Somewhere I can go to Check my MIPS Status?

- You can check your participation status using the National Provider Identifier (NPI) Look-up Tool on qpp.cms.gov: https://qpp.cms.gov/participation-lookup
2020 FINAL RULE - MIPS
Performance Categories Overview
2020 Final Rule – MIPS
Performance Category High Level Changes

• **Quality:** Increase the data completeness threshold to 70%; continue to remove low-bar, standard of care process measures; address benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment; focus on high-priority outcome measures; and add new specialty sets

• **Cost:** Add 10 new episode-based measures to continue expanding access to this performance category; revise the existing Medicare Spending Per Beneficiary Clinician (MSPB Clinician) and Total Per Capita Cost (TPCC) measures

• **Improvement Activities:** Increase the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice; update the Improvement Activity Inventory and establish criteria for removal in the future; and conclude the CMS Study on Factors Associated with Reporting Quality Measures

• **Promoting Interoperability:** Keep the Query of Prescription Drug Monitoring Program measure as an optional measure; remove the Verify Opioid Treatment Agreement measure; and reduce the threshold for a group to be considered hospital-based
2020 FINAL RULE - MIPS
Quality Performance Category
MIPS- 2020 Basics
Quality Performance Category

**Basics for 2020**

- 45% of your MIPS Final Score

- Total of 218 quality measures

- You select 6 individual measures
  - 1 must be an outcome measure OR a high-priority measure (if an outcome is not available)
    - High-priority measures fall within these categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, Care Coordination, and Opioid-Related
  - If less than 6 measures apply, you should report on each applicable measure
  - May also select a specialty-specific set of measures
Basics for 2020

- Bonus points are available
  - 2 points for outcome or patient experience (after the first required outcome measure is submitted)
  - 1 point for other high-priority measures (after the first required measure is submitted)
  - 1 point for each measure submitted using electronic end-to-end reporting
  - Small practice bonus of 6 points

- Data completeness
  - What does this mean?
    - We check to see if you or your group have submitted data on a minimum percentage of your patients that meet a quality measure’s denominator criteria
  - In 2020, the thresholds are:
    - 70% for data submitted on QCDR measures, CQMs, and eCQMS (all-payer data)
    - 70% for data submitted on Medicare Part B claims measures (Part B data)
  - Measures that do not meet the data completeness criteria earn 0 points
    - Small practices receive 3 points for measures that do not meet data completeness
2020 FINAL RULE - MIPS
Cost Performance Category
**MIPS- 2020 Basics**

Cost Performance Category

*Basics for 2020*

- 15% of your MIPS Final Score

- No reporting requirement – data is pulled from administrative claims

- We will measure you on:
  - Medicare Spending Per Beneficiary (MSPB) measure
  - Total Per Capita Cost measure
  - 18 episode-based measures

- In order to be scored on a cost measure, you or your group must have enough attributed cases to meet or exceed the case minimum for that cost measure
Cost Performance Category Measures – 2020 Final Rule

- Added 10 new episode-based measures to continue expanding access to the Cost performance category
- Revised the existing Medicare Spending Per Beneficiary Clinician (MSPB Clinician) and Total Per Capita Cost (TPCC).
## Overview:
- New episode-based measures and current global measures’ attribution methodologies revised
- Different measure attribution for individuals and groups

### Measures

<table>
<thead>
<tr>
<th>2019 Final</th>
<th>2020 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measures:</strong></td>
<td><strong>Measures:</strong></td>
</tr>
<tr>
<td>- Total Per Capita Cost (TPCC)</td>
<td>- TPCC measure <em>(Revised)</em></td>
</tr>
<tr>
<td>- Medicare Spending Per Beneficiary (MSPB)</td>
<td>- MSPB Clinician (MSPB-C) measure <em>(Name and specification Revised)</em></td>
</tr>
<tr>
<td>- 8 episode-based measures</td>
<td>- 8 existing episode-based measures</td>
</tr>
<tr>
<td><strong>Case minimums:</strong></td>
<td><strong>10 new episode-based measures</strong></td>
</tr>
<tr>
<td>- 10 for procedural episodes</td>
<td>No changes to case minimums</td>
</tr>
<tr>
<td>- 20 for acute inpatient medical condition episodes</td>
<td></td>
</tr>
</tbody>
</table>
Renal or Ureteral Stone Surgical Treatment Measure

• In 2013, 23,000 Medicare beneficiaries were hospitalized with a primary diagnosis of kidney stones

• Approximately 1.1 million beneficiaries with a primary diagnosis of kidney stones received ambulatory and outpatient (OP) evaluation and management care

• Total expenditure among Medicare beneficiaries 65 and older for treatment of urinary tract stones exceeds $1 billion each year

• Cost measure evaluates a clinician’s risk-adjusted cost to Medicare for beneficiaries who receive surgical treatment for renal or ureteral stones during the performance period

• Measure includes costs of services that are clinically related to the attributed clinician’s role in managing care during each episode from 90 days prior to the clinical event that opens, or “triggers,” the episode through 30 days after the trigger
Renal or Ureteral Stone Surgical Treatment Measure

**Episode Window:** Pre-trigger window: 90 days; Post-trigger window: 30 days

**Triggers:**
- Procedure code for removal or crushing of kidney or ureteral stone (CPT/HCPCS 50080, 50081, 50590, 52352, 52353, 52356)
- If occurring inpatient, must occur during a relevant admission (MS-DRG 668, 669, 670)

**Attributed clinicians:** any clinician who bills a trigger code for the episode group on the day of the procedure for outpatient procedures or during the inpatient stay for inpatient procedures
Renal or Ureteral Stone Surgical Treatment Measure

Clinically-related Costs Included in Measure:

• Preoperative Management
• Postoperative Management
• Rehabilitation / Durable Medical Equipment (DME) / Supplies
• Preoperative Stent or Catheter Placement
• Postoperative Stent Placement / Removal / Exchange
• Follow-Up Visit Related to Postoperative Pain
• Postoperative Infection, Other
• Postoperative UTI or Procedure-Related Infection
• Repeat Procedure for Stones
• Other ER Visit or Hospitalization
2020 FINAL RULE
CHANGES - MIPS

Improvement Activities
Performance Category
Basics for 2020

• 15% of your MIPS Final Score

• Total of 105 Improvement Activities for 2020

• Each activity contains a weight:
  - Medium – worth 10 points
  - High – worth 20 points

• Select an activity and attest “yes” to completing

• You must earn 40 points to receive the full Improvement Activities category score
  - Small practices, non-patient facing clinicians, and/or clinicians located in rural or health professional shortage areas (HPSAs) receive double-weighting and report on no more than 2 activities to receive the highest score
Overview:
- Modification of definition of rural areas
- Increased participation threshold for groups
- Conclusion of CMS study

### Definition of Rural Area

<table>
<thead>
<tr>
<th></th>
<th>2019 Final</th>
<th>2020 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural area means a ZIP code designated as rural, using the most recent</td>
<td>Rural area means a ZIP code designated as rural by the Federal Office of</td>
</tr>
<tr>
<td></td>
<td>Health Resources and Services Administration (HRSA) Area Health Resource</td>
<td>Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP Code</td>
</tr>
<tr>
<td></td>
<td>File data set available.</td>
<td>file available.</td>
</tr>
</tbody>
</table>

The 2020 Final Rule- MIPS Improvement Activities Performance Category Changes include modifications to the definition of rural areas, an increased participation threshold for groups, and the conclusion of a CMS study.
## 2020 Final Rule- MIPS

Improvement Activities Performance Category Changes

### Requirement for Improvement Activity Credit for Groups

<table>
<thead>
<tr>
<th>2019 Final</th>
<th>2020 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group or virtual group can attest to an improvement activity if at least one clinician in the TIN participates.</td>
<td>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 year.</td>
</tr>
</tbody>
</table>

### Overview:

- Removal of improvement activities
- Modification and addition of improvement activities
- Conclusion of CMS study
2020 FINAL RULE-MIPS
Promoting Interoperability Performance Category
MIPS- 2020 Basics
Promoting Interoperability Performance Category

Basics for 2020

• 25% of your MIPS Final Score

• Must use 2015 Edition Certified EHR Technology (CEHRT)

• Performance-based scoring at the individual measure level

• Four Objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange
Overview:
- Reduction of the threshold for a group to be considered hospital-based
- Revised measures

Hospital-Based MIPS Eligible Clinicians in Groups

<table>
<thead>
<tr>
<th>2019 Final</th>
<th>2020 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>A group is identified as hospital-based and eligible for reweighting when <strong>100%</strong> of the MIPS eligible clinicians in the group meet the definition of a hospital-based MIPS eligible clinician.</td>
<td>A group is identified as hospital-based and eligible for reweighting when more than <strong>75%</strong> of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician.</td>
</tr>
<tr>
<td>No change to definition of an individual hospital-based MIPS eligible clinician.</td>
<td></td>
</tr>
</tbody>
</table>

2020 Final Rule- MIPS
Promoting Interoperability Performance Category Changes
2020 FINAL RULE-MIPS
Third Party Intermediaries
CMS is focusing on improved partnerships with third parties to help reduce the clinician reporting burden and improve the services clinicians receive.

Measure Requirements:

- **Beginning with the 2020 performance period**, requiring QCDRs to work together to harmonize their similar QCDR measures

- **Beginning with the 2021 performance period**, third party intermediaries, such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries, are required to consolidate and enhance their services by:
  - Supporting all MIPS performance categories that require data submission;
  - Providing enhanced performance feedback and allowing clinicians to view their performance on a given measure in comparison to others; and
  - Requiring that QCDR measures be fully developed and tested prior to self-nomination.
2020 FINAL RULE-MIPS
Performance Threshold and Payment Adjustment
2019 Final Performance Threshold

- **30** point performance threshold.
- Additional performance threshold for exceptional performance set at **75** points.
- Payment adjustment could be up to **+7%** or as low as **-7%**.

2020 Final Performance Threshold

- **45** point performance threshold
- Additional performance threshold for exceptional performance set at **85** points.
- Payment adjustment could be up to **+9%** or as low as **-9%**.

*To ensure budget neutrality, positive MIPS payment adjustment factors will be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.*
## 2020 Final Rule- MIPS

### Performance Threshold and Payment Adjustments

<table>
<thead>
<tr>
<th>Final Score 2019</th>
<th>Payment Adjustment 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥75 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Eligible for additional payment for exceptional performance — minimum of additional 0.5%</td>
</tr>
<tr>
<td>30.01-74.99 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Not eligible for additional payment for exceptional performance</td>
</tr>
<tr>
<td>30 points</td>
<td>• Neutral payment adjustment</td>
</tr>
<tr>
<td>7.51-29.99</td>
<td>• Negative payment adjustment greater than -7% and less than 0%</td>
</tr>
<tr>
<td>0-7.5 points</td>
<td>• Negative payment adjustment of -7%</td>
</tr>
</tbody>
</table>

### 2020 Final

<table>
<thead>
<tr>
<th>Final Score 2020</th>
<th>Payment Adjustment 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥85 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Eligible for additional payment for exceptional performance — minimum of additional 0.5%</td>
</tr>
<tr>
<td>45.01-84.99 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Not eligible for additional payment for exceptional performance</td>
</tr>
<tr>
<td>45 points</td>
<td>• Neutral payment adjustment</td>
</tr>
<tr>
<td>11.26-44.99</td>
<td>• Negative payment adjustment greater than -9% and less than 0%</td>
</tr>
<tr>
<td>0-11.25 points</td>
<td>• Negative payment adjustment of -9%</td>
</tr>
</tbody>
</table>

### 2021 Final:

Performance Threshold = 60 points; Additional Performance Threshold = 85 points
HELP & SUPPORT
Technical Assistance
Available Resources

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

Small & Solo Practices
Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or assistance getting connected, contact QPP-SURS@HHS.gov.

Technical Support
All Eligible Clinicians Are Supported By:

- Quality Payment Program Website: qpp.cms.gov
  Serves as a starting point for information on the Quality Payment Program.

- Quality Payment Program Service Center
  Assists with all Quality Payment Program questions.
  1-866-298-6292 TTY: 1-877-715-622 QPP@CMS.HHS.gov

- Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance for SURS: https://qpp.cms.gov/about/small-underserved-rural-practices
Get help and support: https://qpp.cms.gov/about/help-and-support#technical-assistance
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