

Quality Payment PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

2020 Cost Performance Category Quick Start Guide

Updated 5/20/2021

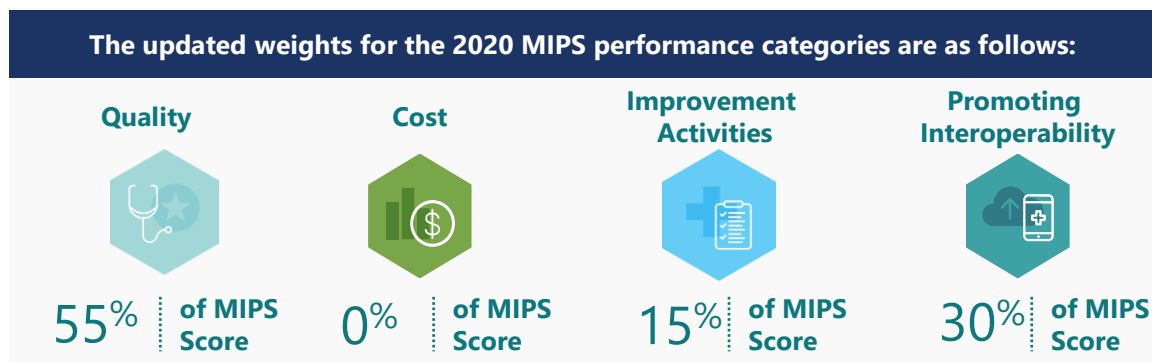


Reweight the Cost Performance Category to 0% for the 2020 Performance Period

UPDATED 5/20/2021

CMS is reweighting the Cost performance category from 15% to 0% for the 2020 performance period for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. The 15% Cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(D).

As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they will receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year. This reweighting of the Cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policy under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), § 414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3). Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC will still have their Cost performance category weighted to 0%.



For more information about this policy and a table that includes reweighting scenarios, please refer to the QPP listserv, distributed on 5/20/2021, in [Appendix B](#) of this document.

Please Note: The proceeding content in this guide remains largely untouched for informational/historical reference purposes only.

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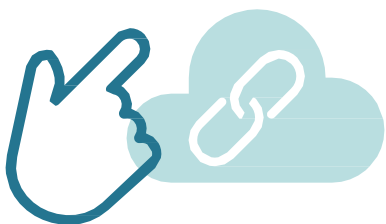
Purpose: This resource focuses on the Cost performance category, providing high level information about the cost measures, including calculation and attribution for the 2020 performance period. For comprehensive information about these measures, please refer to the Measure Information Forms (linked in the [Help, Resources, and Version History](#) section).

COVID-19 and 2020 Participation: For the 2020 performance year, we will be using our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, and virtual groups to **submit an application** requesting reweighting of one or more MIPS performance categories to 0%. We have introduced a new high-weighted COVID-19 clinical trials improvement activity, which provides an opportunity for clinicians to receive credit in MIPS. For more information about the impact of COVID-19 on Quality Payment Program participation and additional flexibilities proposed in the 2021 QPP Proposed Rule on Quality Payment Program participation, see the Quality Payment Program [COVID-19 Response webpage](#).



How to Use This Guide





Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

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Hyperlinks

Hyperlinks to the [QPP website](#) are included throughout the guide to direct the reader to more information and resources.



Overview



COVID-19 and 2020 Participation

CMS continues to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We are applying the MIPS automatic extreme and uncontrollable circumstances (EUC) policy to all individual MIPS eligible clinicians for the 2020 performance period. We also reopened the MIPS EUC application for groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2021 at 8 p.m. ET.

Please note that applications received by March 31, 2021 won't override previously submitted data for individuals, groups and virtual groups. However, data submission for an APM Entity won't override performance category reweighting from an approved application.

For more information about the impact of COVID-19 on Quality Payment Program participation, see the Quality Payment Program [COVID-19 Response webpage](#) or the [Quality Payment Program COVID-19 Response Fact Sheet](#).

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across four categories that lead to improved quality and value in our healthcare system.

If you're [eligible for MIPS in 2020](#):

- You generally have to submit data for the [Quality](#), [Improvement Activities](#), and [Promoting Interoperability](#) performance categories. (We collect and calculate data for the Cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2020 performance period and applied to payments for covered professional services beginning on January 1, 2022.

To learn more about how to participate in MIPS:

- Visit the [How MIPS Eligibility is Determined and Individual or Group Participation web pages on the Quality Payment Program website](#).
- View the [2020 MIPS Eligibility and Participation Quick Start Guide](#).
- Check your current participation status using the [QPP Participation Status Tool](#).

What is the MIPS Cost Performance Category?

The Cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare beneficiaries, they can affect the amount and types of services that are provided to their patients. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high quality care at a reasonable cost.

MIPS performance category weights in 2020:

Quality

45% of MIPS Score

Cost

15% of MIPS Score

Improvement
Activities

15% of MIPS Score

Promoting
Interoperability

25% of MIPS Score

REMINDER: We are reweighting the Cost performance category to 0% for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. When no additional reweighting applies, the 2020 MIPS performance category weights are as follows: Quality: 55%, Cost: 0%, Improvement Activities: 15%, Promoting Interoperability: 30%. We are leaving the content in this guide as-is for historical reference.

What's New with Cost in 2020?

- **Revised Medicare Spending Per Beneficiary measure:**
 - Updated name – Medicare Spending Per Beneficiary Clinician (MSPB Clinician) measure
 - Refined attribution methodology for medical and surgical episodes
 - Service exclusions for costs that are unlikely to be influenced by clinicians
- **Revised Total Per Capita Cost (TPCC) measure:**
 - Refined attribution methodology for identifying primary care relationships
 - Specialty exclusions for clinicians who don't provide primary care services
 - Refined risk adjustment to account for changes in patient health status during the year
- **Added 10 new Episode-based cost measures**





Get Started with Cost Measures in Four Steps



Get Started with Cost Measures in Four Steps



Get Started with Cost Measures in Four Steps

Step 1. Understand the Cost Performance Category Measures

There are 20 cost measures in total for the 2020 performance period.

Measure Name	Description	Adjustments*	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	Assesses the primary care clinician's overall care for a Medicare patient during the performance period	<ul style="list-style-type: none"> ✓ Payment standardized ✓ Risk adjusted ✓ Specialty-adjusted 	20 Medicare patients	Medicare Part A & B claims
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient	<ul style="list-style-type: none"> ✓ Payment standardized ✓ Risk adjusted 	35 episodes	Medicare Part A & B claims
Episode-based measures (18 measures)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode's time frame	<ul style="list-style-type: none"> ✓ Payment standardized ✓ Risk adjusted 	20 episodes for acute inpatient measures 10 episodes for procedural measures	Medicare Part A & B claims

*For more information on payment standardization, risk adjustment, and specialty adjustment, please see the [Help, Resources, and Version History](#) section.

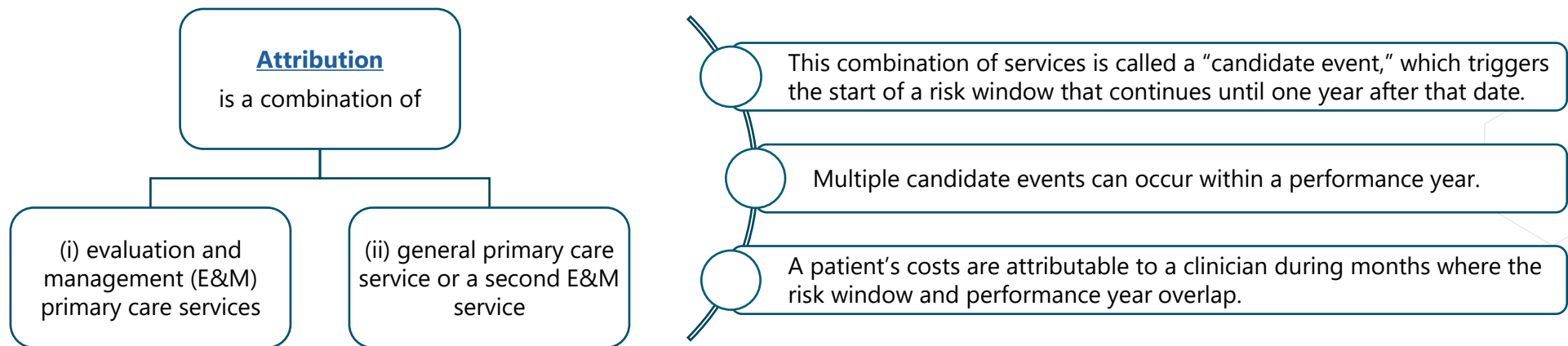
Get Started with Cost Measures in Four Steps

Step 2. Understand How Cost Measures are Calculated

This section provides a brief overview of the steps used to calculate the cost measures.

Total Per Capita Cost (TPCC) Measure Calculation

We are making changes to the methodology for the TPCC measure calculation beginning with performance year 2020.



We will exclude eligible clinicians who:

primarily deliver non-primary care services (e.g. general surgery)

OR

practice in specialties unlikely to be responsible for primary care services (e.g. dermatology)

- We will also determine a patient's risk score on a monthly, rather than annual, basis, using risk factors from the year prior to each month. This will help us reflect changes in the Medicare patient's health status during the performance period for risk adjustment.
- We will assess costs on a monthly basis rather than an annual basis.

Get Started with Cost Measures in Four Steps

Step 2. Understand How Cost Measures are Calculated *(continued)*

TPCC Measure Calculation *(continued)*

Step	Description/Additional Information
1. Identify candidate events	This is the start of a primary care relationship between a clinician and Medicare patient.
2. Apply service category and specialty exclusions	This excludes candidate events for certain clinicians. For example, clinicians whose candidate events meet thresholds for certain service categories (e.g., global surgery) or practice under certain specialties (e.g., dermatology).
3. Construct risk windows	For remaining candidate events, this opens a year-long risk window beginning with the initial E&M primary care service of the candidate event.
4. Attribute months to TINs and TIN-NPIs	Months in the risk window that occur during the performance period are attributed to the remaining eligible TIN-NPIs within the TIN responsible for the majority share, or plurality, of candidate events for a patient.
5. Calculate monthly standardized observed cost	This sums the cost of all services billed for the beneficiary during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
6. Risk-adjust monthly costs	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
7. Apply specialty adjustment	This accounts for the fact that costs vary across specialties and across TINs with varying specialty compositions.
8. Calculate the measure score	This is done by dividing each TIN and TIN-NPI's risk-adjusted monthly cost by the specialty-adjustment factor and multiplying by the observed cost across the total population of patient months where the risk window overlaps with the performance year.

Get Started with Cost Measures in Four Steps

Step 2. Understand How Cost Measures are Calculated *(continued)*

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Measure Calculation

We are also making changes to the MSPB Clinician methodology beginning with performance year 2020.

- The [attribution methodology](#) will distinguish between medical episodes and surgical episodes.
- We will exclude unrelated services specific to groups of Medicare Severity – Diagnosis Related Group (MS-DRGs) aggregated by Major Diagnostic Categories (MDCs), such as orthopedic procedures.

Step	Description/Additional Information
1. Define the population of index admissions	An episode is opened by an inpatient hospital admission ("index admission"). Medicare Part A and Part B claims billed 3 days prior to and during the index admission and 30 days after hospital discharge are considered for inclusion.
2. Attribute MSPB Clinician episodes	Episodes with medical MS-DRGs are attributed to: <ol style="list-style-type: none"> 1) the TIN that billed at least 30% of inpatient E&M services during the index admission, and 2) any TIN-NPI who billed at least one E&M service that was used to meet the 30% threshold for the TIN. Episodes with surgical MS-DRGs are attributed to the TIN and TIN-NPI that provided the main procedure for the index admission.
3. Exclude unrelated services and calculate episode standardized observed cost	This removes services clinically unrelated to the index admission and sums the cost of the remaining services. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Risk-adjust MSPB Clinician episode costs to calculate expected cost	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
5. Exclude outliers and winsorize costs	This mitigates the effect of outlier high- and low-cost episodes on each TIN-NPI or TIN's MSPB Clinician measure score.
6. Calculate MSPB Clinician Measure score	This is done by calculating the ratio of standardized observed episode costs to winsorized expected episode costs and multiplying the average of this cost ratio across episodes for each TIN-NPI or TIN by the national average observed episode cost.

Get Started with Cost Measures in Four Steps

Step 2. Understand How Cost Measures are Calculated *(continued)*

Episode-based Measure Calculation

Step	Description/Additional Information
1. Trigger and define an episode	This relies on billing codes that open, or "trigger," an episode. The pre- and post-trigger period length of the episode varies by measure.
2. Attribute the episode to a clinician	For acute inpatient condition episodes, this is a clinician billing E&M services under a TIN that bills 30% of inpatient E&M services during the inpatient stay. For procedural episodes, this can be any clinician who bills the trigger procedure code.
3. Assign costs to the episode and calculate the standardized episode observed cost	The cost of the assigned services is summed to determine each episode's standardized observed cost. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Exclude episodes	This removes unique groups of patients in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
5. Risk-adjust cost to calculate expected episode costs	This step accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
6. Calculate the measure score	This is done by calculating the ratio of standardized observed episode costs to expected episode costs and multiplying the average cost ratio across episodes for each TIN-NPI or TIN by the national average episode cost.

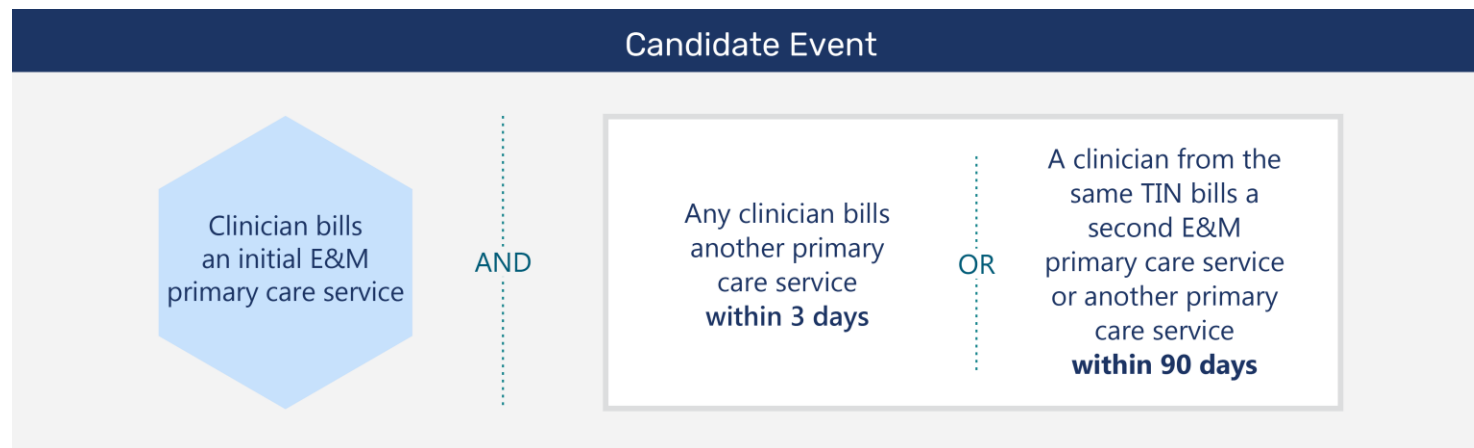
Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians

Although we generally attribute cost measures to individual clinicians, we can assess cost measure performance at the individual clinician (TIN-NPI) level or group (TIN) level, depending on how you participate.

TPCC Measure Attribution¹

TPCC attribution begins with a “candidate event,” or services triggering the start of the primary care relationship.



¹ Please review the revised [Total Per Capita Cost Measure Information Form](#) for information about TIN (group) attribution.

Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

TPCC Measure Attribution *(continued)*

TIN-NPI Attribution When TIN Has 11 Candidate Events

Clinician: HCFA Specialty

Candidate Events

Exclusions

TIN-NPI Attribution

A: Cardiology

Over 15% of clinician's candidate events had 10- or 90-day global surgery with same beneficiary

Candidate Event 1
Candidate Event 2



Excluded from attribution based on **global surgery service exclusion**

B: Optometry

Candidate Event 3
Candidate Event 4
Candidate Event 5
Candidate Event 6



Excluded from attribution based on **optometry specialty exclusion**

C: Family Practice

Candidate Event 7
Candidate Event 8
Candidate Event 9
Candidate Event 10



No exclusions apply

D: Geriatric Medicine

Candidate Event 11



No exclusions apply

Clinicians A and B **will not be attributed**

Beneficiary months for candidate events 1-6 will not be attributed at either the TIN or TIN-NPI level

Clinician C who is responsible for the plurality of the beneficiary's attributable candidate events **will be attributed** beneficiary months for candidate events 7 – 10

Clinician D **will not be attributed** any beneficiary months because they do not bill the plurality of candidate events for this beneficiary. Beneficiary months for candidate event 11 will not be attributed at the TIN-NPI level

Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

MSPB Clinician: Episode Attribution

MSPB Clinician attribution begins by identifying the “episode,” triggered by an inpatient hospital admission.



Episodes are classified as either medical or surgical, based on the MS-DRG.

- A **medical episode** is
 - First attributed to the TIN billing at least 30 percent of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
 - 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.
- A **surgical episode** is attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

MSPB Clinician: Medical Episode Attribution Example

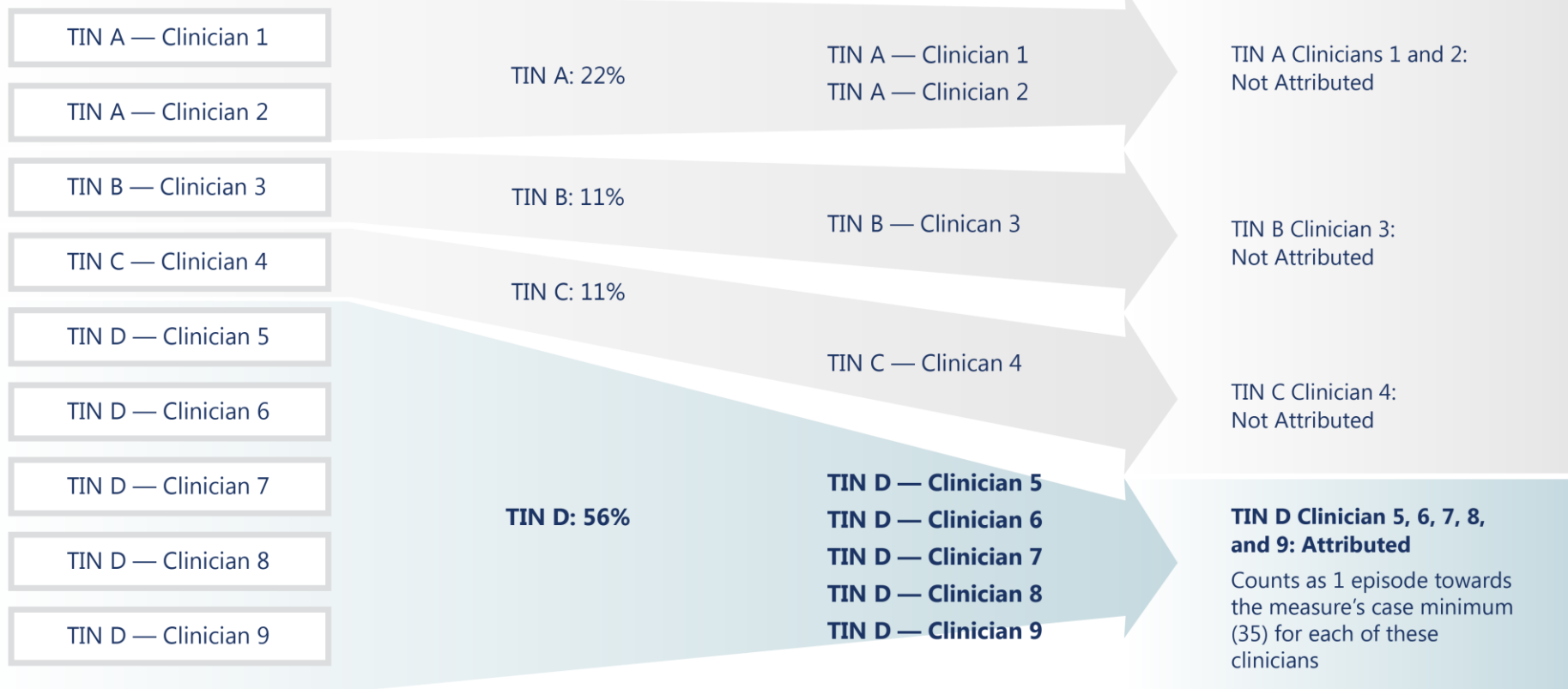
Medical MS-DRG Episode Attribution

1. We look for E&M services provided during the index admission

2. We look for the TIN responsible for least 30% of E&M services billed during the index admission

3. We identify clinicians in that TIN who billed an E&M service during the index admission for the episode

4. We attribute the episode to the clinicians identified in Step 3



Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

MSPB Clinician: Surgical Episode Attribution Example

Surgical Episode Attribution Example

1. We identify TINs and Clinicians who billed CPT/HCPCS codes during Index Admission for a surgical episode

TIN A — Clinician 1

TIN A — Clinician 2

TIN B — Clinician 3

TIN C — Clinician 4

TIN C — Clinician 5

TIN C — Clinician 6

2. We identify TINs and Clinicians that billed relevant CPT/HCPCS codes for the surgical episode

TIN A: Yes
Clinician 1: Yes
Clinician 2: No

TIN B: No
Clinician 3: No

TIN C: No
Clinician 4: No
Clinician 5: No
Clinician 6: No

3. We attribute the episode to the TIN(s) and clinician(s) identified in step 2

TIN A: Attributed
Clinician 1: Attributed
Clinician 2: Not Attributed

TIN B: Not Attributed
Clinician 3: Not Attributed

TIN C: Not Attributed
Clinician 4: Not Attributed
Clinician 5: Not Attributed
Clinician 6: Not Attributed

Get Started with Cost Measures in Four Steps

Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

Episode-based Measure Attribution

For **acute inpatient episodes**, an episode is:

- First attributed to the TIN billing at least 30 percent of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

For **procedural episodes**, we attribute the episode to any clinician who bills the code that triggers the episode.

Episode-based Measure Attribution

Pre-Trigger Period (if applicable)

Post-Trigger Period

Attribution

Attributed
Clinician

Other
Clinicians/Providers

Trigger Service

Service Assigned to Episode

Service Not Assigned to Episode

Episode Window

Get Started with Cost Measures in Four Steps

Step 4. Understand What Cost Performance Feedback Will Be Available

MIPS eligible clinicians, groups, and virtual groups who meet the case minimum for any of the cost measures will receive category- and measure-level scoring information in their performance feedback. Each measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

You can compare your costs for each measure with the benchmark provided to better understand your performance relative to your peers. To see what performance feedback looked like in previous years, review the cost section of the [2018 Performance Feedback FAQs](#).

We have also provided patient-level reports for viewing and downloading by clinicians and groups who were scored on the TPCC and MSPB Clinician measures and are currently investigating more detailed cost feedback for the 2019 Episode based measures. Visit the [2018 MIPS Performance Feedback Beneficiary-Level Data Reports Supplement](#) on the Resource Library for more information. (Note, this is the most current resource at the time of publication.)

Final performance feedback will be available by July 2021 when you sign in to qpp.cms.gov.

NOTE: CMS won't provide 2020 cost performance feedback because the Cost performance category will be reweighted to 0% for the 2020 performance period.



Help, Resources, and Version History



Help, Resources, and Version History

Where Can You Go for Help?

- 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.
 - 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](#).

Help, Resources, and Version History

Additional Resources

The [QPP Resource Library](#) houses fact sheets, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

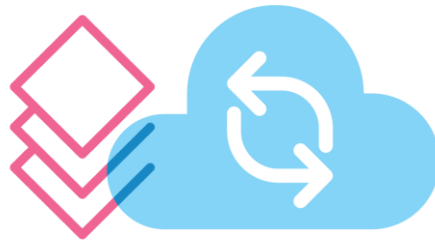
Resource	Description
2020 MIPS Quick Start Guide	A high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2020 performance period.
2020 MIPS Eligibility and Participation Quick Start Guide	A high-level overview and actionable steps to understand your 2020 MIPS eligibility and participation requirements.

Help, Resources, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Change Description
5/20/21	Updated content to reflect that the cost performance category will be weighted at 0% for all MIPS eligible clinicians in the 2020 performance year.
8/28/20	Added disclaimer language regarding changes to 2020 MIPS in response to COVID-19.
3/19/20	Corrected typo from MSPC-C to MSPB Clinician on page 8 and updated the MSPB Clinician measure name throughout
1/7/20	Original posting



Appendix



Episode-based Cost Measures for the MIPS 2020 Performance Year

Measure Topic	Measure Type	New in 2020
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	No
Knee Arthroplasty	Procedural	No
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	No
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	No
Screening/Surveillance Colonoscopy	Procedural	No
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Yes
Elective Primary Hip Arthroplasty	Procedural	Yes
Femoral or Inguinal Hernia Repair	Procedural	Yes
Hemodialysis Access Creation	Procedural	Yes
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Yes
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	Yes
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	Yes
Renal or Ureteral Stone Surgical Treatment	Procedural	Yes
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	No
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	No
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	No
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Yes
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	Yes

Appendix B

CMS Reweighting 2020 MIPS Cost Performance Category Listserv

***The following QPP listserv message was distributed on 5/20/2021.**

CMS Reweighting 2020 MIPS Cost Performance Category

The Centers for Medicare & Medicaid Services (CMS) recognizes the impact of the COVID-19 pandemic public health emergency (PHE) on clinicians across the country and we continue to offer flexibilities to provide relief where possible. Under § 414.1350(d)(3), the Merit-based Incentive Payment System (MIPS) cost performance category weight is 15% of the final score for the 2020 performance period/2022 MIPS payment year. We would like to inform all MIPS eligible clinicians that we're reweighting the cost performance category from 15% to 0% for the 2020 performance period. The 15% cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(D). Please see the table below for reweighting scenarios.

Our analysis of the underlying data for the 2020 performance year, in comparison to prior years' data, shows that the volume of data available to calculate the scores for the cost measures has significantly decreased overall. As a result, we do not believe we can reliably calculate scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians. Given these circumstances, in accordance with § 414.1380(c)(2)(i)(A)(2), we will assign a weight of 0% to the cost performance category for the 2020 performance period and redistribute the prescribed weight of 15% to another performance category or categories.

Specifically, we do not believe we can reliably calculate scores for the cost measures based on the following reasons, as shown by our analysis of the cost performance category data for the 2020 performance year:

- A significant decrease in service utilization in 2020 demonstrates cost measures may not accurately characterize patient risk due to the lack of diagnosis information in the lookback periods used for risk adjustment.
- Episodes with COVID-19 diagnoses generally have higher observed and risk-adjusted costs, indicating COVID-19 impacted service utilization and wasn't sufficiently accounted for through risk adjustment.
- The overall number of clinicians who met 2020 cost measure case minimums substantially decreased from prior performance years. A substantial portion of clinicians had episodes with COVID-19.

Clinicians don't need to take any action as a result of this decision because the cost performance category relies on administrative claims data.

MIPS Performance Category Weight Redistribution Policies Finalized for the 2020 Performance Period

Listserv message continues on the following slide.

Appendix B

CMS Reweighting 2020 MIPS Cost Performance Category Listserv (continued)

***The following QPP listserv message was distributed on 5/20/2021.** (continued)

The table below illustrates the 2020 performance category weights and reweighting policies that CMS will apply to clinicians under MIPS. As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they will receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year.

MIPS Performance Category Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Additional Reweighting Applies	55%	0%	15%	30%
Reweight 2 Performance Categories				
No Promoting Interoperability, No Cost	85%	0%	15%	0%
No Quality, No Cost	0%	0%	15%	85%
No Improvement Activities, No Cost	70%	0%	0%	30%

* This table may be found at § 414.1380(c)(2)(ii)(D).

This reweighting of the cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policies under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), § 414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3). Clinicians who aren't covered by the automatic EUC policy or who did not apply to request reweighting under the EUC policy will still have their cost performance category weighted to 0%.

Questions?

Please contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.