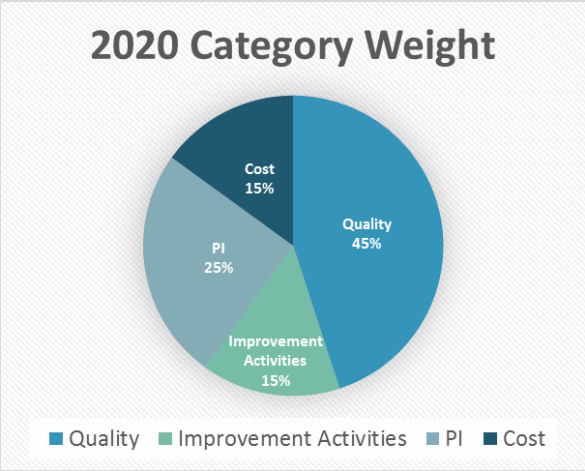
Overview of Key Changes within the CY 2020 QPP Final Rule

In November, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for changes and updates to the Quality Payment Program (QPP) for CY 2020 and beyond. A summary of the key changes/updates made within the final rule are provided below. For more information, the complete text of the final rule is available here and a CMS Fact Sheet here.

Changes/Updates to the Merit-Based Incentive Payment System (MIPS)

MIPS Category Weights and Performance Thresholds

CMS will not be increasing the Cost category weight for the 2020 performance year (PY) and will instead retain the 2019 performance year category weights.



Notably, under statutory law, the Cost and Quality category weights **will still have to equal 30%** by 2022, so the category weights will increase going forward unless legislative action is taken to change this requirement.

The performance and exceptional performance thresholds for PY 2020 & 2021 have been increased.

	Performance Threshold	Exceptional Performance Threshold
PY 2020	45 points	85 points
PY 2021	60 points	85 points

Quality Performance Category

CMS finalized the following changes/updates to the MIPS Quality category:

- Increasing the data completeness requirement for Medicare Part B Claims measures, as well as QCDR measures, MIPS CQMs, and eCQMs from 60% to 70%, collectively;
- Finalizing additions to Quality Measure Removal criteria so that CMS has the ability to remove MIPS quality measures that have not met case minimum and reporting volumes required for benchmarking over the past 2 years;
- Establishing a flat percentage benchmark for certain quality measures where an increased benchmark may incentivize inappropriate care. Specifically, CMS will be changing the benchmark

for certain measures so that any performance rate at or above 90% would be counted as in the top decile. For PY 2020, this new 90% flat benchmark will apply to the following quality measures:

- **MIPS #1 (NQF 0059):** Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- **MIPS #236 (NQF 0018)**: Controlling High Blood Pressure

Cost Performance Category

CMS has finalized the following changes/updates to the Cost category under MIPS:

- 10 new episode-based measures:

Measure Topic	Episode Measure Type
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Elective Primary Hip Arthroplasty	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition
Lower Gastrointestinal Hemorrhage (only for groups)	Acute inpatient medical condition
Lumbar Spine Fusion for Degenerative Disease, 1-3 levels	Procedural
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural

- Changes to patient attribution for the Total Per Capita Cost (TPCC) measure
  - Beginning PY 2020, TPCC attribution will require a combination of
    - A"candidate event"—being the first E/M service
      - This would initiate a year-long risk window where the clinician or clinician group could be held responsible for a beneficiary's treatment costs.

      AND
    - One or more additional services indicative of general primary care (e.g., routine chest X-ray, electrocardiogram, etc.) **OR** a second E/M service provided on a later date.
  - TPCC will not apply to clinicians who: 1) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy); or 2) are in specialties unlikely to be responsible for providing primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology)
- Changes to patient attribution for the Medical Spending Per Beneficiary (MSPB) measure
  - There are separate attribution methods for medical episodes (where the index admission has a medical MS-DRG) and surgical episodes (where the index admission has a surgical MS-DRG).
  - Medical Episodes
    - First attributed to the TIN billing at least 30% of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay.

        - The episode is then attributed to any clinician in the TIN who billed at least one inpatient E/M service that was used to determine the episode's attribution to the TIN.
    - Surgical Episodes
        - Attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure.

Promoting Interoperability Category

CMS has finalized the following changes/updates to the Promoting Interoperability (PI) category under MIPS for PY 2020:

- CMS will be removing the Verify Opioid Treatment Agreement measure
- CMS will be including the Query of PDMP measure as an optional yes/no response

Improvement Activities Category

CMS has finalized the following changes/updates to the Improvement Activities (IA) category under MIPS for PY 2020:

- Establishes new requirement for Improvement Activity credits for group or virtual group practices. Specifically, CMS will require that at least 50% of eligible clinicians within a group or virtual group must perform the same Improvement Activity during any continuous 90-day period to gain credit.
- Establishes removal factors to consider when proposing to remove improvement activities from the Inventory
- Removes the following 15 Improvement Activities from PY 2020:
    - Participation in Systematic Anticoagulation Program (IA_PM_1)
    - Implementation of additional activity as a result of TA for improving care coordination (IA_CC_3)
    - Participation in Quality Improvement Initiatives (IA_PSPA_14)
    - Annual Registration in the Prescription Drug Monitoring Program (IA_PSPA_5)
    - Initiate CDC Training on Antibiotic Stewardship (IA_PSPA_24)
    - Unhealthy alcohol use (IA_BMH_3)
    - Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan (IA_BE_11)
    - Use of QCDR to support clinical decision making (IA_BE_2)
    - Use of QCDR patient experience data to inform and advance improvements in beneficiary (IA_BE_9)
    - Participation in a QCDR, that promotes implementation of patient self-action plans (IA_BE_10)
    - Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination (IA_CC_6)
    - Leveraging a QCDR for use of standard questionnaires (IA_AHE_4)
    - Leveraging a QCDR to standardize processes for screening (IA_AHE_2)
    - Use of QCDR data for quality improvement such as comparative analysis reports across patient populations (IA_PM_10)

  - TCPI Participation (IA_CC_4)
- Modifying the following 7 Improvement Activities for PY 2020:
  - Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)
  - Anticoagulant Management Improvements (IA_PM_2)
  - Additional improvements in access as a result of QIN/QIO TA (IA_EPA_4)
  - Implementation of formal quality improvement methods, practice changes, or other practice improvement processes (IA_PSPA_19)
  - Participation in a QCDR, that promotes use of patient engagement tools (IA_BE_7)
  - Use of QCDR data for ongoing practice assessment and improvements (IA_PSPA_7)
  - Completion of Collaborative Care Management Training Program (IA_BMH_10)
- Adding the following new Improvement Activities for PY 2020

Subcategory	Activity Title	Activity Description
Beneficiary Engagement	**Drug Cost Transparency**	MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine.
Care Coordination	**Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes**	MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period.

MIPS Value Pathway (MVP) Framework

CMS has finalized its proposed new MVP framework, set to take effect in PY 2021, as part of the Agency's efforts to "move away from siloed performance category activities and measures and move towards a set of measure options more relevant to a clinicians scope of practice that is meaningful to patient care." Most of the MVP framework is under development, and CMS mentions numerous times throughout the Final Rule that it will continue to engage with stakeholders in CY 2020. As a reminder, the MVP framework would offer condition-based pathways in which all four MIPS category measure requirements were aligned to address a specific patient condition (i.e., Diabetes, Surgery, etc.) based on a foundation consisting of the following components: Promoting Interoperability; Population Health Measures; Enhanced Performance Feedback; and, Patient-Reported Outcomes.

Changes/Updates to Advanced APMs

CMS has finalized the following updates/changes to Advanced APM requirements for PY 2020:

- Amend the 30% marginal risk requirement for Other Payer Advanced APM models: CMS would no longer require such models to accept 30% marginal risk across all possible levels of actual

expenditures (percent above Total Cost of Care, TCOC), but would allow for **an average** of 30% marginal risk across possible levels of actual expenditures. Under the previous universal marginal risk requirement, CMS states that several other payer arrangements were denied 'Other Payer Advanced APM' status because, even though they included strong financial risk components and well exceeded the 30% marginal risk requirement at the most common levels of losses, they employed risk rates below 30% at much higher levels of losses. CMS believes that such models should be considered Other Payer Advanced APMs, because their average marginal risk well exceeds 30%.

- CMS will not be updating its Partial QP (PQ) status exemption. CMS had proposed to change the exemption so that the Partial QP status MIPS exemption only applied to the specific NPI/TIN reporting the data, but this proposal was not finalized. For PY 2020, the Partial QP exemption will continue to be applied at the NPI level (therefore, all NPI/TIN combinations will be exempt).
- CMS will apply a minimum score of 50% (deemed in the final rule as 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. This credit will be added to the MIPS quality performance score, subject to a cap of 100 as a total score for the Quality performance category.

Physician Compare

As stated in the Proposed Rule, CMS will be releasing aggregate MIPS data in late 2019, including the minimum and maximum MIPS performance category and final scores beginning with Year 2.