Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

2020 MIPS Group Participation User Guide

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

Already know what MIPS is?
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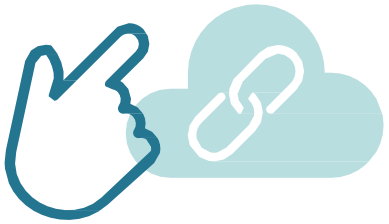
Purpose: *This resource focuses on MIPS group participation, providing high level and practical information about eligibility, performance categories, and scoring.*

How to Use This Guide

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.

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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

Overview

COVID-19 and 2020 Participation

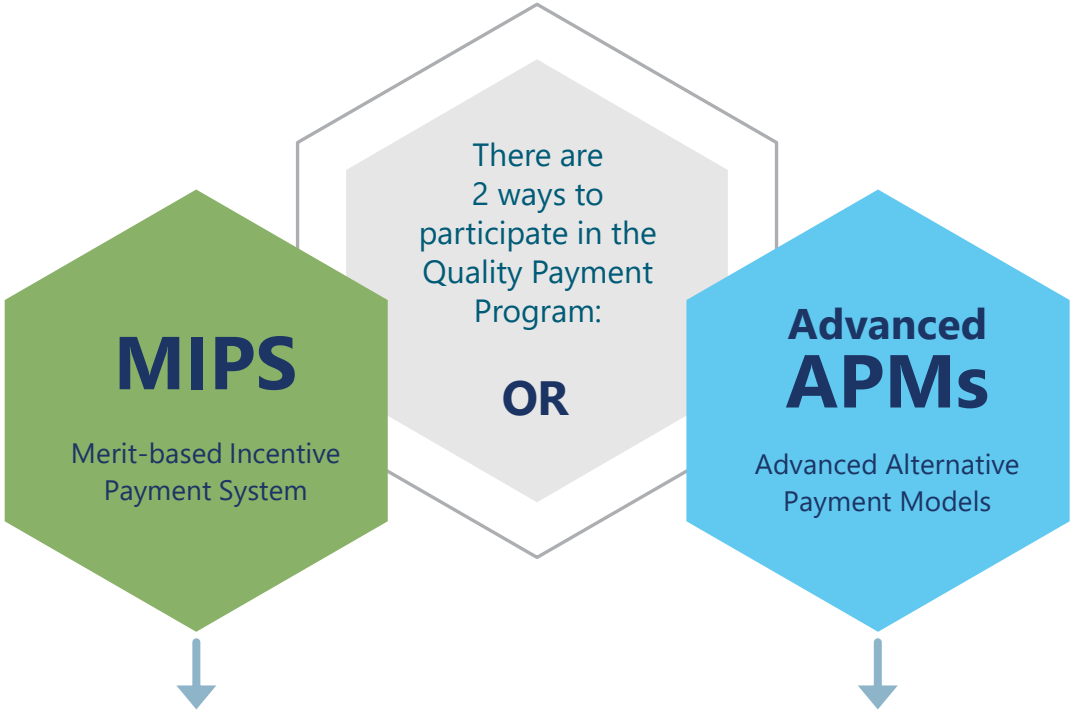
The 2019 Coronavirus (COVID-19) public health emergency has impacted all clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2020 performance year, we will be using our Extreme and Uncontrollable 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% due to the current COVID-19 public health emergency. We have already introduced a new high-weighted COVID-19 clinical trials improvement activity, which provides an opportunity for clinicians to receive credit in MIPS for the important work they are already doing across the country.

Additionally, in the 2021 QPP Proposed Rule, we propose for the 2020 performance year to 1) allow APM Entities to submit Extreme and Uncontrollable Circumstances applications and 2) to increase the complex patient bonus from a 5- to 10-point maximum for MIPS participants to offset the additional complexity of their patient population due to COVID-19. For more information about the impact of COVID-19 on Quality Payment Program participation, see the Quality Payment Program COVID-19 Response webpage.

Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which rewards value in one of 2 ways:



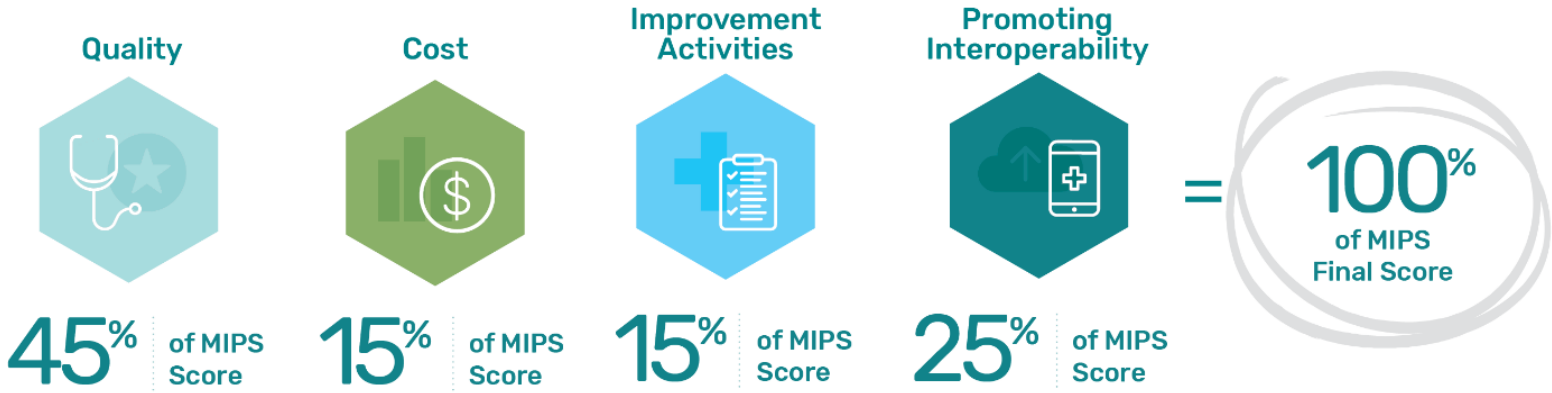
If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

Overview

Introduction to the Merit-based Incentive Payment System (MIPS)

Under MIPS, there are 4 performance categories that could impact your future Medicare payments. Each performance category is scored by itself and has a specific weight that contributes to your MIPS final score. Your payment adjustment is determined based on your final score. Below are the 4 performance categories and their weights for the 2020 MIPS performance year:



MIPS eligible clinicians have the option to participate in MIPS as an individual (submitting data that represents their individual performance), as part of a group (submitting aggregated data that represents the collective performance of clinicians in the practice), as part of a virtual group. Those who participate in an Alternative Payment Model (APM) Entity will be assessed and scored under the APM scoring standard.

This guide will focus on MIPS group participation.

Overview

Quick Reference: Group Participation at a Glance

The following table provides a high-level overview of the different aspects of group participation, which are explored in greater detail throughout this guide.

Note: We have added the term "Quick Reference" next to easy-to-read tables and summaries throughout this guide.

Eligibility & Participation	To participate in MIPS as a group, the practice (TIN) must: • Exceed the established low-volume threshold **OR** be eligible to opt-in as a group; **and** • Include at least 1 MIPS eligible clinician. You may also have a special status or other designation that qualifies you for reduced reporting requirements or bonus points. • Find your eligibility information on qpp.cms.gov **Helpful hint**: Sign in to qpp.cms.gov to review current eligibility information for your practice. Don't have an account? Review the QPP Access User Guide.
Measure & Activity Selection/ Review	• Choose your 2020 quality measures. • *Groups that want to report CMS Web Interface measures and/or administer the Consumer Assessment for Healthcare Plans and Systems (CAHPS) for MIPS Survey needed to register between April 1, 2020 and June 30, 2020.* • Choose your 2020 improvement activities. • Review the required 2020 promoting interoperability measures. **Note**: Groups with 16 or more clinicians will be also be evaluated and scored on the All-Cause Hospital Readmission measure, calculated using administrative claims, if they meet the case minimum of 200 eligible instances.
Data Collection	• Clinicians in the group perform the quality actions associated with the practice's selected measures (as appropriate to their scope of practice). Data is collected for the entire 12-month performance period. • At least 50% of the clinicians in the group perform/implement each selected improvement activity for a minimum of 90 continuous days, unless otherwise specified in the activity description. • All clinicians perform the required promoting interoperability measures and collect the data in your practice's 2015 Edition CEHRT for a minimum of 90 continuous days. **Note:** In group participation, the practice aggregates data across the TIN, which could include covered professional services furnished by individual NPIs within the TIN who aren't required to participate in MIPS.

Overview

Quick Reference: Group Participation at a Glance *(continued)*

Data Submission	• Groups may submit their data themselves or use a third-party intermediary to submit their measure and activity data. • The available **submission type(s)** – or method(s) by which data is submitted to CMS – vary by performance category.
Scoring	• The practice will have its performance assessed and scored across all performance categories at the group level. • MIPS eligible clinicians participating as a group will get the group's final score unless they earn a higher score through individual participation.
Payment Adjustments	• Each MIPS eligible clinician included in the group will receive a MIPS payment adjustment based on the group's performance, unless they have an individual final score that's higher than group's final score.

Group Participation Frequently Asked Questions

What Does it Mean to Participate in MIPS as a Group?

When you participate as a group, your practice is choosing to submit aggregated MIPS data on behalf of all the clinicians in the practice for each performance category requiring data submission: Quality, Improvement Activities and Promoting Interoperability. (There are no data submission requirements for the Cost performance category; we collect this data for you and calculate a score for the group.)

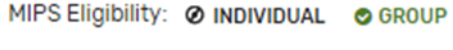
- The group will earn a final score based on the aggregated data submitted (or collected for you) across all performance categories.

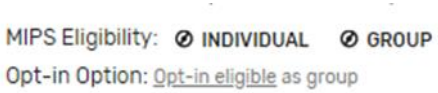
Each MIPS eligible clinician in the group will receive the same final score and payment adjustment unless the clinician was also individually eligible to participate in MIPS and submitted individual-level data that resulted in a higher final score.

How Do We Know if Our Practice Can Participate as a Group?

There are 2 ways that you can find your practice's **current group level eligibility** on qpp.cms.gov. Final eligibility will be available in December 2020.

1. Enter the National Provider Identifier (NPI) of any clinician in your practice into our QPP Participation Status Lookup Tool.
    a. Click on "PY 2020" if the display doesn't default to displaying the 2020 Participation Status
    b. Find your practice on the list of the clinician's "Associated Practices" and look for the "Group" indicator of MIPS eligibility
    c. Your practice has the option to participate as a group if there is a green check mark or text indicating that the practice is opt-in eligible as a group.

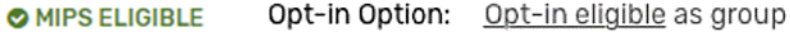




Group Participation FAQs *(continued)*

How Do We Know if Our Practice Can Participate as a Group? *(continued)*

2. Sign in to qpp.cms.gov and navigate to "Eligibility & Reporting" on the left-hand navigation.
    a. Make sure to select 2020 as the Performance Year at the top of the page
    b. Look for the indicator under your practice's name
    c. You have the option to participate as a group if you see text indicating that you are MIPS eligible, or opt-in eligible as a group.



If Our Practice is Eligible as a Group, are We Required to Participate as a Group?

There is **no requirement** to participate as a group. If your practice is eligible at the group level, you have the option to participate as a group.

- If your practice chooses to participate as a group, the MIPS eligible clinicians who aren't eligible as individuals will be included in MIPS and receive a payment adjustment.

- If your practice chooses not to participate as a group, the MIPS eligible clinicians who are eligible as individuals will need to participate as individuals.

Group Participation FAQs *(continued)*

Who are the MIPS Eligible Clinicians in Our Group?

For the 2020 performance year, MIPS eligible clinicians include the following clinician types:

- **Physicians***
- **Physician Assistants**
- **Nurse Practitioners**
- **Clinical Nurse Specialists**
- **Certified Registered Nurse Anesthetists**
- **Clinical Psychologists**
- **Physical Therapists**
- **Occupational Therapists**
- **Qualified Speech-Language Pathologists**
- **Qualified Audiologists**
- **Registered Dietitians or Nutritional Professionals**

**Including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry; osteopathic practitioners; and chiropractors[1])*

[1]With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

Group Participation FAQs *(continued)*

Who are the MIPS Eligible Clinicians in Our Group? *(continued)*

For group participation, a MIPS eligible clinician:

Is an eligible clinician type AND Enrolled in Medicare prior to the performance period AND Is not identified as a Qualifying APM Participant (QP)

When participating as a group, it is the group, and not each individual MIPS eligible clinicians, who must exceed the low-volume threshold at the group level.

If We Choose to Report as a Group, Whose Data Do We Need to Include?

If you choose to participate in MIPS as a group, you will need to collect and submit the available data from all of the clinicians in your group as appropriate to the quality measures and improvement activities you select. This includes the data of clinicians that aren't eligible for MIPS or a MIPS payment adjustment.

For the Quality, Cost and Improvement Activities performance categories, performance is measured across all clinicians within the group, including those that aren't MIPS eligible clinicians. For the Promoting Interoperability performance category, groups are required to submit the data collected in certified Electronic Health Record (EHR) technology (CEHRT) on behalf of their MIPS eligible clinicians.

Overview
Group Participation FAQs *(continued)*

Which Clinicians in Our Practice are Eligible for a Payment Adjustment Based on Our Group Submission?

MIPS eligible clinicians (as indicated by clinician type) who enrolled in Medicare before January 1, 2020 are eligible for a MIPS payment adjustment based on the group submission, provided that they aren't:

- Identified as a Qualifying APM Participant (QP) **OR**
- Identified as a Partial QP who didn't elect to participate in MIPS **OR**
- Scored under the APM scoring standard (these clinicians will get a payment adjustment based on their APM Entity score).

MIPS eligible clinicians who did not exceed the low-volume threshold at the individual level and those who start billing Part B claims under your Taxpayer Identification Number (TIN) in the final 3 months of the MIPS performance period, between 10/1/2020 and 12/31/2020, are eligible for a MIPS payment adjustment based on the group's final score.

Your practice may choose to participate in MIPS as a group and the MIPS eligible clinicians within the practice may also choose to participate as individuals. If the MIPS eligible clinicians within your practice exceed the low-volume threshold at the individual level or elect to opt-in, they will have 2 final scores: one from their individual participation and one from the group participation. They will receive the MIPS payment adjustment associated with the higher final score when billing Part B claims under your practice's Taxpayer Identification Number (TIN) in the 2022 payment year.

How is a Group Different From a Virtual Group?

There are 2 main distinctions between a group and a virtual group: **1)** the number of TINs involved in the group or virtual group, and **2)** the need to notify the Centers for Medicare & Medicaid Services (CMS) in advance.

Group	Virtual Group
1. A group is defined as a **single** TIN with 2 or more eligible clinicians (including at least one MIPS eligible clinician) as identified by their NPI who have reassigned their Medicare billing rights to the TIN. 2. There is no requirement for a practice to alert CMS of their intent to participate as a group in advance of data submission.	1. A virtual group is defined as **a combination of 2 or more TINs** assigned to 1 or more solo practitioners (who are also MIPS eligible clinicians) or to 1 or more groups consisting of 10 or fewer eligible clinicians (including at least 1 MIPS eligible clinician), or both. 2. Clinicians that wish to form a virtual group must submit an election prior to the performance year. The virtual group election period for the 2020 performance year closed December 31, 2019. **Want more information on virtual groups?** Additional information on virtual group participation is available in the Virtual Group Toolkit.

Overview

Group Participation Examples

Group Participation Examples

Let's look at a couple of examples of group participation:

Example 1: A practice has 4 physicians on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A enrolled in Medicare during the performance period.
- Clinician B enrolled in Medicare prior to the performance period, but didn't exceed the low-volume threshold as an individual at this practice
- Clinicians C and D each enrolled in Medicare prior to the performance period, and exceed the low-volume threshold as individuals at this practice

For the 2020 performance year, the practice:

- Participates in MIPS at the group level,
- Exceeds the low-volume threshold as a group, and
- Submits aggregated data they collected from all 4 physicians.

The group earns a final score that corresponds to a +1.2% MIPS payment adjustment based on their performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services furnished by **Clinicians B, C and D** in the payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- Clinician A is not eligible to receive a MIPS payment adjustment because the clinician was newly enrolled in Medicare.

Group Participation Examples *(continued)*

Group Participation Examples *(continued)*

Example 2: A practice has a clinical social worker (Clinician A) and 3 physicians (Clinicians B, C and D) on staff, all of whom have reassigned their billing rights to the TIN.

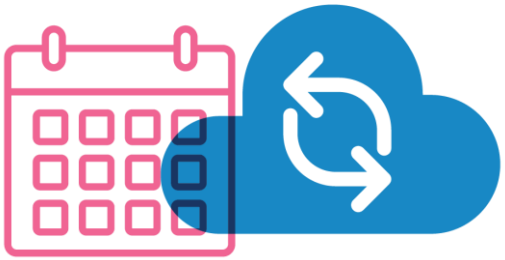
- Clinician A is a clinical social worker which is not a MIPS eligible clinician type.
- Clinician B is a MIPS eligible clinician type, but didn't exceed the low-volume threshold as an individual at this practice
- Clinicians C and D are MIPS eligible clinician types, and exceed the low-volume threshold as individuals at this practice

For the 2020 performance year, the practice:

- Participates at the group level, exceeds
- Exceeds the low-volume threshold as a group, and submits
- Submits aggregated data collected from all 4 clinicians as appropriate to the measures and activities selected.

The group earns a final score that corresponds to a +0.5% MIPS payment adjustment based on their performance. The **MIPS payment adjustment** will be applied to the payments for covered professional services furnished by **Clinicians B, C and D** in the 2022 payment year.

- The MIPS payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.
- The payment adjustment will not be applied to Clinician A because she is not a MIPS eligible clinician type.



Eligibility & Participation

Eligibility & Participation

Low Volume Threshold

How Do You Determine if Our Practice is Eligible to Participate in MIPS as a Group?

We look at your Medicare Part B claims during 2 12-month segments, called the MIPS Determination Period, to evaluate the total volume of care your practice provides to Medicare patients.

Segment 1
October 1, 2018 – September 30, 2019

AND

Segment 2
October 1, 2019 – September 30, 2020

During each segment, we look to see if you and your practice exceed the low-volume threshold criteria:

Charges: Bill more than $90,000 for Part B covered professional services under the Physician Fee Schedule (PFS)

AND

Patient Count: See more than 200 Part B patients

AND

Covered Services: Provide 200 or more covered professional services to Part B patients

TIP: One professional claim line with positive allowed charges is considered one covered professional service.

To be eligible for MIPS, your practice must exceed all 3 of the low-volume threshold criteria during both 12-month segments of the MIPS Determination Period. (If your practice is newly formed or has otherwise established a new TIN in segment 2, we will only evaluate your eligibility during the segment 2).

Your practice can participate in MIPS as a group if it is identified by a single TIN with 2 or more clinicians (at least 1 of whom is a MIPS eligible clinician) and exceeds the low-volume threshold at the group level. Your practice may be eligible to opt-in to participate as a group if you exceed some, but not all of the low-volume threshold criteria.

Eligibility & Participation

Low Volume Threshold *(continued)*

What Does it Mean if Our Group is "Opt-in Eligible"?

If your group is otherwise eligible for MIPS and exceeds 1 or 2, but not all 3 low-volume threshold criteria, you are considered **opt-in eligible**.

If the group is opt-in eligible, you can:

Do nothing. Your group is not required to participate in MIPS.

OR

Elect to opt-in. If your group decides to opt-in, the group will submit data at the group level, receive performance feedback, and the MIPS eligible clinicians within the group will receive a MIPS payment adjustment in 2022.

OR

Elect to voluntarily report. If your group wants to participate in MIPS but doesn't want its clinicians to receive a MIPS payment adjustment in 2022, the group can voluntarily report data and receive performance feedback.

Voluntary Reporting

If your group chooses to voluntarily report, your group will receive performance feedback based on the measures and activities for which you submitted data. This can help to inform the group's potential future MIPS participation. You will submit data and receive performance feedback, but the group's clinicians will not receive a MIPS payment adjustment. You can voluntarily report if you are identified as MIPS exempt or as opt-in eligible.

The decision to opt-in to MIPS is irreversible. If you are considering this option, be sure to explore program requirements to ensure that you're prepared to collect and report on data needed to demonstrate successful performance.

Eligibility & Participation

Eligible Groups vs. Opt-in Eligible Groups

	Your Group is Eligible and Chooses to Submit Data as a Group	Your Group is Opt-In Eligible and Elects to Opt-in	Your Group Voluntarily Reports
Is the group required to make an active election indicating the chosen participation option?	NO	YES	YES, if you are opt-in eligible NO, if your group isn't MIPS Eligible
Will the group receive performance feedback?	YES	YES	YES
Will the MIPS eligible clinicians in the group receive a positive, neutral, or negative payment adjustment?	YES	YES	NO
Is the group's data eligible to be published on Physician Compare?	YES	YES	YES (but, able to opt-out of public reporting during preview period).
Will the group's Quality measure submissions be used to establish historical MIPS measure benchmarks for future program years?	YES	YES	NO

Eligibility & Participation

Eligible Groups vs. Opt-in Eligible Groups *(continued)*

Can Our Group's Eligibility Change?

Yes, eligibility can change once we reconcile eligibility results from the 2 segments of the MIPS determination period. If you group falls below all 3 elements of the low-volume threshold in either segment, you will be ineligible as a group.

- If you are currently eligible as a group, your group could:
  - Remain eligible;
  - Become opt-in eligible; or
  - Become ineligible (can still voluntarily report)
- If you are currently opt-in eligible as a group, your group could:
  - Remain opt-in eligible; or
  - Become ineligible (can still voluntarily report).
- If you are currently ineligible as a group, your group will remain ineligible

Did you know?

It is possible for a practice to be opt-in eligible or ineligible as a group AND for a clinician in the practice to be individually eligible and required to participate in MIPS.

This can happen when a group falls below the low-volume threshold in the first segment and a new clinician joins in the second segment and exceeds the low-volume threshold.

Helpful hint: When you sign in to check your group's eligibility, you can also view individual eligibility for the clinicians in your practice.

When you sign in **before** eligibility is updated in December 2020:

- Your clinician list displays the clinicians who appeared in your TIN's Part B claims submitted with dates of service from Oct. 1, 2018 to Sept. 30, 2019 and received by CMS by October 30, 2019.

When you sign in **after** eligibility is updated in December 2020:

- Your clinician list displays the clinicians who appeared in your TIN's Part B claims submitted with dates of service from Oct. 1, 2019 to Sept. 30, 2020 and received by CMS by October 30, 2020.
- If you have clinicians who participate in a MIPS APM, you may also see clinicians who did not bill Part B claims but were identified as part of your practice on an APM participation list.

Eligibility & Participation

Quick Reference: Special Status Designations

We determine if a group qualifies for most special statuses by reviewing Medicare Part B claims data from 2 12-month segments during the MIPS determination period.

The following table outlines special status designations and their impact on group reporting requirements for the 2020 performance year.

If a group has a "special status," this will be indicated on qpp.cms.gov.

Sign In and navigate to the "Eligibility" page or check the QPP Participation Status NPI Lookup Tool *(Click **Expand** next to the clinician's name and scroll down to 'Practice Level' in the Other Factors section)*

Special Status/ Reporting Factor	Description	Impact to MIPS Reporting and Scoring
Ambulatory Surgical Center (ASC)-based	All MIPS eligible clinicians associated with your practice are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no promoting interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Hospital-based	More than 75% of the MIPS eligible clinicians associated with your practice are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no promoting interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.
Non-patient Facing	More than 75% of the clinicians billing under your practice's TIN meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	Each submitted improvement activity will earn double points (e.g., a high weighted activity will earn 40 points). Group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0%. If no promoting interoperability data is submitted, the 25% performance category weight will be reallocated to another performance category or categories.

Eligibility & Participation

Quick Reference: Special Status Designations *(continued)*

Special Status/ Reporting Factor	Description	Impact to MIPS Reporting and Scoring
Facility-based	More than 75% of the clinicians in the TIN are facility-based as individuals. Groups are attributed to the facility at which the plurality of clinicians in the TIN were assigned as individuals. **Note:** Because this status is based solely on the first 12-month segment, the facility-based status and attributed facility currently displayed on qpp.cms.gov is final for the 2020 performance period.	Your group may qualify to receive scores for the Quality and Cost performance categories based on your assigned facility's Fiscal Year (FY) 2021 Hospital Value Based Purchasing (VBP) Program score. *To receive facility-based scoring as a group, your group must submit group level data for the Improvement Activities and/or Promoting Interoperability performance category(ies) to signal your practice's intent to participate as a group.
Small practice	There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.	Each submitted improvement activity will earn double points (e.g., a high weighted activity will earn 40 points). Groups who submit at least 1 quality measure will also receive 6 bonus points in the Quality performance category.
Health Provider Shortage Area (HPSA)	More than 75% of the clinicians in the TIN are designated as practicing in a HPSA as individuals.	Each submitted improvement activity will earn double points (e.g., a high weighted activity will earn 40 points).
Rural	More than 75% of the clinicians in the TIN are designated as practicing in a rural area as individuals.	Each submitted improvement activity will earn double points (e.g., a high weighted activity will earn 40 points).

Quality Performance Category

Quality Performance Category

Overview

The Quality performance category assesses health care processes, outcomes, and patient experiences of their care. This category accounts for 45% of your final score.

Measure Selection

How Many Quality Measures Do We Need to Select?

You will need to:

Report at least 6 measures; of the 6 quality measures, groups need to select 1 outcome measure or a high priority measure if an outcome measure is not available	OR	Report at least 6 measures from a specialty measure, unless the set contains fewer measures; groups need to select one outcome measure from the specialty measure set, or a high priority measure if an outcome measure is not available	OR	Register for the CMS Web Interface and report on all 10 CMS Web Interface measures

Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population and can choose from one or more collection types.

A collection type is a set of quality measures with the same data completeness criteria and specifications that follow a consistent format.

Where Can I Find Information on the 2020 Quality Measures?

You can find measure descriptions, specifications, and benchmarks on the Explore Measures & Activities tool on qpp.cms.gov.

Helpful Hints:
- Make sure you've selected the 2020 performance period.
- Search by key words or terms applicable to the care you provide.

You can also review the 2020 Quality Quick Start Guide for more tips on choosing quality measures.

Quality Performance Category

Measure Selection *(continued)*

Does Our Group Have to Report Quality Data if We're a Facility-Based Practice?

If your group is identified by CMS as having a facility-based special status and if your group's assigned facility has a FY 2021 Hospital VBP Program score, your group can use that score for the Quality performance category in lieu of submitting quality measures.

However, **groups must submit data for the Improvement Activities and/or Promoting Interoperability performance categories** to receive facility-based scoring. This data submission alerts us of your group's intent to participate as a group.

Keep in mind:

- We won't know if your group's assigned facility has a FY 2021 Hospital VBP Program score until the performance year is over.
- You can still submit quality measures and we'll use whichever results in a higher combined Quality and Cost performance category score – either: the MIPS quality measures you submit and the MIPS cost measures we calculate for you; OR the Quality and Cost scores derived from your assigned facility's Hospital VBP Program score.
- Please review the 2020 Facility-Based Quick Start Guide for more information

What Do We Need to Know About Collection Types?

With the exception of the CMS Web Interface measures, groups can report measures from a combination of collection types for a single Quality performance category score.

For example, a small practice could:

Report 2 Medicare Part B claims measures throughout the performance period.	+	Work with a Qualified Clinical Data Registry (QCDR) to collect and report 2 electronic Clinical Quality Measures (eCQMs) and 2 QCDR measures on their behalf during the 2020 submission period.	=	All 6 of these measures would contribute to a single Quality performance category score for the group.

The table beginning on the next page walks through the different collection types, provides links to the 2020 measure specifications and provides helpful hints.

Quality Performance Category

Measure Selection *(continued)*

What Do We Need to Know About Collection Types? *(continued)*

Collection Type	Quality Measures Available For 2020	What You Need to Know
eCQMs	2020 eCQM Specifications	• Groups can report eCQMs if they have 2015 Edition CEHRT by December 31, 2020. • Groups can report their eCQMs themselves or work with a third-party intermediary to report these measures on their behalf. • eCQMs can be reported in combination with claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
Medicare Part B Claims Measures	2020 Medicare Part B Claims Measure Specifications and Supporting Documents	• Only small practices (15 or fewer clinicians) can report Medicare Part B claims measures. • When reporting as a group, claims measures must still be reported with the clinician's individual (rendering) NPI. Do not report claims measures with the group's organizational NPI. • Claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure. • Review the 2020 Part B Claims Reporting Quick Start Guide for more information.
CQMs	2020 Clinical Quality Measure Specifications and Supporting Documents	• Groups can work with a third-party intermediary to collect and report these measures on their behalf. • MIPS CQMs can be reported in combination with claims measures, eCQMs, QCDR measures, and the CAHPS for MIPS Survey measure.
QCDR Measures	2020 QCDR Measure Specifications	• Groups will need to work with a CMS-approved QCDR to report these measures on their behalf. • QCDR measures can be a great option for groups that provide specialized care or who have trouble finding MIPS measures that feel relevant to their practice. • QCDR measures can be reported in combination with eCQMs, MIPS CQMs, claims measures, and the CAHPS for MIPS Survey measure.

Quality Performance Category

Measure Selection *(continued)*

What Do We Need to Know About Collection Types? *(continued)*

Collection Type	Quality Measures Available For 2020	What You Need to Know
CMS Web Interface Measures	2020 CMS Web Interface Specifications and Supporting Documents	• Groups (with 25 or more eligible clinicians) must register in advance to report through the CMS Web Interface. • All 10 measures must be reported under this option, and each measure must be reported for the first 248 patients (or all patients if the sample has less than 248 patients) in the sample. • CMS Web Interface measures can be reported in addition to the CAHPS for MIPS Survey measure. • Review the 2020 CMS Web Interface Quick Start Guide for more information.
CAHPS for MIPS Survey Measure	CAHPS for MIPS Survey Fact Sheet	• Groups (with 2 or more eligible clinicians) must register in advance to conduct the CAHPS for MIPS Survey. • The CAHPS for MIPS Survey assesses patients' experiences with primary care services. This measure is most appropriate for groups that provide primary care services. • The group assumes all costs associated with the CMS approved survey vendor they contract with to administer the survey. • This measure can be reported in combination with eCQMs, MIPS CQMs, claims measures, and QCDR measures. It can also be reported in addition to the CMS Web Interface measures. • Review the 2020 CAHPS for MIPS Survey Overview Fact Sheet for more information.
Administrative Claims	All Cause Hospital Readmission Measure Specification is not yet available	• Groups with 16 or more clinicians will be automatically evaluated on this measure. • This measure doesn't count as 1 of the 6 measures required for reporting.

Quality Performance Category

Data Collection & Submission

How Much Data Do We Need to Collect?

There is a **12-month performance period** for the Quality performance category which means that your group must collect data for each quality measure from January 1 – December 31, 2020.

The **data completeness** requirement for Medicare Part B Claims measures, QCDR measures, MIPS CQMs, and eCQMs increased to 70% in 2020. (Note that data completeness is specific to Medicare patients for Medicare Part B claims measures only; QCDR measures, MIPS CQMs and eCQMs should include all-payer data.) Measures that don't meet data completeness will earn 0 points, unless you're a part of a small practice in which case the measure will earn 3 points.

> **Example:** Your small practice is reporting Measure 111 as a Medicare Part B claims measure. Your practice sees 100 Medicare patients between January 1 and December 31, 2020 who meet the criteria for the measure's eligible population. To meet the data completeness requirement, your group must report patient exceptions/exclusions and clinician performance on the measure for at least 70 of those Medicare patients.
>
> Selectively reporting data that misrepresents your performance in a disingenuous manner, commonly referred to as "cherry-picking," results in data that aren't true, accurate, or complete and may subject you to audit.

In group participation, quality measure data (numerators, denominators, etc.) are aggregated for all the clinicians in the group when submitting eCQMs, MIPS CQMs and/or QCDR measures. Your quality measure data should represent performance for all clinicians in the group (as applicable to the measure), not just the MIPS eligible clinicians in the practice.

Groups registered for the CMS Web Interface and small practices choosing to report Medicare Part B claims measures will submit data for their quality measures at the Medicare patient level.

EHR-based Quality Reporting

If you transition from one EHR system to another during the performance year, you should aggregate the data from the previous EHR and the new EHR into one report for the full 12 months prior to submitting the data. If a full 12 months of data is unavailable (for example, if aggregation is not possible), your data completeness must reflect the 12-month period. If you are submitting eCQMs, both EHR systems must be 2015 Edition CEHRT.

International Classification of Diseases 10th Revision (ICD-10) Updates

Each year, the Value Set Authority Center (VSAC) releases updates to ICD-10 coding that take effect October 1st. We will identify the measures that are significantly impacted by these updates in the 2020 MIPS Quality Measures Impacted by ICD-10 Code Updates Fact Sheet released in early October. Measures that are significantly impacted will have a 9-month performance period, ending September 30th, before the ICD-10 code changes take effect. Other measures may be impacted by these code changes, but not significantly enough to shorten the performance period. You should continue to report these measures according to the specification, reporting on encounters that use the codes identified in the measure's 2020 specification. You will not report on encounters that use updated codes not identified in the measure's 2020 specification.

Quality Performance Category

Data Collection & Submission *(continued)*

How Do We Submit Our Data?

Data will generally be submitted during the 2020 submission period, January 4 – March 31, 2021. Some data can be submitted by the group, while other data must be submitted by a third-party intermediary. The table below outlines the different submission types available for the Quality performance category.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Practice/Group representative)	Medicare Part B Claims Measure	Through your routine billing practices	Throughout the performance period
	eCQMs	Sign in to qpp.cms.gov and upload a Quality Reporting Document Architecture III file	January 4 – March 31, 2021
	CMS Web Interface Measures	Manually enter your data or upload a file into the CMS Web Interface OR Use our CMS Web Interface Application Programming Interface (API)	January 4 – March 31, 2021
Third-Party Intermediaries (QCDRs, Qualified Registries, and Health IT Vendors)	eCQMs MIPS CQMs QCDR Measures	Sign in to qpp.cms.gov and upload a QRDA III or QPP JavaScript Object Notation (JSON) file OR Use our QPP Submission API	January 4 – March 31, 2021
CMS Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of qpp.cms.gov	Early 2021, following data collection (standardized annual timeframe)

Cost Performance Category

Cost Performance Category

Overview

The Cost performance category measures Medicare payments made for care provided to patients and accounts for 15% of your group's final score.

Measure Review

For 2020, there are 20 cost measures:

- The Total per Capita Cost (TPCC) measure;
- The Medicare Spending per Beneficiary Clinician (MSPB-Clinician) measure; and
- 18 Episode-based measures.

Your group won't choose measures for the Cost performance category. We look at your group's claims data to determine which of these measures apply to you.

Where Can I Find Information on the 2020 Cost Measures?

You can find the measure descriptions and specifications ("Cost Measure Information Forms") and code lists on the Explore Measures & Activities tool on qpp.cms.gov. We only use performance period data to score cost measures, so there is no historical benchmark information for cost measures.

> **Helpful Hint:** Make sure you've selected the 2020 performance period.

Data Collection & Submission

How Do We Submit Our Data?

There are no data submission requirements for the Cost performance category. We use Medicare Part A and B claims data to calculate your group's performance on cost measures.

We will calculate performance on these measures on behalf of all clinicians in your group – including those who aren't eligible to participate in MIPS.

You will only be scored in the Cost performance category on measures for which a benchmark exists and your group meets case minimum. If your group falls below case minimum on all of the cost measures, the 15% weight for the performance category will be reallocated to another performance category or categories.

Improvement Activities Performance Category

Improvement Activities Performance Category

Overview

The Improvement Activities performance category measures participation in activities that improve clinical practice and accounts for 15% of your group's final score.

Activity Selection

How Many Improvement Activities Do We Need to Perform and Submit?

Most groups will need to perform between 2 and 4 activities to receive the maximum 40 points in this performance category. Groups that are identified as non-patient facing, rural, HPSA, or a small practice earn twice the points for each activity and will need to perform between 1 and 2 activities to receive the maximum 40 points.

To receive full credit in this category because you're a certified or recognized patient-centered medical home or comparable specialty practice:

At least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice (by October 1, 2020)	AND	The group must attest their status as a certified or recognized patient-centered medical home or comparable specialty practice during the submission period

Where Can I Find Information on the 2020 Improvement Activities?

You can find activity descriptions and weights on the Explore Measures & Activities tool on qpp.cms.gov.

Helpful Hints:

- Make sure you've selected the 2020 performance period.
- Search by key words or terms applicable to the care you provide.

Improvement Activities Performance Category

Data Collection & Submission

What Are the Requirements for a Group to Attest to Having Completed an Improvement Activity?

Beginning with the 2020 performance year, a group can attest to an activity when at least 50% of the clinicians in the practice perform the activity. Each clinician must perform the activity for a continuous 90-day period during calendar year 2020, unless a different performance period is specified in the activity description. Clinicians in the group don't have to perform the activity concurrently and don't have to be eligible for MIPS to be included in the 50% threshold.

Qualifying APM Participants (QPs) are excluded from MIPS and not required to report on any MIPS performance category. If your group includes some clinicians who participate in an APM and have QP status, they don't count toward the requirement that 50% of clinicians in the group perform the activity. However, you can include them in the 50% if they choose to perform the activity.

Example: Practice A has 4 clinicians and is reporting as a group. Clinician 1 and Clinician 2 are QPs, Clinician 3 and Clinician 4 are not. If Clinicians 1 and 2 (the QPs) don't perform the activity, the group will meet the 50% threshold and can attest to the activity as long as either Clinician 3 or Clinician 4 perform the activity. If Clinicians 1 and 2 (the QPs) perform the activity, the group will meet the 50% threshold and can attest to the activity even if neither Clinician 3 or Clinician 4 perform the activity.

How Do We Submit Our Data?

You can attest to your improvement activities yourself or use a third-party intermediary to submit improvement activity data on your behalf during the 2020 submission period, January 4 – March 31, 2021. The table below outlines the different submission types available for the Improvement Activities performance category.

Not all QCDRs or Qualified Registries support this performance category for the 2020 performance year. If you're working with a QCDR or Qualified Registry to collect and submit your data in other performance categories, you may need to attest to your own improvement activities. The 2020 QCDR Qualified Posting and 2020 Qualified Registries Qualified Posting indicate which vendors support the Improvement Activities performance category.

Beginning with the 2021 performance year, Qualified Registries and QCDRs must support all performance categories to be approved by CMS.

Who	How
You (Practice/Group representative)	Sign in to qpp.cms.gov and attest to the activities you've performed.
You (Practice/Group representative) or a third-party intermediary	Sign in to qpp.cms.gov and upload a file with your activity attestations.
Third-party intermediary	Perform a direct submission on your behalf, using our submissions API.

Promoting Interoperability Performance Category

Promoting Interoperability Performance Category

Overview

The Promoting Interoperability performance category promotes patient engagement and the electronic exchange of health information using 2015 Edition CEHRT. This performance category accounts for 25% of your group's final score.

Measure Review

Which Promoting Interoperability Measures Do We Have to Report?

The 2020 Promoting Interoperability performance category focuses on 4 objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.

Within these objectives, there are 6 required measures in addition to a Security Risk Analysis measure and attestations. Some of these measures have exclusions; if you qualify, you can claim (submit) the exclusion instead of reporting the measure.

Your group may qualify for an exception or automatic reweighting of this performance category.

Where Can I Find Information About the 2020 Promoting Interoperability Measures?

You can find measure specifications, exclusion information, and details about the attestations on the Explore Measures & Activities tool on qpp.cms.gov.

Helpful Hint: Make sure you've selected the 2020 performance period.

Promoting Interoperability Performance Category

Data Collection & Submission

You must use 2015 Edition CEHRT to collect your Promoting Interoperability performance category data.

The 2015 Edition functionality must be in place by the first day of the Promoting Interoperability performance period.	The product must be certified to the 2015 Edition criteria by the last day of the Promoting Interoperability performance period.	MIPS eligible clinicians must be using the 2015 Edition functionality for the **full** Promoting Interoperability performance period.	If your practice has several EHRs and not all are certified to the 2015 Edition, you will submit only the data collected in the 2015 Edition CEHRT.

How Much Data Do We Need to Collect?

Groups need to report the data collected in their 2015 Edition CEHRT for all required measures (or meet and claim an exclusion, if applicable) for a minimum of a continuous 90-day period during calendar year 2020.

In group participation, measure data from CEHRT (numerators and denominators) are aggregated for all of the MIPS eligible clinicians in the group.

You can submit a "yes" for the measures in the Public Health and Clinical Data Exchange objective as long as one MIPS eligible clinician is in active engagement with the registry.

> Groups are only required to submit data from their MIPS eligible clinicians for this performance category.

Promoting Interoperability Performance Category

Data Collection & Submission *(continued)*

How Does Reweighting of the Promoting Interoperability Performance Category Apply to Groups?

A group qualifies for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when:

- The group is identified on the QPP Participation Status Lookup Tool as hospital-based, ASC-based, or non-patient facing at the practice level; **OR**
- All of the group's MIPS eligible clinicians qualify individually for reweighting based on their clinician type, special status, or approved significant hardship exception. If any MIPS eligible clinician within the group doesn't qualify for a reweighting, the group must submit promoting interoperability data.

If the group qualifies for reweighting but submits any data in this performance category, the group will be scored on the data submitted and the Promoting Interoperability performance category will be weighted at 25% of the final score.

What if Clinicians in the Group are Facing a Significant Hardship?

There may be circumstances, out of your control, that make it difficult for you to meet the MIPS requirements. If each of the MIPS eligible clinicians in a group face a significant hardship and may qualify as individuals for reweighting the Promoting Interoperability performance category, the group may submit an application to have their Promoting Interoperability performance category score reweighted to 0%.

Reminder: *In 2020, a group is considered hospital-based and eligible for reweighting when more than 75% of the clinicians in the group meet the definition of a hospital-based individual MIPS eligible clinician.*

Promoting Interoperability Performance Category

Data Collection & Submission *(continued)*

How Does the Promoting Interoperability Performance Category Apply to Groups with Clinicians Facing a Significant Hardship? *(continued)*

If approved, the group will have their Promoting Interoperability performance category score reweighted to zero percent and the category weight will be reallocated to the Quality or Improvement Activities performance categories.

Note: Groups that have been approved for a hardship exception but **submit any data** in this performance category will be scored on the data submitted, and the Promoting Interoperability performance category will be weighted at 25% of the group's final score.

If any MIPS eligible clinician within the group doesn't qualify for a significant hardship exception (or doesn't otherwise qualify for reweighting), the group cannot apply to have their Promoting Interoperability performance category score reweighted to 0% and will need to submit data for this category, submitting all available measure data in their CEHRT.

Groups can submit a hardship exception application when:

- They are a small practice
- The entire practice has decertified EHR technology (impacting all MIPS eligible clinicians)
- The entire practice has insufficient Internet connectivity (impacting all MIPS eligible clinicians)
- The entire practice faces extreme and uncontrollable circumstances (impacting all MIPS eligible clinicians) such as disaster, practice closure, severe financial distress, or vendor issues
- The entire practice lacks control over the availability of CEHRT (impacting all MIPS eligible clinicians)

Simply lacking 2015 Edition CEHRT doesn't qualify the MIPS eligible clinician or group for re-weighting.

Promoting Interoperability Performance Category

Data Collection & Submission *(continued)*

What Data Do We Have to Submit?

In order to receive a score greater than 0 for the Promoting Interoperability performance category, your group must:

- ☑ Submit a "yes" to the Prevention of Information Blocking Attestation;
- ☑ Submit a "yes" to the ONC Direct Review Attestation;
- ☑ Submit a "yes" that you have completed the Security Risk Analysis measure in 2020;
- ☑ Report the 6 required measures or claim their exclusion(s); and
  - For measures that require a numerator and denominator (as defined in the measure specifications), your group must submit at least a one in the numerator.
- ☑ Provide your EHR's CMS Identification (ID) number from the Certified Health IT Product List (CHPL), available at https://chpl.healthit.gov/#/search.

Promoting Interoperability Performance Category

Data Collection & Submission *(continued)*

When Reporting as a Group, Do We Need to Include Data From MIPS Eligible Clinicians Who Individually Qualify for Reweighting?

Yes. When submitting data as a group for the Promoting Interoperability performance category, the group should combine all their MIPS eligible clinicians' data. This includes the data of MIPS eligible clinicians who may qualify for a reweighting of the Promoting Interoperability performance category when submitting data individually.

If these MIPS eligible clinicians are part of the group and have data in the group's CEHRT, their data should be included in the group's data submission, and they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians in the group.

The following types of MIPS eligible clinicians qualify for an automatic reweighting of the Promoting Interoperability performance category to 0% of the final score when submitting data individually:

Promoting Interoperability Performance Category

Data Collection & Submission *(continued)*

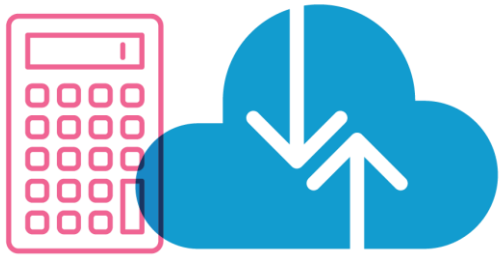
How Do We Submit Our Data?

You can submit your group's Promoting Interoperability performance category data yourself or use a third-party intermediary to submit data on your behalf during the 2020 submission period, January 4 – March 31, 2021. The table below outlines the different submission types available for the Promoting Interoperability performance category.

Not all QCDRs or Qualified Registries support this performance category for the 2020 performance year. If you're working with a QCDR or Qualified Registry to collect and submit your data in other performance categories, you may need to attest to your own promoting interoperability measures. The 2020 QCDR Qualified Posting and 2020 Qualified Registries Qualified Posting indicate which vendors support the Promoting Interoperability performance category.

Beginning with the 2021 performance year, Qualified Registries and QCDRs must support all performance categories to be approved by CMS.

Who	How
You (Practice/Group representative)	Sign in to qpp.cms.gov and attest to (manually enter) your promoting interoperability data.
You (Practice/Group representative) or a third-party intermediary	Sign in to qpp.cms.gov and upload a file with your data.
Third-party intermediary	Perform a direct submission on your behalf, using our submissions API.



Scoring and Payment Adjustments

Scoring and Payment Adjustments

Frequently Asked Questions

How is Our Group's Data Scored?

For practices that choose to participate at the group level, group performance is assessed and scored at the practice (TIN) level across all 4 MIPS performance categories for the 2020 performance year.

Each category is scored based on the aggregated (group-level) data submitted or collected on your group's behalf.

How are Payment Adjustments Applied?

Each MIPS eligible clinician participating in MIPS at the group level will receive a payment adjustment in the 2022 payment year based on the group's performance in 2020. MIPS payment adjustments will be applied to covered professional services furnished by MIPS eligible clinicians under the Physician Fee Schedule.

For MIPS eligible clinicians who submit data as a part of a group AND individually, you will be evaluated as an individual and as a group for all performance categories. We will take the higher of the 2 final scores and apply the MIPS payment adjustment associated with it.

When the practice (TIN) participates as a group, any individual (NPI) included in the TIN who is excluded from MIPS because they aren't a MIPS eligible clinician type or are identified as a new Medicare-enrolled clinician, a QP, or Partial QP won't receive a MIPS payment adjustment, regardless of their MIPS participation. MIPS eligible clinicians who are below the low-volume threshold as individuals will receive a MIPS payment adjustment when reporting as a group provided no other exclusions apply to them.

What Happens if a Clinician Joins Our Group After September 30 of the Performance Year?

We finalized in past rulemaking our policy for clinicians who start billing Medicare Part B claims at a practice (TIN) between October 1 and December 31, 2020. When the practice participates as a group, these clinicians will receive the group's final score and associated payment adjustment unless they are otherwise excluded (see the answer to the previous question). These clinicians will receive a neutral payment adjustment if the practice doesn't report as a group.

What Happens if a Clinician Leaves Our Group During the Performance Year?

When submitting data as a group, your practice will aggregate data from the MIPS eligible clinicians billing under your TIN as appropriate to the measures and activities you select. This may include data from clinicians who left your practice prior to the end of the performance period. Even though the clinician left your practice, that clinician will still receive a final score and payment adjustment based on your practice's performance which may follow the clinician to any new practice (TIN) they join for the 2022 payment year.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time 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 resources available in the QPP Resource Library.

Help, Resources, Glossary, and Version History

Glossary

Help, Resources, Glossary, and Version History

Additional Resources

The following resources are available on the QPP Resource Library:

- 2020 MIPS Quick Start Guide
- 2020 MIPS Eligibility and Participation Quick Start Guide
- 2020 Quality Quick Start Guide
- 2020 Part B Claims Reporting Quick Start Guide
- 2020 Facility-based Quick Start Guide
- 2020 Promoting Interoperability Quick Start Guide
- 2020 Improvement Activities Quick Start Guide
- 2020 MIPS APMs Improvement Activities Scores Fact Sheet
- 2020 Cost Quick Start Guide
- 2020 MIPS Data Validation Criteria
- 2020 Registration Guide for CMS Web Interface and CAHPS for MIPS Survey
- 2020 CMS Web Interface Quick Start Guide

Help, Resources, Glossary, and Version History

Version History

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

Date	Change Description
9/15/2020	Original posting

Appendix

Appendix A

MIPS Group Participation Timeline

Participation and data submission deadlines for the 2020 performance year are included in the chart below. You can also visit the performance year 2020 timeline on qpp.cms.gov.

Below are some key dates for MIPS group participation:

Dec. 2019	Jan. 1, 2020	Apr. 1, 2020	May 2020	June 30, 2020	Oct 3, 2020	Dec. 2020	Dec. 31, 2020
Initial 2020 MIPS performance period eligibility available. **DO NOW:** Check preliminary eligibility on qpp.cms.gov.	2020 MIPS performance period begins. **DO NOW:** Review collection types and available quality measures so you can start collecting quality data.	Registration period begins for the CMS Web Interface and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey. **DO NOW**: Create a QPP account and request the Security Official role for your practice if you don't have QPP credentials and your group wants to register.	Promoting Interoperability Significant Hardship Exception and Extreme & Uncontrollable Circumstance Exception Applications Window Opens. **DO NOW:** Review information and FAQs about exception applications on the QPP website and QPP Resource Library.	Registration deadline for the CMS Web Interface and CAHPS for MIPS Survey. **DO NOW:** Complete your registration before 5:00 p.m. Eastern Time.	The first day of the final continuous 90-day performance period in 2020 (applicable to most improvement activities and to the Promoting Interoperability performance category). **DO NOW:** Start performing your measures and activities if you haven't already.	Final 2020 MIPS performance period eligibility available on qpp.cms.gov. **DO NOW:** Check final eligibility on qpp.cms.gov.	2020 MIPS performance period ends. **DO NOW:** Prepare for data submission. Promoting Interoperability Performance Category Hardship Exception and Extreme & Uncontrollable Circumstance Exception Applications Window Closes. **DO NOW:** Complete and submit your hardship exception.

Appendix A

MIPS Group Participation Timeline *(continued)*

Below are some key dates for MIPS group participation *(continued)*:

Jan 4, 2021 – March 31, 2021	July 2021	Jan. 1, 2022
MIPS data submission period for the 2020 performance period. **DO NOW:** Create a QPP account and request a role for your practice so you can submit data or review data submitted on your behalf.	MIPS performance feedback will be available. **DO NOW:** Sign in to qpp.cms.gov to review your performance feedback and associated payment adjustment for your clinicians.	MIPS payment adjustments for the 2020 performance year go into effect. **DO NOW:** Review the MIPS payment adjustment applied to covered professional services furnished by your MIPS eligible clinicians on your remittance advance.

Appendix B

Data Submission Checklists Overview

Once your practice has decided to participate as a group, you will need to make some decisions about the ways you will collect and submit your aggregated data for each of the performance categories requiring data submission.

- If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
- There is no checklist for the Cost performance category because there are no data submission requirements. We calculate your cost data for you.

Appendix B

Quality Performance Category Submission Checklist

□ **Determine whether your practice may qualify for facility-based measurement:**

- Sign in to qpp.cms.gov to find out if your practice is identified as facility-based at the group level.
- Review the 2020 Facility-Based Quick Start Guide.
- Understand that we can't confirm whether your assigned facility has the Hospital Value Based Purchasing Program used for PY 2020 MIPS facility-based scoring until the end of, or after, the 2020 MIPS performance period.

□ **If your practice is not facility-based, or is facility-based but chooses to collect and submit additional quality measures, you will need to:**

- Select your measures and collection type(s):
  - If you'll be reporting any Medicare Part B claims measures, begin adding quality data codes (QDCs) to your clinicians' claims.
  - If applicable, register for the CMS Web Interface by June 30, 2020.
  - If applicable, register to administer the CAHPS for MIPS Survey by June 30, 2020.
  - If you're administering the CAHPS for MIPS Survey, review the list of 2020 CMS-approved survey vendors.
  - If reporting eCQMs, talk to your CEHRT vendor to make sure:
    - Your data can be aggregated to and exported at the TIN-level.
    - Your EHR will be certified to the 2015 Edition by the end of the performance period.
  - If reporting MIPS CQMs, review the 2020 Qualified Postings to find a Qualified Registry or QCDR that supports the measures you've selected.
  - If reporting QCDR measures, review the 2020 Qualified Postings to find a QCDR that has been approved for QCDR measures that are relevant for your practice.
- Make your data available to a third-party intermediary, as appropriate.
- Create a QPP account and connect to your organization (if you haven't already) so you can:
  - **Sign In and Upload** your eCQM data in a CMS-approved file format.
  - Report your measures through the **CMS Web Interface**.
  - Review the data submitted on your behalf during the submission period.
  - Review your performance on claims measures submitted throughout the performance period.

Appendix B

Improvement Activities Performance Category Submission Checklist

- □ **Determine whether your group qualifies for double points for each activity.**
- □ **Review and select your activities.**
- □ **Identify the clinicians who will perform the activities:**
  - Each activity must be performed by at least 50% of the clinicians in the group.
  - Activities don't need to be performed concurrently, but each clinician must perform the activity for a minimum of 90 continuous days during calendar year 2020, unless otherwise specified in the activity description.
- □ **Decide whether you will work with a third-party intermediary to submit data for you:**
  - If you decide to work with a Qualified Registry, review the 2020 Qualified Registries Qualified Posting and find one that supports the Improvement Activities performance category.
  - If you decide to work with a QCDR, review the 2020 QCDRs Qualified Posting and find one that supports the Improvement Activities performance category.
- □ **Make your data available to a third-party intermediary, as appropriate.**
- □ **Create a QPP account and connect to your organization (if you haven't already) so you can:**
  - **Sign In and Upload** your activity data in a CMS-approved file format.
  - **Sign In and Attest** to your activities (providing 'Yes' values to the activities you've performed).
  - Review the data submitted on your behalf during the submission period.

Appendix B

Promoting Interoperability Performance Category Submission Checklist

□ **Determine whether your group qualifies for reweighting. If your group doesn't qualify for reweighting in this category or does qualify but is able to collect and submit the promoting interoperability measures, you will need to:**

- **Determine your performance period:**
  - A minimum of a continuous 90-day period in 2020.
  - Your EHR must have 2015 Edition functionality in place by the first day of your performance period.
  - Your EHR must be certified to the 2015 Edition by the last day of your performance period.
- **Perform your annual Security Risk Analysis.**
- **Decide whether you will work with a third-party intermediary to submit data for you:**
  - If you decide to work with a Qualified Registry, review the 2020 Qualified Registries Qualified Posting and find one that supports the Promoting Interoperability performance category.
  - If you decide to work with a QCDR, review the 2020 QCDRs Qualified Posting and find one that supports the Promoting Interoperability performance category.
  - If you decide to extract your measures directly from your CEHRT, talk to your CEHRT vendor to make sure your data can be aggregated to and exported at the TIN-level.
- **Make your data available to a third-party intermediary, as appropriate (including your EHR's ONC certification ID).**
- **Create a QPP account and connect to your organization (if you haven't already) so you can:**
  - **Sign In and Attest** to your promoting interoperability data (reporting aggregated numerators and denominators, or 'Yes/No' values, as appropriate for measures and required attestation statements).
  - **Sign In and Upload** your promoting interoperability data in a CMS-approved file format.
  - Review the data submitted on your behalf during the submission period.

Appendix C

Performance Category Weight Redistribution Policies

Performance Category Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Reweighting Applies	45%	15%	15%	25%
Reweight 1 Performance Category				
No Cost	55%	0%	15%	30%
No Promoting Interoperability	70%	15%	15%	0%
No Quality	0%	15%	15%	70%
No Improvement Activities	60%	15%	0%	25%
Reweight 2 Performance Categories				
No Cost **and** No Promoting Interoperability	85%	0%	15%	0%
No Cost **and** No Quality	0%	0%	15%	85%
No Cost **and** No Improvement Activities	70%	0%	0%	30%
No Promoting Interoperability **and** No Quality	0%	50%	50%	0%
No Promoting Interoperability **and** No Improvement Activities	85%	15%	0%	0%
No Quality **and** No Improvement Activities	0%	15%	0%	85%