

Executive Summary
2020 Physician Fee Schedule Final Rule
Quality Payment Program Provisions

Key Quality Payment Program (QPP) Financial and Operational Impacts from the 2020 Final Physician Fee Schedule Rule

The 2020 performance period corresponds to the 2022 payment year. The Merit-based Incentive Payment System (MIPS) payment adjustments will be $\pm 9\%$, to be applied to 2022 payments to physicians. CMS estimates that approximately 879,966 clinicians will be MIPS-eligible clinicians during the 2020 performance period and about 348,000 will not be MIPS eligible. The final numbers will depend on factors including how many clinicians are excluded from MIPS (based on their status as qualifying alternative payment model participants [QPs] or Partial QPs), the extent of reporting by groups (rather than as individuals), and the number who elect to opt in to MIPS. A detailed breakout of participation estimates by MIPS eligibility status categories is provided in Table 122 of the rule.

Budget neutrality is required within the QPP, by statute. CMS estimates that positive and negative payment adjustments distributed in payment year 2022 will each total \$433 million (down from \$584 million estimated for payment year 2021). As in prior QPP years, an additional \$500 million will be available for distribution for exceptional performance. The actual exceptional payment amounts will be finalized based on the final population of MIPS-eligible clinicians for the 2022 MIPS payment year and the distribution of their composite final scores.

CMS estimates that the maximum possible positive payment adjustment attainable for payment year 2022 will be 6.2% combined from the MIPS base adjustment and the adjustment for exceptional performance. CMS projects that 92.5% of eligible clinicians will have a positive or neutral payment adjustment and 7.5% will have a negative payment adjustment. Finally, CMS estimates that between 210,000 and 270,000 clinicians will meet thresholds to become QPs, resulting in total lump sum alternative payment model (APM) incentive payments of \$535-600 million for the 2022 QPP payment year. The APM bonus remains at 5% and will be applied to a QP's covered Part B professional services furnished during 2021, the calendar year immediately preceding the payment year.

- 1) Finalized Weights by MIPS Performance Category.** Beginning with the 2018 MIPS performance period and 2020 MIPS payment year, CMS will reweight the performance categories for a MIPS-eligible clinician if it determines that data for a performance category are inaccurate, unusable, or otherwise compromised due to circumstances outside of the control of the clinician or its agents if it learns the relevant information prior to the beginning of the associated MIPS payment year. CMS also finalizes its proposal that this reweighting policy will not be voided by the submission of data for the Promoting Interoperability (PI) performance category. Below are the final weightings for payment years 2020 – 2022 (performance years 2018 – 2020).

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MIPS Performance Category Weighting: 2020 – 2022			
Performance Category	2020 MIPS Payment Year (Final)	2021 MIPS Payment Year (Final)	2022 MIPS Payment Year (Final)
Quality ¹	50%	45%	45%
Cost	10%	15%	15%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

2) Quality Performance Category. Appendix 1 of the final rule catalogs the groups of MIPS measures with their finalized changes for performance year 2020 (unless otherwise noted) and future years. Significant changes include:

- Three new measures were finalized for inclusion and are found in Table Group A.
- The modifications to numerous existing specialty sets and seven new specialty sets proposed were finalized without changes and are found in Table Group B of the final rule.
- The 55 previously finalized quality measures proposed for removal were reduced to 42. Thirteen will continue as previously specified for performance year 2020. Details are available in Table Group C of the final rule.
- The 78 previously finalized quality measures with substantive changes proposed for 2020 are found with their finalized 2020 specifications in Table Group D of the final rule.

Additionally, the following proposed changes were not finalized:

- Addition of Adult Immunization Status was not finalized as the relevant clinical guidelines are in the process of revision.
- The proposed population health measure, All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions, found in Table Group A, was not finalized based upon multiple concerns raised by commenters.

3) Cost Performance Category. CMS finalizes its proposal to add 10 new episode-based measures and finalizes revisions to the existing Medicare Spending per Beneficiary Clinician and Total per Capita Cost measures. The table below summarizes the cost measures in use for the 2020 performance period.

¹ CMS increases the data completeness thresholds to 70% for performance year 2020 for MIPS clinical quality measures (CQMs), and eCQMS as well as for Medicare Part B claims-based measures.

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TABLE 47: Summary Table of Cost Measures for the 2020 Performance Period and Future Performance Periods		
Measure Topic	Measure Type	Measure Status
Total Per Capita Cost (TPCC)	Population-Based	Revised and proposed for 2020 performance period and beyond
Medicare Spending Per Beneficiary Clinician (MSPB)	Population-Based	Revised and proposed for 2020 performance period and beyond
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Knee Arthroplasty	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Screening/Surveillance Colonoscopy	Procedural episode-based	Currently in use for 2019 Performance Period and Beyond
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond
Simple Pneumonia with Hospitalization	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition episode-based	Currently in use for 2019 Performance Period and Beyond
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Elective Primary Hip Arthroplasty	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Femoral or Inguinal Hernia Repair	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Hemodialysis Access Creation	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition episode-based	Proposed for 2020 Performance Period and Beyond
Lower Gastrointestinal Hemorrhage (<i>at group level only</i>)	Acute inpatient medical condition episode-based	Proposed for 2020 Performance Period and Beyond
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Renal or Ureteral Stone Surgical Treatment	Procedural episode-based	Proposed for 2020 Performance Period and Beyond

4) **Improvement Activities (IA).** The IA performance category is usually weighted at 15% during MIPS scoring but may be reweighted under certain specified circumstances (e.g., participation in a MIPS APM). For performance year 2020, CMS added two, modified seven, and removed 15 activities from the IA inventory for performance period 2020. The two new activities are Drug Price Transparency and Completion of an Accredited Safety or Quality Improvement Program.

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CMS did not propose any changes to current IA data submission mechanisms or data submission criteria for performance period 2020. CMS did propose two changes to IA reporting by groups.

CMS finalizes two changes to the IA category for performance year 2020. First, CMS increases the group reporting threshold such that at least 50% of a group's clinicians (counted as national provider identifiers, or NPIs) would be required to complete an IA for the entire group (as a taxpayer identification number, or TIN) to receive IA category credit. This would be an increase from the current requirement that at least one clinician from the group must report in order for the group to receive credit.

Second, CMS requires that at least 50% of the NPIs within a group must perform the same IA for the same continuous 90-day period within a performance year. CMS indicates that a group's patient outcomes are more likely to be positively influenced when a substantial fraction of the group's clinicians engage in the same IA. A separate attestation would be required for each IA that was completed by 50% or more of the group's members for the same 90-day period.

5) Promoting Interoperability. CMS addresses two PI measures introduced into use for performance year 2019: 1) Query of Prescription Drug Monitoring Program (PDMP), and 2) Verify Opioid Treatment Agreement. CMS proposed that for performance year 2020: 1) reporting the Query PDMP measure would be optional and would be eligible for 5 bonus points (CMS finalizes the PDMP changes as proposed; this change results in increasing the e-prescribing measure score maximum to 10 points), and 2) the Verify Opioid Treatment Agreement measure would be removed. CMS finalizes the measure's removal without modification.

The Support Electronic Referral Loops by Sending Health Information measure was formerly named "Send a Summary of Care" and was given its current name for 2019 reporting. The measure had a potential participation exclusion that was retained for the renamed measure, but CMS did not specify how the points for the renamed measure would be redistributed were the exclusion to be claimed. CMS finalized that the 20 points assigned to the renamed measure would be redistributed to the Provide Patients Access to Their Health Information measure, were the exclusion to be claimed. The revision is applicable beginning with the 2019 performance period and subsequent years.

The Support Electronic Referral Loops by Receiving and Incorporating Health Information measure replaced two existing measures, entitled, respectively, the "Request/Accept Summary of Care" and "Clinical Information Reconciliation" measures for performance year 2019. A potential participant exclusion was established at that time for the new measure. However, the language of the exclusion subsequently has been misconstrued by some users. CMS, therefore, revised the exclusion to read "Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period". The revised exclusion language is applicable beginning with the 2019 performance period and subsequent years. The 20 points currently associated with the measure would continue to be distributed to the Provide Patients Access to Their Health

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Information measure, were the exclusion to be claimed. If exclusions to both Support Electronic Referral Loops measures are claimed, the combined 40 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

CMS provides an updated table showing the PI performance category scoring methodology for use in 2020 and subsequent years, inclusive of the finalized changes discussed above. Table 49,

reproduced below from the final rule, does not reflect the potential point redistributions if reporting exclusions are claimed as described above.

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing*	10 points
	Query of PDMP	5 points (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information*	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information*	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting* Electronic Case Reporting* Public Health Registry Reporting* Clinical Data Registry Reporting* Syndromic Surveillance Reporting*	10 points

*Exclusion available

Related to PI Reporting by nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals, CMS finalizes the continued PI reweighting to zero, as proposed. This extends the policy first finalized in 2017.

PI Reporting by Groups of Hospital-Based MIPS-eligible Clinicians. CMS has previously established a policy to assign a weight of zero to the PI performance category for a hospital-based MIPS-eligible clinician. If hospital-based clinicians choose to report PI data, however, the clinicians will be scored using their data under the PI category scoring policies currently in effect for other MIPS-eligible clinicians. In response to stakeholder concerns about application of the reweighting policy to

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hospital-based physician groups, CMS proposed for performance year 2020 and subsequent years to define a hospital-based MIPS-eligible clinician as one who furnishes 75% or more of his or her covered professional services in settings with place of service (POS) codes 19, 21, 22 or 23 (based on claims for a MIPS determination period) and that the definition would also include a group or virtual group in which more than 75% of the NPIs billing under the group's or virtual group's TIN meet the definition of a hospital-based individual MIPS-eligible clinician. CMS finalizes the changes for hospital-based clinicians, as proposed.

PI Reporting by Groups of Non-patient facing MIPS-eligible Clinicians. CMS, in the final rule, adopts language similar to that proposed for hospital-based clinician groups in the regulations applicable to non-patient facing groups; that is, requiring that 75% or more, rather than the current 100%, of a non-facing clinician group's members qualify as non-patient facing in order for the entire group to be eligible for PI category reweighting.

6) APM Scoring Standard for MIPS-eligible Clinicians Participating in MIPS APMs. Clinicians participating in MIPS APMs receive quality scores based on their participation in the model. If no quality data are available for scoring, the MIPS categories are reweighted to 75% Promoting Interoperability and 25% Improvement Activities. CMS expects that the following ten APMs will satisfy the requirements to be MIPS APMs for the 2020 MIPS performance period. The final determinations will be announced via the [QPP website](#).

- Comprehensive ESRD Care Model (all tracks)
- Comprehensive Primary Care Plus Model (all tracks)
- Next Generation ACO Model
- Oncology Care Model (all tracks)
- Medicare Shared Savings Program (all tracks)
- Medicare ACO Track 1+ Model
- Bundled Payments for Care Improvement Advanced
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Vermont Medicare ACO Initiative
- Primary Care First (All tracks)

Allowing Clinicians Participating in MIPS APMs to Report on MIPS Quality Measures. CMS finalizes its proposal to allow MIPS APM clinicians to report on MIPS quality measures in the same way that it currently permits them to report for the Promoting Interoperability category under the MIPS APM scoring standard. This policy will begin with the 2020 performance period. Specifically, CMS will attribute one quality score to each MIPS-eligible clinician in an APM Entity by looking at both individual and TIN-level data submitted for the eligible clinician and using the highest reported score, excepting scores reported by a virtual group. It will then use the highest individual or TIN-level score attributable to each MIPS-eligible clinician in the APM Entity to determine an average, which will be the APM Entity score.

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APM Quality Reporting Credit. Beginning with the 2020 performance period, CMS finalizes its proposal to apply a minimum score of 50% (one half of the highest potential score for the quality performance category), called an “APM Quality Reporting Credit,” to APM Entity groups participating in MIPS APMs, with the exceptions described below. The credit will be added to any MIPS quality measure scores CMS receives, with a cap of 100% for the quality category. For example, if the additional MIPS quality score were 70%, it will be added to the 50% credit for a total of 120%, but the total assigned will be 100%.

The APM Quality Reporting Credit will not apply to APM Entities reporting only through a MIPS quality reporting mechanism according to the requirements of their APM. For example, the credit will not apply to the Medicare Shared Savings Program, which requires participating ACOs to report through the CMS web Interface and the CAHPS for ACOs’ survey measures.

7) Performance Range. During 2020, MIPS payment adjustments will be applied and APM incentive payments made will be made based upon QPP Year 2 (2018) performance period data. MIPS adjustments will range from -5 to +5% and will be applied to payments made to clinicians for covered Part B professional services furnished during 2020. Some clinicians who meet a separately specified threshold also will receive an additional positive adjustment in 2020 for exceptional 2018 MIPS performances. The MIPS adjustment percentage will continue to increase annually until reaching -9 to +9% for payment year 2022, and the exceptional performance bonus will continue through payment year 2024.

CMS finalizes its proposal to set the performance threshold at 45 points for the 2022 MIPS payment year (2020 performance year) and at 60 points for the 2023 MIPS payment year (2021 performance year).

CMS finalizes the additional performance thresholds for exceptional performance for the 2022 and 2023 MIPS payment years (2020 and 2021 performance years) to be 85 points, respectively, an increase from 75 points previously established for 2021. Clinicians with final scores at or above the additional performance threshold are eligible to share in the \$500 million available for additional payments for exceptional performance. The table below illustrates the potential adjustment continuum.

Scoring the Quality Performance Category. CMS finalizes its proposals to extend a number of policies for scoring the quality performance category to payment year 2022.

- *Three-Point Floor.* For the 2022 payment year, CMS finalizes its proposal to continue the 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period.
- *Scoring Measures that Do Not Meet Case Minimum, Data Completeness, and Benchmarks Requirements.* Table 50 in the final rule summarizes the scoring policies for the 2020 MIPS performance period for measures that are submitted but cannot be scored because they do not

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meet case minimum or data completeness requirements (Class 1 measures), or because they do not have a benchmark (Class 2 measures).

- *Incentives to Report High-Priority Measures.* CMS finalizes its proposal to maintain for the 2022 payment year the cap on high-priority bonus points, which is set to equal 10% of the total possible measure achievement points that the MIPS-eligible clinician could receive in the quality performance category.
- *Incentives to Use Certified EHR Technology (CEHRT) to Support Quality Performance Category Submissions.* CMS finalizes its proposal to continue for the 2022 payment year the assignment of bonus points for end-to-end electronic reporting.
- *Improvement Scoring.* CMS finalizes its proposal to continue previously adopted policy for improvement scoring for the 2022 payment year. Specifically, it will compare the eligible clinician's quality performance category achievement percentage score for the 2020 performance period to an assumed quality performance category achievement percentage score of 30% if the MIPS-eligible clinician earned a quality performance category score less than or equal to 30% for the 2019 MIPS performance period.

Complex Patient Bonus for 2022 MIPS Payment Year. CMS finalizes its proposal to continue for 2022 the complex patient bonus adjustment, which is meant to protect access to services for complex patients and avoid disadvantaging the clinicians who care for them.

8) **MIPS Value Pathway (MVP) Program.** Starting with the 2021 MIPS performance period, CMS will apply a new MVP framework to the QPP. The final rule defines an MVP as “a subset of measures and activities” established through rulemaking, rather than the proposed rule’s wording of “as specified by CMS.” All MVPs will share the following features:

- Connecting measures and activities across the 4 MIPS performance categories and aligning them to specific clinical conditions and/or the practitioners who treat them
- Incorporating an administrative claims-based quality measure set focusing on population health as a base requirement for each pathway
- Providing actionable data and feedback to clinicians (e.g., outlier analysis)
- Enhancing information provided to patients, including at the individual clinician level (e.g., patient reported outcome measures or PROMs, experience of care survey scores).

CMS believes that standardization gained through applying the MVP framework will enhance accountability across the wide range of existing clinical practice sizes, specialties and composition. Ultimately, CMS believes this will create the robust practice performance information necessary to move more quickly to value-based care.

9) **APMs.** For payment years 2019 and 2020, eligible clinicians can become QPs, and thereby be excluded from MIPS, based only upon their extent of Advanced APM participation (i.e., payments or patient counts, through the “Medicare Option”). All Advanced APMs are sponsored by CMS.

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For payment years 2021 and later, QP status also can be reached by combining Advanced APM participation with Other Payer Advanced APM participation (i.e., through the All-Payer Combination Option). Payment arrangements that may qualify as Other Payer Advanced APMs include those between eligible clinicians and Medicare Health Plans, Medicaid programs, CMS Multi-Payer Models, and what CMS terms “Remaining Other Payers.” Determinations of whether an APM sponsored by a payer other than Medicare (“Other Payer”) meets criteria to be treated as an Other Payer Advanced APM are made by CMS using the Payer Initiated or Eligible Clinician Initiated process.

A clinician reaching QP status for any payment year from 2019 through 2024, will receive a lump sum incentive payment for that year, equal to 5% of their immediately preceding year’s estimated aggregate payments for Part B covered professional services. No lump sum incentives will be paid after 2024. Beginning with payment year 2026, QPs will receive a higher annual PFS update than non-QPs

The statutory criteria for a payment model to meet the requirements of an Advanced APM include:

- At least 75% of the eligible clinicians in the Advanced APM Entity must use CEHRT in clinical care delivery.
- Payment for covered professional services must be based, at least in part, on quality measures comparable to those of the MIPS Quality performance category. Beginning with performance year 2020, at least one of the measures must be finalized on the MIPS final list of measures; endorsed by a consensus-based entity; or determined by CMS to be evidence-based, reliable and valid. At least one of the measures also must be an outcome measure, if available.
- Participating APM Entities must be able to bear risk for more than nominal monetary losses. CMS approaches this criterion as having two parts: 1) describing ways to bear risk (e.g., repayment, forfeiture of future payment; the “financial standard”) and 2) what constitutes more than nominal monetary losses (e.g., percentage of revenues, actual loss amount; “the nominal amount standard”). Other than for Medical Home Models, the applicable revenue-based nominal amount standard will remain at 8% through the 2024 QP Performance Period. For models not expressing risk in terms of revenues, the total expenditure-based nominal amount standard will remain indefinitely at 3%.

10) Qualifying Advanced APMs. CMS expects that the following 11 APMs will satisfy the requirements to be Advanced APMs for the 2020 MIPS performance period. The final determinations will be announced via the QPP website.

- Comprehensive Care for Joint Replacement Payment Model (CEHRT track)
- Comprehensive ESRD Care Model (Two-Sided Risk Arrangement)
- Comprehensive Primary Care Plus Model (all tracks)
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)
- Medicare Shared Savings Program (Track 2, Basic Track Level E, and the Enhanced Track)

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- Medicare ACO Track 1+ Model
- Bundled Payments for Care Improvement (BPCI) Advanced
- Maryland Total Cost of Care Model (Maryland Care Redesign Program, Maryland Primary Care Program)
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative)

11) Aligned Other Payer Medical Home Model. CMS finalizes its proposal to add the term Aligned Other Payer Medical Home Model, to be defined as a payment arrangement with all the following features:

- Is operated by a payer other than Medicare or Medicaid
- Formally partners with CMS in a CMS Multi-Payer Model that also is a Medical Home Model
- Has a primary care focus (i.e., the practice must include primary care practitioners and offer primary care services) and empanels each patient to a primary clinician
- Demonstrates at least four of the following: planned coordination of chronic and preventive care; patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood; patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

12) Bearing Risk: Defining Excess Expenditures. CMS finalizes its proposal to revise the definition of expected expenditures, when used for assessing risk-bearing, to exclude excess expenditures. CMS will require that the expected expenditures under the terms of the APM not exceed the Medicare Part A and B expenditures for a participant in the absence of the APM. If the expected expenditures do exceed those that would occur in the model's absence, the excess expenditures will not be counted toward meeting the nominal amount standard.

13) APM Entity Termination. CMS finalizes revised regulatory language stating that an eligible clinician is not a QP or Partial QP for the year if an APM Entity were to terminate before incurring financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs.

14) All-Payer Combination Option and Other Payer Advanced APMs. The revenue and payment thresholds for qualifying under the All-Payer Combination are listed below. The total amount is also the Medicare-only qualifying threshold.

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TABLE 64A: QP Payment Amount Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Payment Count Threshold					
Medicare Minimum	N/A	N/A	25%	25%	25%
Total			50%	50%	75%
Partial QP Payment Count Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			40%	40%	50%

TABLE 64B: QP Patient Count Thresholds – All-Payer Combination Option

Payment Year	2019	2020	2021	2022	2023 and later
QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	20%	20%	20%
Total			35%	35%	50%
Partial QP Patient Count Threshold					
Medicare Minimum	N/A	N/A	10%	10%	10%
Total			25%	25%	35%