Proposed MIPS Updates

This CY 2020 Medicare Physician Fee Schedule Proposed Rule discusses several updates to the Merit-based Incentive Payment System (MIPS) for performance year 2020 and beyond. The comment period for this rule closes September 27, 2019.

As confirmed in the last year's Medicare Physician Fee Schedule final rule, physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), clinical psychologists, dietitians, and audiologists were added as eligible clinicians for the 2019 MIPS performance year (i.e., the 2021 payment year). PT, OT, and SLP eligibility for participation in MIPS continues into the 2020 performance year (i.e., the 2022 payment year).

WHAT IS NOT CHANGING

For the 2020 performance year, the following elements of MIPS remain the same as in 2019:

- The low-volume threshold*
  - *Eligible individual clinicians who exceed all 3 elements* of the low-volume threshold (applied at the National Provider Identifier (NPI)/Tax ID number (TIN) level) *are required to participate in MIPS* or be subject to the full penalty during the payment year. The three elements of low-volume threshold remain the same as in 2019:
    1. Provided ≤ $90,000 in allowed charges for covered professional services
    2. Treated ≤ 200 Part B enrolled individuals who are furnished Medicare Physician Fee Schedule services
    3. Rendered ≤ 200 covered professional services (defined as a line item on the claim) during the eligibility period
  - *Groups* (identified by TIN) that exceed all 3 elements of the low-volume threshold may elect to participate in MIPS as a group, but *are not required to participate*
- Eligible clinician types*
  - PTs, OTs, and SLPs in private practice (i.e., those who bill on professional claims, the CMS 1500 form or 837p) are considered eligible providers for participation in MIPS in 2020. Therapists providing outpatient/Medicare Part B services in a hospital, skilled nursing facility, rehab agency, or other institutional setting (i.e., those billing on a UB-04) *remain not eligible* to participate in MIPS.
- Opt-in policy*
  - Eligible clinicians who exceed at least one, but not all three, criteria of the low-volume threshold are able to opt-in to MIPS in 2020 to be measured on performance. If a MIPS eligible clinician does not meet at least one criterion, he/she is excluded from participation in the program.
- MIPS determination period*
  - To determine eligibility for participation in MIPS, CMS reviews data from two 12-month segments, together called the "determination period." Clinicians and groups must exceed the low-volume threshold during *both* segments of the determination period to be eligible (For 2019, Segment 1 is 10/1/17-9/30/18; Segment 2 is 10/1/18-9/30/19).

Clinicians who work in more than one practice or group (that is, clinicians who have assigned their billing rights to more than one TIN), must check their eligibility status for each practice.
    - Clinicians should check their participation status by entering their NPI into the **CMS Quality Payment Program (QPP)** website participation lookup tool. (*Note:* Currently, only eligibility for the 2019 performance year is posted.)
- Collection types*
    - MIPS Clinical Quality Measures, or CQMs (submitted via a Qualified Registry or Qualified Clinical Data Registry, or QCDR)
    - eCQMs (submitted via certified electronic health record technology or CEHRT)
    - Part B claims measures
    - QCDR measures
    - CAHPS for MIPS
    - CMS Web Interface measures
- Submitter types (individual, group, virtual group)
- Submission types*
    - Direct (via Qualified Registry, QCDR, or EHR)
    - Log-in and upload
    - Log-in and attest
    - Medicare Part B claims for small practices (15 or fewer MIPS eligible clinicians)
    - CMS Web Interface (available for practices/groups with 25 or more MIPS eligible clinicians, requires use of CEHRT)
- CEHRT requirements for participation in the Promoting Interoperability category (2015 Edition Certification)
- Topped out measures
- Measure, activity and performance category scoring methodologies*, for example:
    - Quality – At least 6 measures, one of which must be an outcome measure or other high priority measure
    - Improvement Activities – 40 points
- 3-point floor for scored quality measures
    - For the 2022 payment year, CMS proposes the same 3-point floor for each quality measure that can be reliably scored against a benchmark
- Improvement scoring
    - CMS will continue to assume a quality performance category achievement percent score of 30% if a MIPS eligible clinician earned a quality achievement score of less than or equal to 30% the previous year. Specifically, for the 2022 payment year, CMS will compare performance year 2020 to 2019, and 2019 will be scored at 30% if the clinician's quality score during that year was 30% or less.
- Bonus points
    - Small practice bonus (6 points added to quality score for practices of fifteen or fewer MIPS-eligible clinicians)

- High-priority measures (1 point for each additional high priority measure that meets case minimum and data completeness; benchmark is not required; bonus points for high priority measures cannot exceed 10% of the total available measure achievement points)
- End-to-end electronic reporting using CEHRT (1 point for each eCQM)

- Scoring for Improvement Activities (weighted double for small practices)

*Details around these items/policies are not found specifically in the CY 2020 Proposed Rule, but were obtained from the CMS QPP website and the CY 2019 Final Rule and added to this document for reference.

PROPOSED CHANGES TO MIPS

MIPS Value Pathways (MVPs) Request for Information

In an effort to further transform the MIPS program by empowering patients and simplifying MIPS to improve value and reduce burden, CMS is proposing to apply a new MIPS Value Pathway (MVP) framework to future proposals beginning with the 2021 MIPS performance year (i.e., the 2023 payment year). This MVP framework would connect measures and activities across the four MIPS categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance the information provided to patients.

CMS believes this MVP framework will reduce the complexity of the program and the burden to participate and will balance flexibility with standardization to allow for better comparisons across providers/clinicians. MVPs will be organized around clinician specialty or health condition and encompass a set of related measures and activities. Beginning with the 2020 call for measures process, quality measure stewards must link their MIPS quality measures to existing and related cost measures and improvement activities, as applicable and feasible. Eventually, all MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a specialty or health condition, and population health and cost claims-based measures would be applied when a specific case minimum is met. Initially there would be a uniform set of promoting interoperability measures in each MVP. In future years, CMS will consider customizing them.

CMS is seeking public comments on the following issues related to the MVP Framework:

1. How to construct MVPs, including approach, definition, development, specifications, and examples
2. How to select measures and activities
3. How to determine MVP assignment
4. How to transition to MVPs

CMS gives examples of four possible MVPs: Preventive Health, Diabetes Prevention and Treatment, Major Surgery, and Opthamology. Two of the four examples listed in Table 34 are listed here:

MVP Example	Quality Measures	Cost Measures	Improvement Act	Promoting Interop
Preventive Health	▪ Tobacco Use: Screening & Cessation Intervention (#226) ▪ Osteoarthritis: Function & Pain Assessment (#109) ▪ Adult Immunization Status (TBD) ▪ Controlling High Blood Pressure (236) ▪ PLUS: population health admin claims quality measures (e.g., all-cause hospital readmission)	▪ Total per capita cost ▪ Medicare spending per beneficiary	▪ Chronic care & preventive care for empaneled patients (IA_PM_13) ▪ Engage patients & families to guide improvement in system of care (IA_BE_14) ▪ Collection & use of patient experience & satisfaction data on access (IA_EPA_3)	All measures in Promoting Interoperability
Diabetes Prevention & Treatment	▪ Hemoglobin A1c poor care control (>9%) (#001) ▪ Diabetes: Medical attention for nephropathy (#119) ▪ Controlling high blood pressure (#236) ▪ PLUS: population health admin claims quality measures	▪ Total per capita cost ▪ Medicare spending per beneficiary	▪ Glycemic management services (IA_PM_4) ▪ Chronic care & preventive care for empaneled patients (IA_PM_13)	All measures in Promoting Interoperability

CMS states they anticipate that eventually many clinicians would have at least one relevant MVP, while other clinicians may have several relevant to their clinical practice.

Quality Category

To meet reporting thresholds for the Quality category in performance year 2020, eligible clinicians participating in MIPS must continue to report at least six measures, including at least one outcome measure, **on at least 70% of all eligible patients, *regardless of payer*, if using a reporting method other than via the claim** (such as a Qualified Registry or QCDR). If utilizing Medicare Part B claims reporting (again, this method of reporting continues to be available to small practices only), data must be submitted on at least 70% of eligible Medicare Part B patients. If an outcome measure is not applicable

and available, clinicians must report another high priority measure. If fewer than six measures apply, clinicians must report on all available measures.

The proposed rule discusses the following changes to the MIPS Quality Measures Specialty Set for PTs and OTs in 2020: (added measures in teal)

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient with Knee Impairments using FOTO Patient Reported Outcome Measurement (PROM)
127	Diabetic Foot/Ankle Care, Ulcer Prevention – Eval of Footwear	218	…Hip Impairments using FOTO PROM
128	BMI Screening and Follow-up	219	…Foot/Ankle Impairments using FOTO PROM
130	Documentation of Current Meds	220	…Lumbar Impairments using FOTO PROM
~~131~~	~~Pain Assessment and Follow-up~~ (Proposed to be deleted in 2020)	221	…Shoulder Impairments using FOTO PROM
134	Screening for Depression & Follow-up	222	… Elbow/Wrist/Hand Impairments using FOTO PROM
154	Falls: Risk Assessment	~~223~~	~~… Other General Ortho Impairments using FOTO (PROM)~~ (Proposed to be deleted in 2020)
155	Falls: Plan of Care	TBD	…Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen & Follow-up Plan	226	Tobacco Use: Screening and Cessation Intervention
182	Functional Outcome Assessment	281	Dementia: Cognitive Assessment
		318	Falls: Screening for Future Fall Risk

The quality measures available in the Physical Medicine Specialty Set measures that are applicable to PT/OT based on 2019 measure specifications are listed below (one removed measure is in teal):

Measure	Description	Measure	Description
128	BMI Screening and Follow-up	182	Functional Outcome Assessment
130	Documentation of Current Meds	226	Tobacco Use: Screening and Cessation Intervention
~~131~~	~~Pain Assessment and Follow-up~~ (Proposed to be deleted in 2020)	402	Tobacco Use and Help with Quitting Among Adolescents
154	Falls: Risk Assessment	431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
155	Falls: Plan of Care		

The proposed rule lists the following measures in a specialty set for Speech Language Pathology:

Measure	Description	Measure	Description
130	Documentation of Current Meds	182	Functional Outcome Assessment
181	Elder Maltreatment Screen & Follow-up Plan	226	Tobacco Use: Screening and Cessation Intervention

Measure 131, Pain Assessment and Follow-up, is proposed to be removed from these measure sets (and other sets listed in the proposed rule) for performance year 2020. In addition, measure 223, Functional status change for patients with general orthopedic impairments and two dementia measures are also proposed to be deleted (measures 282, Dementia functional status assessment and 288, Dementia education and support of caregivers).

Some of the measures applicable to PT and OT in both of these specialty sets may be reported or collected via a Registry/QCDR only, while others can be reported by either a Registry/QCDR or the Medicare Part B claim. Measures 281 and 318, new measures in the PT/OT Specialty Set for performance year 2020, are not available for either Registry or claims reporting, but only for reporting via the CMS Web Interface or by end-to-end reporting using CEHRT. Once the CY 2020 final rule and the measure specifications are released, providers will be able to determine the final collection type and applicability of each measure to their clinical practice.

For the 2022 payment year, CMS proposes the same 3-point floor for each quality measure that can be reliably scored against a benchmark based on a baseline period. Scoring remains essentially the same as for the 2021 payment year (2019 performance year), with the only change being the increased threshold for data completeness (70%).

TABLE 43: Quality Performance Category: Proposed Scoring Policies for the CY 2020 MIPS Performance Period

Measure Type	Description	Scoring Rules
Class 1	Measures submitted or calculated that meet all of the following criteria: 1) Has a benchmark 2) Has at least 20 cases 3) Meets the data completeness standard (70% for 2020, as proposed)	3 to 10 points based on performance compared to the benchmark
Class 2	Measures that are submitted and meet data completeness, but do not have either of the following: 1) A benchmark 2) At least 20 cases	3 points
Class 3	Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum	MIPS eligible clinicians other than small practices will receive zero points; small practices – 3 points

Improvement Activities Category

In addition to the Quality category, MIPS-eligible PTs, OTs, and SLPs must continue to report Improvement Activities in 2020. Eligible clinicians or groups must attest to completing improvement activities for at least a continuous 90-day period during the 12-month performance period. Activities continue to be categorized as “high-weighted” or “medium-weighted” based on the amount of time and resources it takes to implement and complete the activity.

CMS proposes to remove 15, modify 7, and add 2 new activities for 2020, and to adopt improvement activity removal factors which reflect those factors finalized for quality measure removal in the CY 2019 final rule.

For performance year 2020, CMS proposes two changes to the group reporting requirement for improvement activities:

1. Increase the group reporting threshold from at least one clinician to *at least 50% of the group* beginning with the 2020 performance year, and
2. At least 50% of a group's NPIs must perform the same activity *for the same continuous 90 days* in the performance period beginning in 2020

(*NOTE:* Currently, if at least one clinician within the group performs the activity for a continuous 90 days in the performance period, the entire group may report that activity, i.e., attest that the activity has been completed. And, all MIPS eligible clinicians reporting as a group receive the same score.)

MIPS Category Weighting

For the 2022 payment year (the 2020 performance year), CMS proposes to weight the four MIPS categories as follows:

MIPS Category	2020 Weight	2020 Weight for PT/OT/SLP
Quality	45%	85%
Cost	15%	0%
Improvement Activities	15%	15%
Promoting Interoperability	25%	0%

PTs, OTs, and SLPs will continue to have the cost and promoting interoperability categories reweighted to the quality category in 2020.

MIPS Scoring

CMS proposes a performance threshold of 45 points for the 2022 payment year (i.e., 2020 performance year), and 60 points for 2023. The "additional performance threshold," or exceptional performance benchmark, is proposed to be 80 points for payment year 2022 and 85 for payment year 2023. This means, participating clinicians and groups must achieve more than 45 points in the program to receive a positive payment adjustment, and participants who achieve 80 or more points are eligible for an additional incentive.

The maximum payment adjustment for 2022 is +/- 9%. The MIPS program remains budget neutral, however, such that incentives are paid based on penalties incurred. Incentive percentages are based on a "scaling factor" that increases as the number (and amount) of penalties increase. More MIPS eligible clinicians with scores above the performance threshold means the scaling factor decreases; more clinicians below the performance threshold means the scaling factor increases. As the scaling factor

increases, the incentive percentage increases. For example, if the scaling factor is 0.395, a clinician who scores 100 points in MIPS would receive a 3.95% adjustment, along with the exceptional performance bonus (which is paid from additional dollars).

TABLE 52: Illustration of Points System and Associated Adjustments Comparison – 2021 vs. 2022 payment years

***NOTE*: Table 52 in the proposed rule compares payment years 2020, 2021, 2022, and 2023. Only 2021 and 2022 are summarized here for information purposes.

2021 MIPS Payment Year		**2022 MIPS Payment Year (Proposed)**	
Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment
0.0-7.5	Negative 7%	0.0-11.25	Negative 9%
7.51-29.99	Negative adjustment greater than -7% and less than 0% on a sliding scale	11.26-44.99	Negative adjustment greater than -9% and less than 0% on a sliding scale
30.0	0% adjustment	45.0	0% adjustment
30.01-74.99	Positive adjustment greater than 0% on a sliding scale ranging from 0 – 7% for scores from 30.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.	45.01-79.99	Positive adjustment greater than 0% on a sliding scale ranging from 0 – 9% for scores from 45.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.
75.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5 – 10% for scores from 75.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.	80.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5 – 10% for scores from 80.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.

Qualified Registries and QCDRs (i.e., Third-Party Intermediaries)

For performance year 2021, CMS proposes that Qualified Registries and QCDRs must be able to submit Quality, Improvement Activities, and Promoting Interoperability data, and Health IT vendors must be able to submit data for at least one category. Qualified Registries and QCDRs that only represent MIPS eligible clinicians that are eligible for reweighting under the promoting interoperability category (e.g., physical therapists) are not required to report this category.

In addition, CMS is proposing two additional criteria for approval as a third-party intermediary to ensure continuity of services to MIPS eligible clinicians:

1. The entity (Qualified Registry or QCDR) must agree to provide services for the entire performance period and applicable data submission period
2. Prior to discontinuing services to a MIPS eligible clinician, group, or virtual group during a performance period, the third-party intermediary must support the transition of the clinician/group to an alternate data submission mechanism/intermediary according to a CMS-approved transition plan

Qualified Registries (like Casamba), beginning in performance year 2021, must also be able to offer enhanced feedback reporting at least four times per year on how clinicians/groups compare to others who have submitted data on a given measure within the Registry.

For more information, access **CMS's Quality Payment Program Fact Sheet**.

CMS's Quality Payment Program Resource Library.

And, the **CY 2020 Proposed Rule**.