2020 is the fourth year of the MACRA Quality Payment Program (QPP), under which physicians may choose to participate in an Advanced Alternative Payment Model (APM) or submit data to the Merit-Based Incentive Payment System (MIPS).

MIPS consolidates and sunsets the previous quality reporting programs by the Centers for Medicare and Medicaid Services (CMS), including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive program (Meaningful Use), into one program. In 2020, MIPS has four weighted performance categories: quality (45%), based on PQRS; cost (15%), based on VM; promoting interoperability (PI) (25%), previously advancing care information (ACI); and improvement activities (15%).

This resource provides guidance and considerations on the different MIPS categories and the multiple reporting mechanisms available for MIPS reporting for each category to help you determine which reporting option (group, individual, or Virtual Group) and reporting options (claims, EHR, registry, etc.) is best for your practice.
Are you exempt from participation?

Exempt from MIPS

- Newly-enrolled Medicare physicians who enroll in Medicare for the first time during the performance year
- Physicists below the low-volume threshold. Physicians who either:
  - Have Medicare Part B allowed charges ≤ $90,000, OR
  - Provide care to 200 or fewer Medicare Part B patients
- Physicians participating in Advanced APMs
- Provide 200 or fewer professional services under the Physician Fee Schedule

Practice Tip: Use the CMS NPI-level lookup tool on the CMS QPP website to determine participation eligibility. Physicians should keep a record of the eligibility/exemption status provided by CMS.
Quality Category Considerations

- Minimum of 6 individual measures, including one outcome measure or a high-priority measure if an outcome measure is not available
  - Intermediate outcome measures count as an outcome measure
  - High-priority measures are defined as appropriate use, patient safety, efficiency, patient experience, care coordination, and opioid-related measures
- OR alternatively (to the 6 individual measures) report one specialty measure set
- Report each measure for at least 70% of applicable patients (report data for that measure for at least 70% of the patients who meet the measure's denominator criteria, discussed in detail below)

Did you previously submit quality measures for the 2017, 2018, and/or 2019 MIPS performance year?
- If yes, check the updated measure specifications for 2020 as well as the 2020 measure benchmarks to make sure that there have been no changes to the numerator, denominator, exceptions, and other measure specifications.
- There are 219 MIPS individual measures, across all specialties and settings, available for 2020 reporting. Visit the CMS measures search tool for a list of all MIPS measures, which can also filter the measures by specialty.

Did you report a measures group in previous PQRS reporting periods or a specialty-specific measure set for 2017, 2018, and/or 2019 MIPS participation?
- If yes, then it is likely that you may have a specialty-specific measure set that is applicable to your practice for 2020 MIPS reporting for the quality category.
- New specialty-specific measure sets have also been added for 2020 reporting.
- Use the CMS measures search tool to determine which measure sets are available.
PI Category Considerations

- The 2020 PI performance score is based on a single set of 4 objectives and their related measures.
- The four objectives are:
  - Electronic-prescribing
  - Health information exchange
  - Provider-to-patient exchange, and
  - Public health and clinical data exchange
- You are **only required to report certain measures** from each of the objectives unless an exclusion is claimed.

Did you previously report PI measures for 2019 MIPS participation? Understand the new changes for the 2020 PI category.

- CMS has removed the Verify Opioid Treatment Agreement measure
- CMS has changed the optional Query of Prescription Drug Monitoring Program (PDMP) measure to require a “yes/no” response instead of a numerator and denominator

For 2020 MIPS participation, physicians must use the 2015 Edition CEHRT

- Visit the [Certified Health IT Product List](#) (CHPL) to determine if your EHR is a 2015 Edition CEHRT

Improvement Activities Category Considerations

- This category rewards physicians for participating in activities that improve clinical practice or care delivery that are likely to result in improved outcomes.
- Report any combination of medium- and high-weight activities to achieve 40 points.
- Solo practitioners and small practices (15 or fewer ECs), non-patient facing physicians, and/or physicians in a rural area or health professional shortage area (HPSA)
  - Medium-weight activities = 20 points each
  - High-weight activities = 40 points each
- Groups of more than 16 ECs
  - Medium-weight activities = 10 points each
  - High-weight activities = 20 points each
Did you report improvement activities for the MIPS 2017, 2018, and/or 2019 participation years?

- If you reported data for the improvement activities category as part of 2019 MIPS participation, review the list of 2020 improvement activities to check for modifications or updates to the improvement activities for 2020 participation.
- Review the 2020 data validation criteria used for audits and validating the data submitted for the Improvement Activities category.

It is likely that you are already performing at least one improvement activity in your practice but may be calling it by a different name. It is recommended that you review the list of 105 Improvement Activities and select that are already applicable to your practice.

- Cross-walk your current practice activities to the menu of 2020 improvement activities.

In 2020, there are 105 improvement activities to choose from that are eligible for MIPS credit. Determine which apply best to your practice.

The activities are organized into 8 subcategories. The table below provides examples of the subcategories and sample activities available for the improvement activities category:

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Example Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Practice Access</td>
<td>• e.g., same day appointments for urgent need or after-hours access to advice or services</td>
</tr>
<tr>
<td>Population Management</td>
<td>• e.g., adopting and implementing processes to develop Advance Care Planning</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>• e.g., timely communication of test results or exchange of clinical information to patients</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>• e.g., participation in a QCDR that promotes use of patient engagement tools</td>
</tr>
<tr>
<td>Patient Safety and Practice Assessment</td>
<td>• e.g., annual registration in a prescription drug monitoring program</td>
</tr>
<tr>
<td>Achieving Health Equity</td>
<td>• e.g., engaging new Medicaid patients and following-up in a timely manner</td>
</tr>
<tr>
<td>Emergency Response and Preparedness</td>
<td>• e.g., participation on Disaster Medical Assistance Team</td>
</tr>
<tr>
<td>Behavioral and Mental Health</td>
<td>• e.g., integrating behavioral health with primary care to address substance use disorders or other health conditions</td>
</tr>
</tbody>
</table>
Cost Category Considerations

- This category measures and attributes costs to physicians for the services they provide
- No reporting/data submission is required for the cost category
- CMS will use administrative claims data to assess your cost performance on the following measures (if applicable):
  - Medicare spending per beneficiary clinician (MSPB-C) measure
  - Total per capita cost (TPCC) for all attributed beneficiaries measure
  - Elective outpatient percutaneous coronary intervention (episode measure)
  - Knee arthroplasty (episode measure)
  - Revascularization for lower extremity chronic critical limb ischemia (episode measure)
  - Routine cataract removal with intraocular lens (IOL) implantation (episode measure)
  - Screening/surveillance colonoscopy (episode measure)
  - Acute Kidney Injury Requiring New Inpatient Dialysis (episode measure)
  - Elective Primary Hip Arthroplasty (episode measure)
  - Femoral or Inguinal Hernia Repair (episode measure)
  - Hemodialysis Access Creation (episode measure)
  - Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels (episode measure)
  - Lumpectomy, Partial Mastectomy, Simple Mastectomy (episode measure)
  - Non-Emergent Coronary Artery Bypass Graft (episode measure)
  - Renal or Ureteral Stone Surgical Treatment (episode measure)
  - Intracranial hemorrhage or cerebral infarction (episode measure)
  - Simple pneumonia with hospitalization (episode measure)
  - ST-elevation myocardial infarction (STEMI) with PCI (episode measure)
  - Inpatient Chronic Obstructive Pulmonary Disease Exacerbation (episode measure)
  - Lower Gastrointestinal Hemorrhage (episode measure)

Did you previously receive a score for the cost category for 2017, 2018, 2019, and/or 2020 participation?

- CMS used administrative claims data to provide feedback on the cost measures, so it is recommended that you review your previous years’ feedback reports to determine if CMS provided any information on the cost category measures.
- The MIPS feedback reports to gain a better understanding of what your performance will look like in this category going forward.
- Review the PAI Cost Category Overview resource to learn more.
Do you care for patients who may have one of the conditions/diagnoses associated with one or more of the episode-based measures?

- If your patient population consists primarily of patients that have a condition/diagnosis associated with an episode-based measure, it is possible you may be scored for those measures for the cost category.
- If you do not specialize or regularly see patients with the measure-associated conditions/diagnoses, you may not meet the case minimum for the measures and it is possible that those measures could be excluded from your cost category performance score.
- If the case minimum is not met for all measures (including MSPB-C and TPCC), then the cost category will be reweighted to 0% and the quality category will be reweighted to 60%, PI weight would be 25% and, the improvement activities weight would be 15%.

Selecting a Participation Option

Individual Reporting
If you are electing to report as an individual, no registration is required, and payment adjustments will be based on your individual performance across the MIPS categories.

Group Reporting
If you are reporting as a group, payment adjustments will be based on group performance. Group registration is required only if you elect to report data via the CMS Web Interface and/or if you report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey measure. **The registration deadline for these reporting options is June 30, 2020.** If your group or Virtual Group reported through the CMS Web Interface for 2019 performance year, then you are automatically register for the 2020 performance year.

The CMS Web Interface is only an option for groups with 25 or more clinicians. The CAHPS for MIPS survey is only an option for groups with 2 or more clinicians. Per CMS, the survey is not appropriate for practices that do not provide primary care services.

Virtual Group Reporting¹

Virtual Groups represent a separate participation option made effective in 2018. Virtual Groups are defined as a combination of 2 or more TINs assigned to 1 or more solo practitioners or 1 or more groups consisting of 10 or fewer clinicians. Physicians and other ECs can elect to form a

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¹ Virtual Group election must be made prior to the beginning of the performance period; therefore, physicians and other clinicians must have elected to form a Virtual Group by the December 31, 2019 deadline for 2020 MIPS participation.
Virtual Group regardless of their geographic location or specialty, and there are no limits on the number of solo practitioners and groups that can come together to form a Virtual Group.

Unlike the group participation option which is limited to physicians under the same TIN/practice, the Virtual Group participation option allows multiple solo practitioners and small practices to come together “virtually” with each other to participate. Similar to group participation, Virtual Group participants will have their performance assessed collectively as a group in all four MIPS categories.

Participation Must be the Same Across All MIPS Categories.

**Selecting Reporting Mechanisms**
Physicians should be aware of reporting options as well as specific applicability by category and reporting type. For 2020, there are generally five collection type options via which physicians can submit their MIPS data.

- **Medicare Part B claims**
  - Quality measures are reported through routine billing processes
  - Only available to small practices (15 or fewer ECs)

- **Direct**
  - Third-party intermediaries transmit data through a computer-to-computer interaction (e.g., an API)
  - Third-party intermediaries include qualified clinical data registries (QCDRs), qualified registries, and EHR vendors

- **CMS Web Interface**
  - Web-based application with a required set of measures
  - Only available to groups of 25 or more clinicians

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Reporting mechanisms that can be used to submit your MIPS data depend on the category and whether you participate as an individual, group, or Virtual Group. You can report different categories using different collection types and reporting mechanisms; you are not required to submit MIPS data using one collection type or reporting mechanism across all the categories. Additionally, you can submit quality measures and improvement activities data using multiple reporting mechanisms and CMS will aggregate the data for scoring purposes.

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Individual (themselves or working with a Qualified Registry, QCDR, or CEHRT)</td>
</tr>
<tr>
<td></td>
<td>Medicare Part B Claims; Direct; Log-In and Upload</td>
</tr>
<tr>
<td></td>
<td>Group or Virtual Group (themselves or working with a Qualified Registry, QCDR, or CEHRT)</td>
</tr>
<tr>
<td></td>
<td>Medicare Part B Claims (only for those with small practice designation); Direct; Log-In and Upload; CMS Web Interface (for 25 or more ECs); CAHPS for MIPS Survey; Administrative Claims</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Individual, Groups, Virtual Groups, and Third-Party Intermediaries (e.g., Qualified Registry, QCDR, CEHRT, CMS-approved survey vendor)</td>
</tr>
<tr>
<td></td>
<td>Direct; Log-In and Upload; Log-In and Attest (via qpp.cms.gov)</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>Individual, Groups, Virtual Groups, and Third-Party Intermediaries (e.g., Qualified Registry, QCDR, CEHRT,)</td>
</tr>
<tr>
<td></td>
<td>Log-In and Upload; Log-In and Attest (via qpp.cms.gov)</td>
</tr>
<tr>
<td>Cost</td>
<td>Individual, Group or Virtual Group</td>
</tr>
<tr>
<td></td>
<td>No submission required. CMS will use administrative claims data.</td>
</tr>
</tbody>
</table>
How do I select the best option to report?

<table>
<thead>
<tr>
<th>Reporting Option</th>
<th>Pros/Cons</th>
</tr>
</thead>
</table>
| Medicare Part B Claims                    | • No additional administrative cost; an affordable option  
• Only available to solo practitioners and small practices  
• Quality data codes/G-codes may be reported by billing staff or billing companies  
• Confusion and inaccurate reporting of quality data codes/G-codes for the quality measures  
• Only available for the quality category for certain measures (not an option for reporting all MIPS measures) |
| Log-in and Upload or Attest via CMS QPP Submission Portal | • Affordable options  
• Must have an HCQIS Access Roles and Profile (HARP) system account  
• Allows ECs to attest and upload their electronic files from an EHR. qualified registry, or QCDR for the categories  
• More real-time scoring provides insight into performance  
• Attestation does not require submission of data |
| Qualified Clinical Data Registry (QCDR) / Qualified Registry | • Most MIPS measures are reportable via registries and QCDRs  
• QCDRs include MIPS and non-MIPS measures (eligible for MIPS credit that can be specialty-specific and may be more applicable to some physicians)  
• Participants must pay a registration fee and additional costs (varies per registry/QCDR vendor). However, some national specialty societies offer registries/QCDRs at no or low cost  
• Performance feedback may be provided within the performance period  
• Difficulty linking to EHR systems and automatically extracting the data  
• Manual data entry option may be time consuming |
### Reporting Option

<table>
<thead>
<tr>
<th>Reporting Option</th>
<th>Pros/Cons</th>
</tr>
</thead>
</table>
| **2015 Edition** Certified Electronic Health Record Technology (CEHRT) | • Many practices already use EHRs in daily practice, but not all practices may have access to EHRs  
• Convenient collection of data captured directly from CEHRT system  
• CEHRT vendors may submit the data on your behalf, but you must trust that the vendor will correctly and accurately submit the information  
• Limited availability of applicable quality measures that can be reported via an CEHRT |
| CMS Web Interface | • Only available for groups of 25 or more ECs  
• Higher reporting thresholds for quality measures (must report data on more measures)  
• Must register with CMS by June 30, 2020  
• May enter data manually or upload data directly from EHR system |
| CAHPS | • Takes place of one quality measure for the MIPS quality category  
• Must register with CMS by June 30, 2020  
• Must pay a CMS-certified survey vendor to conduct CAHPS for MIPS survey  
• Must be reported in conjunction with another reporting mechanism |
| Administrative Claims | • No submission is required  
• Uncertainty about your performance and how CMS will use the data in its calculations |

**Note:** You must keep records for all data submitted to MIPS for audit purposes. It is recommended that you keep documentation for at least 6 years.
### What are my reporting deadlines?

<table>
<thead>
<tr>
<th>Claims reporting</th>
<th>CMS Web Interface</th>
<th>QCDR, registry and CEHRT reporting mechanisms</th>
<th>CAHPS for MIPS survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Claims for services provided in 2020 must be processed by March 1, 2021</td>
<td>• January 2 - March 31, 2021</td>
<td>• March 31, 2021 (or sooner depending on your vendor’s own deadlines)</td>
<td>• Will be administered to beneficiaries from October 2020 through January 2021</td>
</tr>
<tr>
<td>• Contact your local MAC for additional guidance</td>
<td></td>
<td></td>
<td>• Will be communicated to you by your CMS-approved vendor of choice</td>
</tr>
</tbody>
</table>

### Where can I go for more information?

Please visit [PAI’s QPP Resource Center](#) and the [CMS’s QPP Resource Library](#) for additional information and resources.