Quality Payment Program

2020 MIPS Performance Categories Overview
Last updated on 06/03/2020

The American College of Rheumatology has created this resource to assist practices in understanding the four performance categories of 2020 MIPS, and to summarize critical changes in reporting due to CMS’ Final Rule. The reporting requirements of each performance category are subject to change by CMS rules or policies. The information in this document was compiled directly from online CMS sources or interviews with measure builders and registry professionals.

For the most up-to-date information, please visit the Quality Payment Program website. To learn more about reporting for 2020, see this MIPS Quick Start Guide.

Quality Category (45% of the final score)

This category measures health care processes, outcomes, and patient experiences of their care. These measures are statistically adjusted for clinic demographics, so the measured difference that remains is due to the quality of care. Measuring for quality aims to bridge that gap by tracking data and leveraging it for a better understanding of how to deliver comprehensive quality care. Quality measures capture and turn data into simple statistics, making it easier for previously siloed physicians to share information that increases the quality of care.

Reporting requirements include:

- Submitting data for six quality measures.
- Reporting performance data for 70% of the patients who qualify for each measure (data completeness). In other words, practices should report on at least 70% of patients who fall within the measure denominator (eligible population) for the entire performance period.
  - Note: Measures that don’t meet data completeness earn 0 points. The exception to this is small practices who continue to earn 3 points per measure.
There are three different types of quality measures that practices can select from within the RISE registry: 1) ACR QCDR measures, 2) CQMs, and 3) eCQMs.

**ACR QCDR Quality Measures**
These are rheumatology-specific measures created and owned by the ACR. Practices can only report on these via the RISE registry. The majority of these measures are not yet benchmarked, and therefore practices can receive up to 3 points for reporting these measures. Most of these measures are high-priority measures; practices earn bonus points for submissions past their required 6 measures.

**Clinical Quality Measures (CQMs) & Electronic Clinical Quality Measures (eCQMs)**
The main difference between eCQMs and CQMs is eCQMs require all structured data to be captured electronically via the EHR/PM systems. In most cases, CQMs have some level of additional manual data collection from the medical record. With CQMs, the information found in clinical notes and other EHR fields is used to qualify patients for numerator/denominator, while eCQMs use only codes. Practices can receive up to 10 points for reporting these measures.

Practices can review the 2020 quality measures they can report on via the RISE registry here -> [https://www.rheumatology.org/Portals/0/Files/RISE-Quality-Payment-Program-Measures-2020.pdf](https://www.rheumatology.org/Portals/0/Files/RISE-Quality-Payment-Program-Measures-2020.pdf)

Practices can learn more about the Quality category and review all the QPP measures for 2020 MIPS here -> [https://qpp.cms.gov/mips/quality-measures](https://qpp.cms.gov/mips/quality-measures)

**Promoting Interoperability (PI) Category (25% of the final score)**
Promoting Interoperability (PI) encourages patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT). CEHRT’s proactively share information with other clinicians or the patient in a comprehensive manner. This category can include sharing test results, visit summaries, and therapeutic plans with the patient and other facilities to coordinate care. **2015 Edition CEHRT is required for participation in this performance category.**

If practices proceed with reporting for PI through the RISE registry, they **must** obtain their PI report from their EHR in advance of reporting. If practices do not obtain this report from their EHR beforehand, they will be unable to report on PI through RISE.

New in 2020, RISE is required by CMS to complete random audits of the PI category. Those practices identified for audit will need to provide the report(s) used to enter PI data. Audits are conducted shortly before submission.

**Hardship Exceptions**
Practices may submit a Promoting Interoperability Hardship Exception Application by **December 31, 2020.** Learn more >

Practices can learn more about the PI category here -> https://qpp.cms.gov/mips/promoting-interoperability?py=2020

**Improvement Activities (IA) Category (15% of the final score)**

This category measures participation in assessment activities on how you improve your care processes, enhance patient engagement in care, and increase access to care. The inventory of over 100 activities allows you to choose what activities are appropriate for your practice from categories such as enhancing care coordination, patient and clinician shared decision-making, and expansion of practice access.

Practices are strongly encouraged to review the 2020 MIPS Data Validation Criteria, which includes suggested documentation for each IA activity. Improvement activities have a continuous 90-day performance period unless otherwise stated in the activity description. Practices **must** decide on the activities to complete and report on for 2020 MIPS while accounting for that period.

New in 2020, RISE is required by CMS to complete random audits of the IA category. Those practices identified for audit must provide documentation for each improvement activity commensurate with the respective suggested documentation outlined in the 2020 MIPS Data Validation Criteria document.

Practices can review and download all 2020 IA activities here -> https://qpp.cms.gov/mips/explore-measures/improvement-activities?py=2020#measures

Practices can learn more about the IA category here -> https://qpp.cms.gov/mips/improvement-activities?py=2020

**Cost Category (15% of the final score)**

This category measures Medicare payments made for care provided to patients, calculated based on your Medicare claims. MIPS uses cost measures to gauge the total cost of care during the year or a hospital stay. CMS uses Medicare Part A and B claims data to calculate cost measure performance, which means clinicians and groups do not have to submit any data for this performance category.

Practices can learn more about the Cost category here -> https://qpp.cms.gov/mips/cost?py=2020
2020 MIPS: Changes from PY2019 to PY2020

With the Final Rule, CMS made the following changes for the 2020 reporting year:

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Change(s)</th>
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| Thresholds            | The performance threshold is 45 points  
The additional performance threshold for exceptional performance is 85 points |
| Quality               | Increasing the data completeness threshold to 70%  
Continuing to remove low-bar, standard of care, process measures as we further implement our Meaningful Measures framework  
Addressing benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment  
Focusing on high-priority outcome measures  
Adding new specialty sets (Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology) |
| Cost                  | Adding 10 new episode-based measures to continue expanding access to this performance category  
Revising the existing Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost measures |
| Improvement Activities| Reducing barriers to patient-center medical home designation by removing specific examples of entity names of accreditation organizations or comparable specialty practice programs |
| **Promoting Interoperability** | Increasing the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice needing to perform the same improvement activity; we are requiring that a group must perform the same activity during any continuous 90-day period within the same performance year  
Updating the Improvement Activity Inventory and establishing factors for consideration for removal  
Concluding the CMS Study on Factors Associated with Reporting Quality Measures  
Including the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure (available for bonus points)  
Removing the Verify Opioid Treatment Agreement measure  
Reducing the threshold for a group to be considered hospital-based (Instead of 100% of clinicians, more than 75% of the clinicians in a group must be a hospital-based individual MIPS eligible clinician in order for the group to be excluded from reporting the measures under the Promoting Interoperability performance category and to have this category reweighted to zero.) |