The Physicians Advocacy Institute’s
Medicare Quality Payment Program (QPP)
Physician Education Initiative

2020 Quality Category Overview
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 for the quality category for individual and small group practices.¹ Because the quality category is weighted at 45% of the 2020 MIPS final score, it is recommended that physicians carefully review all reporting requirements and weigh all options.

¹ This resource focuses on the quality category reporting options for individual and small group practice reporting and does not address reporting requirements and scoring details for the CMS Web Interface reporting mechanism, which applies only to groups of 25 or more eligible clinicians. For details about the CMS Web Interface, visit CMS’s QPP Resource Library.

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What are my options for the quality category?

Like 2019, the 2020 MIPS quality category has a full-year performance period ranging from January 1, 2020 – December 31, 2020. Physicians may choose to report data on quality measures at the individual, group, or Virtual Group level.

Continuing in 2020, physicians, groups, and Virtual Groups may use multiple reporting mechanisms. If the same measures are submitted through multiple mechanisms, CMS will select the option with the greatest performance points for scoring purposes. Furthermore, continuing in 2020, Medicare Part B claims measures can only be submitted by clinicians in a small practice (i.e., 15 or fewer eligible clinicians).

To meet data submission requirements and data completeness criteria, physicians must report at least 6 measures, or one specialty measure set, and report each measure for at least 70% of applicable patients (CMS has raised the data completeness requirement from 60% to 70% for the 2020 performance year). In addition to the 6-measure requirement, groups of 16 or more eligible clinicians, and that meet a case minimum of at least 200 cases, will be subject to the 30-day all-cause hospital readmission measure. This measure will automatically be calculated using administrative claims data and would be counted in addition to the quality reporting requirement.

<table>
<thead>
<tr>
<th>2020 Quality Category Requirements</th>
<th>Minimum of 6 individual measures, including one outcome measure or a high-priority measure if an outcome measure is not available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intermediate outcome measures count as an outcome measure</td>
</tr>
<tr>
<td></td>
<td>High-priority measures are defined as appropriate use, patient safety, efficiency, patient experience, care coordination, and opioid-related measures</td>
</tr>
<tr>
<td></td>
<td>OR alternatively (to the 6 individual measures) report one specialty or sub-specialty measure set</td>
</tr>
<tr>
<td></td>
<td>There are a total of 46 specialty and sub-specialty measure sets available for 2020 reporting</td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
</tbody>
</table>
What are some considerations for the full-year performance period?

For 2020 MIPS participation, the quality category score will be assessed using full calendar year patient data. Full-year performance period does not require full calendar year reporting beginning January 1, 2020. The full-year performance period means that patient data from the full calendar year will be used to assess whether physicians and other clinicians satisfy the data completeness criteria for the quality measures they are reporting. The data completeness criteria must first be satisfied to receive a performance score for a measure.

As you collect and report data, keep in mind that you must meet the 70% data completeness criteria for measures based on full-year patient data. However, you may report more than the required 70% if you choose.  

How do you satisfy the data completeness criteria?

Quality breakdown of “70% of applicable patient” requirement

Report each measure for 70% of applicable patients

“Applicable Patient” means the total amount of patients who meet the denominator criteria specified by CMS for each measure.

“70% of applicable patients” means that, out the total amount of patients who meet the denominator criteria, the measure is reported for at least 70% of those patients.

- E.g., 100 patients meet the denominator criteria for quality Measure 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. The “70% of applicable patients” requirement would be met if some data related to the measure is then reported for at least 70 of those 100 patients, including whether you conducted the quality activity related to the measure or not. For example, the threshold would be met if you reported that you conducted a screening and cessation intervention for 34 patients and did not conduct a screening and cessation intervention for the other 36 patients (34 + 36 = 70) (out of a total of 100 patients who meet the denominator criteria)

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2 CMS set the threshold at 70% rather than at 100% to reduce reporting burden and to accommodate for operational issues that may arise during data collection during the initial years of the QPP. However, CMS intends to increase the threshold in future years.

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Do only Medicare Part B patients count towards “applicable patients” or does this include all patients from all payers? This depends on the type of measure:

- Claims measures – Medicare Part B patients
- Qualified Clinical Data Registry (QCDR) measures, qualified registry (MIPS CQM) measures, and CEHRT (eCQM) measures – Patients from all payers, including Medicare (all-payer mix)

**Note:** the “70% of applicable patients” requirement is not the same as the performance score which determines the number of points you will receive for each measure.

The performance score for each measure is determined by looking at the number of patients that meet the denominator criteria for whom the measure is reported and who are not excluded and seeing for how many of those patients you performed a clinical action that could satisfy the measure (the numerator for the measure). Your numerator/denominator performance will then be compared to the benchmark for the measure, and you will receive points for that measure based on how you performed in relation to the historical benchmark.3

**How is the quality category scored?**

Physicians will receive 0-10 points for each measure they report, based on whether they satisfy the 70% data completeness criteria and their performance in a measure compared to the measure’s benchmark. Solo practitioners and small practices of 15 or fewer eligible clinicians (ECs) will automatically receive 3 points for submitting some information on a measure. Beginning in 2020, practices of 16 or more clinicians will receive 0 points if they fail to meet the data completeness threshold.

If the 70% threshold is met, then physicians will have the opportunity to earn additional points per measure based on their performance as compared to the measure’s benchmark.

If the 70% threshold is not met, then physicians will receive 0 or 3 points per measure based on their practice size.

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3 To review benchmarks for each measure, refer to the 2020 Quality Benchmarks zip file on CMS QPP Resource Library. For quality measures that are reportable through more than one reporting mechanism, please note that the benchmarks vary and selecting one method over another can impact your performance score.
In order to receive a performance score beyond 0 or 3 points per individual quality measure, you must meet the data completeness criteria of “70% of applicable patients,” meet the case minimum requirement of at least 20 cases per measure, and the measure must have a benchmark. If you report CAHPS for MIPS survey data, the 70% data completeness threshold does not apply and a range of 3-10 points will be available for each summary survey measure.

**Topped Out Measures**

For quality measures designated as “topped out” for two consecutive years through the same collection type (e.g., claims, eCQMs, MIPS CQMs, QCDR measures), only a maximum of 7 points can be earned. Topped out measures are defined as measures for which performance is consistently high that “meaningful differences and improvement in performance can no longer be seen.” Measures that are “topped out” for only one year may still be eligible for 10 points.

There are over 60 different topped out measures in 2020. Below are some examples:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin Quality Measure ID: 21
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) Quality Measure ID: 23
- Documentation of Current Medications in the Medical Record Quality Measure ID: 130
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy Quality Measure ID: 52

**Extremely Topped Out Measures**

Continuing in 2020, measures designated as “extremely topped-out measures” will be proposed for removal, in total, and are not subject to the 4-year lifecycle applied to topped-out measures. Measures are considered “extremely topped-out” when their mean performance is within the 98th and 100th percentile range. Measures which meet this percentile benchmark can be located within the [2020 Quality Benchmarks zip file](#) available on the [CMS QPP Resource Library](#).

**Measures with No Benchmark**

For quality measures with no historical benchmark, CMS will calculate benchmarks based on 2020 data. If no benchmark can be calculated, then only a maximum of 3 points can be earned for the measure, as long as data completeness has been met.

**All-Cause Readmission Measure**

For groups of 16 or more eligible clinicians who are subject to the 30-day all-cause readmissions measure and meet the case minimum of at least 200 cases, the benchmark and eligible points will be provided by CMS in early 2020. For CAHPS for MIPS summary survey measures, CMS will
calculate benchmarks based on 2020 data and will provide them when available at the end of the performance period.

**Bonus Points**

Additionally, bonus points can be earned by reporting additional high-priority measures, reporting measures as an individual/small group provider, or reporting measures electronically using an EHR, qualified registry, or a QCDR, and through improvement scoring in the quality category.

For additional details on scoring for the quality category, see **PAI’s MIPS Scoring Overview**.

**What is the minimum I have to report for the quality category only and avoid the MIPS negative 9% payment adjustment in 2022?**

The 2020 MIPS performance threshold is 45 points, meaning physicians must achieve at least 45 points in their overall MIPS final score for 2020 participation to avoid a negative payment adjustment in 2022. There are several ways to achieve 45 points using different MIPS categories. However, physicians can satisfy this requirement, and avoid a negative payment adjustment in 2022, by only reporting data for the quality category if they receive the maximum 10 points for at least 6 measures reported (or maximum points for a specialty measure set reported).

**What measures to report?**

**MIPS Specialty-Specific Measure Sets**

Reporting a specialty-specific measure set may be the least burdensome option if an applicable specialty-specific measure set exists.

There are 46 specialty measure sets available for 2020 reporting.
If the measure set contains more than 6 measures, you are only required to report on 6 total measures (at least one of which must be an outcomes or high-priority measure).

If the measure set contains less than 6 measures, then you are required to report on applicable measures. For example, a measure set may only have 4 measures, and only 3 of those 4 measures are applicable to your practice, then you are only required to report those 3 measures.

Additional details on these specialty-specific measure sets are available using the Specialty Measure Set Overview on the PAI website and on CMS’s Quality Payment Program website.

MIPS and QCDR Individual Measures

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. In addition to MIPS measures, you also have the option to report 6
QCDR measures or a combination of 6 QCDR and MIPS measures. For some physicians, QCDRs may offer more applicable measures based on specialty, condition, practice setting, etc.

Download the Clinical “Quality Measure Specifications and Supporting Documents” and the “2020 Quality Benchmarks” zip files, located in the CMS’s QPP Resource Library. For additional details contact the Measure Steward listed for a particular measure.

These measures specifications will provide a blueprint for each measure with detailed information such as the denominator criteria (patient population), numerator criteria (clinical action), documentation requirements (important for potential audits), and rationale with the evidence base and/or or intent for the measure, among other key information.

Common MIPS Measures

While more applicable, specialty-specific measures may be available for your practice, below are 6 measures that CMS has identified as cross-cutting measures that are broadly applicable regardless of specialty. However, you do not have to report on these measures if they do not apply to you or if you prefer to report on other measures.

Cross-Cutting Measures

#47 – Advance Care Plan ......................................................................................................................... 12
#128 – Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan ........... 13
#130 – Documentation of Current Medications in the Medical Record ...................................................... 15
#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention .......... 16
#236 – Controlling High Blood Pressure .................................................................................................. 17
#317 – Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented ........................................................................................................................................... 19

As you evaluate which measures to report, these measures provide a good starting point. In the Appendix you will find the reporting specifications (extracted from official 2020 CMS measure specifications documents) for each of these measures for claims and registry reporting, along with flow-chart diagrams from CMS that walk you through the specifications and reporting.

CAHPS for MIPS Summary Survey Measures

A group of 2 or more eligible clinicians that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measure must use a survey vendor that is approved by CMS. The 2020 CAHPS for MIPS survey will be conducted by the survey vendor from October 2020 to January 2021. The
CAHPS for MIPS survey counts for one measure towards the MIPS quality category, as a patient experience measure, and also fulfills the requirement to report at least one high priority measure in the absence of an applicable outcome measure. Additionally, the group will be required to submit at least 5 other measures through another reporting mechanism. This mechanism requires registration with CMS by June 30, 2020. For additional details, see the CMS’s QPP Resource Library.

30-Day All-Cause Hospital Readmission Measure

The 30-day all-cause readmission measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized and experienced an unplanned readmission for any cause to a short-stay acute-care hospital within 30 days of discharge. In addition to the 6-measure requirement, groups of 16 or more eligible clinicians that meet the case minimum of at least 200 cases for the 30-day all-cause readmission administrative claims measure will automatically be scored and have that measure score included in their quality category performance score. For additional details about the 30-day all-cause readmission measure, search for the measure on the CMS Clinical “Quality Measure Specifications and Supporting Documents” zip file.

How do I report data and by when?

You have several options for reporting quality category measures data. How you report the information will depend on the reporting mechanism you decide to choose.

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td></td>
<td>(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>Quality</td>
<td><strong>Group or Virtual Group</strong> (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>
</tbody>
</table>

However, not all measures can be reported using all reporting mechanisms. For example, some measures may not be available for claims reporting, but can be reported using a registry.

If reporting using the claims, qualified registry, or QCDR options, you will need to check CMS’s QPP measures specifications lists (discussed above) to identify measures that are reportable through your reporting mechanism of choice.

If reporting using CEHRT, please check with your CEHRT vendor about which quality measures they allow you to report electronically using the CEHRT. For the CEHRT reporting mechanism, measure
specifications are available on the CMS eCQI Resource Center. When you visit the website, select “2020” to ensure you are reviewing the correct information for the 2020 MIPS quality category.

What’s the difference between the “claims” and “administrative claims” mechanisms?

Claims reporting for the MIPS quality category requires eligible clinicians to append quality data codes (QDCs) to denominator eligible Medicare Part B claims to indicate the required quality action or exclusion occurred. This mechanism is only an option if you report data for the quality category at the individual level. Whereas, administrative claims data is data that is already available from billings on Medicare claims without appending QDCs. The administrative claims mechanism is used by CMS for the 30- day ACR measure for groups of 16 or more eligible clinicians.

The chart on the next page, provides clarification on how the data is reported for each mechanism, and also includes some key points you may want to take into consideration as you determine the best reporting mechanism option for you/your practice.

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>Calims 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.
APPENDIX

#47 – Advance Care Plan

2020 Clinical Quality Measure Flow for Quality ID #47 NQF #0326: Advance Care Plan

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

DATA COMPLETENESS

Performance Meta = Performance Not Met (60 patients) = 70 patients = 87.50%
Eligible Population / Denominator (61-92 patients) = 80 patients

Performance Rate = Performance Meta (60 patients) = 60 patients = 57.14%
Data Completeness Numerator (70 patients) = 70 patients

NOTE: Submission Frequency: Patient/Process

SAMPLE CALCULATIONS:

* See the posted measure specification for specific coding and instructions to submit this measure.
#128 – Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan

2020 Clinical Quality Measure Flow for Quality ID #128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.
**SAMPLE CALCULATIONS:**

**Data Completeness:**
\[
\text{Performance\ Met (a' + a = 50\ patients) + Denominator Exception (b = 0\ patients) + Performance\ Not\ Met (c' + c = 29\ patients)}\]
\[
\text{Eligible\ Population / Denominator (i.e. 80\ patients)}\]
\[
\text{= 70\ patients} = 87.50%\]
\[
\text{= 60\ patients}\]

**Performance Rate:**
\[
\frac{\text{Performance\ Met (a' + a = 50\ patients)}}{\text{Data\ Completeness\ Numerator\ (70\ patients) - Denominator\ Exception\ (b = 0\ patients)}} = \frac{50\ patients}{70\ patients} = 71.43\%
\]

* See the posted measure specification for specific coding and instructions to submit this measure.
** See the posted measure specification for specific BMI and follow-up pain definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.

NOTE: Submission Frequency: Patient-Intermediate

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#130 – Documentation of Current Medications in the Medical Record

2020 Clinical Quality Measure Flow for Quality ID #130 NQF #0419: Documentation of Current Medications in the Medical Record

**Disclaimer:** Refer to the measure specification for specific coding and instructions to submit this measure.

**SAMPLE CALCULATIONS:**

Data Completeness—

\[
\text{Performance Met (≥ 40 visits)} - \text{Denominator Exception (≥ 10 visits)} - \text{Performance Not Met (≥ 20 visits)} = \frac{70 \text{ visits}}{80 \text{ visits}} = 87.50\%
\]

\[
\text{Eligible Population / Denominator (≥ 50 visits)} = \frac{80 \text{ visits}}{80 \text{ visits}} = 100\%
\]

Performance Rate—

\[
\text{Performance Met (≥ 40 visits)} - \text{Denominator Exception (≥ 10 visits)} = \frac{40 \text{ visits}}{50 \text{ visits}} = 80\%
\]

\[
\text{Data Completeness Numerator (70 visits)} - \text{Denominator Exception (≥ 10 visits)} = \frac{60 \text{ visits}}{70 \text{ visits}} = 85.71\%
\]

*See the posted measure specification for specific coding and instructions to submit this measure.

**NOTE:** Submission Frequency: Visit

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#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2020 Clinical Quality Measure for Quality ID #226 NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Submission Criteria One

Disclaimer: Refer to the measure specification for the specific coding and instructions to submit this measure.

![Flowchart diagram](chart.png)

**Sample Calculation: Submission Criteria One**

Data Completeness - Performance Met (a = 70 patients) + Denominator Exclusion (b = 10 patients) + Performance Not Met (c = 10 patients) = 90 patients

Data Completeness = (70/90) = 0.7778

Data Completeness Rate = (70/100) = 70%

*See the posted measure specification for specific coding and instructions to submit this measure.

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#236 – Controlling High Blood Pressure

2020 Clinical Quality Measure Flow for Quality ID #236 NQF #0018: Controlling High Blood Pressure

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.
SAMPLE CALCULATIONS:

Data Completeness:

Performance Met (80 patients) + Performance Not Met (C + C' + C' = 20 patients) = 100 patients

Eligible Population / Denominator (80 / 80) = 100

Performance Rate:

Performance Rate = Performance Met (80 patients) / Eligible Population = 70 patients

Data Completeness/Performance (70 patients) = 70 patients / 70 patients = 100%

See the posted measure specification for specific coding and instructions to submit this measure.

* A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Intermediate

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#317 – Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

2020 Clinical Quality Measure Flow #317:
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

![Flowchart diagram showing the process for screening for high blood pressure and follow-up documentation.](chart.png)
## SAMPLE CALCULATIONS:

### Data Completeness:

**Performance Net (a + b ≥ 50 patients) - Denominator Exception (b ≤ 20 patients)** + **Performance Net (c + d ≥ 20 patients)**

<table>
<thead>
<tr>
<th>Eligible Population / Denominator (d = 100 patients)</th>
<th>90 patients</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Net (a + b ≥ 50 patients)</td>
<td>50 patients</td>
<td>71.43%</td>
</tr>
<tr>
<td>Data Completeness Numerator (50 patients) - Denominator Exception (b ≤ 20 patients)</td>
<td>70 patients</td>
<td></td>
</tr>
</tbody>
</table>

* See the posted measure specification for specific coding and instructions to submit this measure.

**NOTE:** Submission Frequency: Patient-Process

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