

2020 Quality Payment Program Final Rule FAQs

[Updated 2/14/2020](#)

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Merit-based Incentive Payment System (MIPS) FAQs

General

Where can I find an overview of the policies that were finalized for the 2020 performance period?

We provide an overview of the major policies we finalized for performance period 2020 in the [CY 2020 Quality Payment Program \(QPP\) Final Rule Fact Sheet](#), which includes a table comparing the previous policy to the newly finalized policy.

We will also host a public webinar in mid-November that reviews the major changes in the final rule. This webinar and registration link will be announced through the QPP listserv; you can also monitor the [QPP Webinar Library](#) on qpp.cms.gov for information about all of our upcoming and past webinars.

Finally, the [Electronic Code of Federal Regulations, Subpart O](#), will be updated to reflect newly codified regulations. (Please note that this resource identifies policies by the payment year instead of the performance period. The 2022 payment year equates to the 2020 performance period.)

Are there any proposed policies that were not finalized?

Yes. We did not finalize:

- Any change to the weights of the Cost and Quality performance categories
- The requirement for QCDRs to foster services (such educational services) to clinicians and groups to improve the quality of care provided to patients

Both policies will be revisited in future rulemaking.

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Are MIPS Value Pathways required for 2020?

No. We will begin to implement the MIPS Value Pathways (MVPs) framework gradually, beginning in the 2021 performance period. Over the coming months, we will continue to collaborate with you, using an incremental approach to create and implement the MVPs framework.

What are the certified electronic health record technology (CEHRT) requirements for the 2020 performance year?

We did not propose any changes to CEHRT requirements for 2020. Clinicians continue to need **2015 Edition CEHRT** to report data for the Promoting Interoperability performance category, and to report electronic clinical quality measures (eCQMs) for the Quality performance category.

We are scheduled to transition to a new EHR system during the performance period. What does this mean for our quality measure reporting and meeting the data completeness threshold?

We have heard from stakeholders throughout the performance period of instances where eligible clinician, groups, and/or their practices or hospitals may undergo a mid-year transition from one EHR system to another EHR system, which may impact a clinician or group's ability to submit a full 12 months of data for the quality performance period. In this situation, we encourage stakeholders to supply a report from the previous EHR for the first time period (as long as that EHR was also 2015 CEHRT) and a report from the new EHR for the second time period and aggregate the data for the full 12 months into one report prior to submitting to CMS. In other scenarios where data for the full 12 months is unavailable (for example if aggregation of EHR reports is not possible), we clarify that the data completeness threshold is always calculated off of a 12-month period.

Eligibility

How do I know if I'm eligible for MIPS in 2020?

We did not propose any changes to eligibility or to the definition of a MIPS eligible clinician for the 2020 performance period.

To be eligible for MIPS, you must:

- Be an eligible clinician type,
- Exceed the low-volume threshold, and
- Not be otherwise excluded because of your Medicare enrollment date or as a Qualifying APM Participant (QP), or as a Partial QP that has elected not to participate.

We anticipate that the [QPP Participation Status Lookup Tool](#) will be updated with initial 2020 MIPS eligibility results in February.

MIPS Eligible Clinician Types	Low Volume Threshold	Other Exclusions
<ul style="list-style-type: none"> • Physician (including doctor of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry) • Osteopathic practitioner • Chiropractor • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • Physical therapist • Occupational therapist • Clinical psychologist • Qualified speech-language pathologist • Qualified audiologist • Registered dietitian or nutrition professional 	<p>You exceed the low-volume threshold and are a MIPS eligible clinician if you</p> <ul style="list-style-type: none"> • Bill more than \$90,000 in Part B covered professional services, AND • See more than 200 Part B patients, AND • Provide more than 200 covered professional services to Part B patients <p>We evaluate individuals, groups and APM entities on the low-volume threshold.</p> <p>We are continuing our policy that allows clinicians, groups and APM entities who exceed 1 or 2 of these thresholds to opt-in to MIPS eligibility and participation.</p>	<p>You are excluded from MIPS if you</p> <ul style="list-style-type: none"> • Enrolled in Medicare on or after January 1, 2020 • Are a Qualifying APM Participant

Are clinical social workers eligible for MIPS? Why is there a clinical social worker specialty measure set?

No. Clinical social workers continue to be excluded from MIPS in the 2020 performance period. However, we have finalized a clinical social worker measure set to help these clinicians prepare in the event that they are added to the definition of a MIPS eligible clinician through future rulemaking.

What changes were made to for the hospital-based designation for groups in the 2020 performance period?

We finalized changes to the threshold that determines whether a group is considered hospital-based. A group is considered hospital-based when **more than 75%** of the clinicians in the group are hospital-based MIPS eligible clinicians

- In 2019, we required that 100% of MIPS eligible clinicians in the group be hospital-based MIPS eligible clinicians.

Measures and Activities

When will measure specifications/supporting documentation and activity descriptions be available for finalized measures/activities?

Measure specifications and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the [QPP Resource Library](#) before the performance period begins on January 1, 2020. We know these are critical resources for planning your participation and we will make these resources available as soon as possible.

We anticipate that this information will be available on the [QPP Resource Library](#) by December. (Filter by the 2020 Performance Year and choose Measure Specifications and Benchmarks as the Resource type.)

Full Resource Library

Search - Hide filters

Performance Year: 2020 OPP Reporting Track: All Performance Category: All Resource Type: Measure Specific

[Clear all filters](#)

The [Explore Measures & Activities](#) tool on the QPP website will be updated for the 2020 performance period soon after in early 2020. You can also refer to [Appendix A](#) for a complete list of 2020 Cost and Promoting Interoperability measures.

When will historical quality benchmarks be available for the 2020 performance period?

The 2020 Quality Benchmarks zip file will be posted on the [QPP Resource Library](#), shortly before the performance period begins on January 1, 2020.

Where can I find a list of topped out quality measures for the 2020 performance period?

We will identify topped out measures through the benchmarking process. The 2020 Quality Benchmarks zip file will be posted on the [QPP Resource Library](#), shortly before the performance year begins on January 1, 2020.

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Are there any final policies to address data issues outside of a clinician's control?

Yes. We are finalizing our proposal, beginning with the 2018 performance period and the 2020 payment year, to reweight performance categories for a MIPS eligible clinician who we determine has data for a performance category that are inaccurate, unusable, or otherwise compromised due to circumstances outside the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. MIPS eligible clinicians and third party intermediaries should inform CMS of events that they believe have resulted in compromised data. (We may also independently learn of such circumstances.) If we determine that reweighting is appropriate, we will follow our existing policies for redistributing performance category weights

Please see the following tables for more information on our final policies to redistribute performance category weights for the 2018-2020 performance periods:

- 2018 performance period: [Table 29 in the CY 2018 PFS Final Rule](#)
- 2019 performance period: [Table 54 in the CY 2019 PFS Final Rule](#)
- 2020 performance period: [Table 55 in the CY 2020 PFS Final Rule](#)

Scoring and Payment Adjustments

How does scoring work in 2020?

In general, our scoring policies are the same as performance period 2019 with some exceptions:

- Quality measures must meet a **70% data completeness** threshold.
 - Reported measures that fall below this threshold **will receive 0 points** (except for small practices that will continue to receive 3 points).
- A flat percentage-based benchmark will be applied to certain quality measures to avoid potentially incentivizing inappropriate treatment.
- For group reporting, **at least 50% of the clinicians in the group must perform an improvement activity** for the group to be able to attest to it.
- The **performance threshold** is set at **45 points**.
- The **additional performance threshold** for exceptional performance is set at **85 points**.

Note that we proposed, but did not finalize, changes to the Quality and Cost performance category weights for 2020.

While we changed the threshold for groups to be considered hospital-based, this revision doesn't change the associated scoring policy:

- As in 2019, groups designated as hospital-based qualify for automatic reweighting of the Promoting Interoperability performance category.

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Did you finalize the policy as proposed for groups attesting to improvement activities?

We did finalize a policy for groups attesting to improvement activities, but the final policy differs from the proposed policy.

- Under the proposed policy, a group or virtual group would have been able to attest to an improvement activity when at least 50% of clinicians in the group or virtual group would have needed to perform the improvement activity for the **same 90-day period** during the performance year.
- Under our finalized policy, we're maintaining the 50% threshold, but clinicians can perform the activity during **any continuous 90-day period** during the performance year. (Everyone does not need to perform the activity at the same time.)

What's the maximum negative payment adjustment for the 2020 performance period/2022 payment year?

As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year and beyond is **-9%**. (The actual adjustment you will receive in the 2022 payment year will be based on your MIPS final score from the 2020 performance period.)

How many points do I need to avoid a negative payment adjustment for the 2020 performance period/2022 payment year?

The performance threshold is the number against which your final score is compared to determine your payment adjustment. The performance threshold for the 2020 performance period is 45 points. See the table below for more information about the relationship between 2020 final scores and 2022 payment adjustments.

Your Final Score for the 2020 Performance Period	Payment Impact for MIPS Eligible Clinicians in the 2022 Payment Year
0.00 – 11.25 points	-9% payment adjustment
11.26 – 44.99 points	Negative payment adjustment (greater than -9% and less than 0%)
45.00 points	Neutral payment adjustment (0%)
45.01 – 84.99 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)
85.00 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) Additional (positive) payment adjustment (scaling factor applied to account for funding pool)

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Public Reporting on Physician Compare FAQs

What type of MIPS aggregate data will be publicly reported on Physician Compare?

Aggregate MIPS data that is publicly reported on Physician Compare will include the minimum and maximum MIPS performance category and final scores, as technically feasible, beginning with CY 2018 data.

Who will have the facility-based clinician indicator on their Physician Compare profile page?

Beginning with Year 3 (CY 2019), if a MIPS eligible clinician is scored using facility-based measurement, we will include an indicator that they were scored this way and will link from Physician Compare to Hospital Compare where facility-based measure information that applies to the clinician or group would be available, as technically feasible.

Alternative Payment Model and Advanced Alternative Payment Model FAQs


How many QPs do you expect for the 2020 QP Performance Period? How does this compare with previous QP performance periods?

We expect to see between 210,000 and 270,000 eligible clinicians become Qualified APM participants (QPs) in the 2020 Performance Period. The projected number of QPs for the 2020 QP Performance Period increased slightly over our projection for the 2019 QP Performance Period. Our previous estimate indicated that between 165,000 and 220,000 eligible clinicians would achieve QP status for the 2019 QP Performance Period. The QP Thresholds (which are established by law) did not increase from the 2019 QP Performance Period to the 2020 QP Performance Period. The number of expected participants in Advanced APMs has increased from 2019 to 2020 due to the increase in the number of Advanced APM participants in 2019.

What are the key changes for clinicians participating in MIPS APMs in the fourth year of QPP?

For the APM Scoring Standard, we are providing new quality reporting options beginning in CY 2020 for APM participants. We have, in previous rules, attempted to streamline MIPS reporting and scoring for MIPS eligible clinicians participating in MIPS APMs. However, quality measures used within certain an APM are not always available for MIPS scoring. In order to offer flexibility and improve meaningful measurement, we will allow APM Entities and MIPS eligible clinicians participating in MIPS APMs the option to report on other MIPS quality measures for the MIPS Quality performance category. APM Entities would receive a calculated score based on individual, TIN, or APM Entity reporting, similar to our approach for the MIPS Promoting Interoperability performance category.

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We also will apply a MIPS APM Quality Reporting Credit for APM participants in MIPS APMs where quality scoring through MIPS is not a requirement of the APM. These MIPS APM participants will receive a credit equal to 50 percent of the MIPS Quality performance category weight and will have the opportunity to submit quality measures and their score will be added to the credit, subject to a total score cap of 100 for the MIPS Quality performance category.

Appendix A

Table 1. Cost measures finalized for the 2020 performance period.

Cost Measure	Status
Medicare Spending per Beneficiary Clinician measure	Updated
Total per Capita Cost measure	Updated
Episode-Based Measures: <ol style="list-style-type: none"> 1. Elective Outpatient Percutaneous Coronary Intervention (PCI) 2. Intracranial Hemorrhage or Cerebral Infarction 3. Knee Arthroplasty 4. Revascularization for Lower Extremity Chronic Critical Limb Ischemia 5. Routine Cataract Removal with Intraocular Lens (IOL) Implantation 6. Screening/Surveillance Colonoscopy 7. Simple Pneumonia with Hospitalization 8. ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) 	Existing/No Change (8)
Episode-Based Measures: <ol style="list-style-type: none"> 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair 4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation 6. Lower Gastrointestinal Hemorrhage (groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment 	New (10)

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Table 2. Promoting Interoperability measures finalized for the 2020 performance period. (All measures are required unless otherwise indicated.)

Objective	Measure
e-Prescribing	e-Prescribing
	<i>Bonus (not required):</i> Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information
	Support Electronic Referral Loops by Receiving and Incorporating Health Information
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	<p><u>Report to two different public health agencies or clinical data registries for any of the following:</u></p> <ol style="list-style-type: none"> 1. Immunization Registry Reporting 2. Electronic Case Reporting 3. Public Health Registry Reporting 4. Clinical Data Registry Reporting 5. Syndromic Surveillance Reporting

Version History Table

Date	Change Description
2/14/2020	Updated links on page 3 to PFS Final Rule tables covering performance category weight redistribution policies.
11/7/2019	Revised exclusions from MIPS on page 3.
11/1/2019	Original version

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