

MIPS Updates for Performance Year 2020 and Beyond

This CY 2020 Medicare Physician Fee Schedule Final Rule discusses several updates to the Merit-based Incentive Payment System (MIPS) for performance year 2020 and beyond.

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 \leq \$90,000 in allowed charges for covered professional services
 2. Treated \leq 200 Part B enrolled individuals who are furnished Medicare Physician Fee Schedule services
 3. Rendered \leq 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. Information regarding 2020 eligibility should be posted in the first quarter of 2020. Clinicians who are required to report in 2019 may wish to assume continued eligibility in 2020 until confirmed otherwise.)
- 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 or Final Rules, but were obtained from the CMS QPP website and the CY 2019 Final Rule and added to this document for reference.

FINALIZED CHANGES TO MIPS

MIPS Value Pathways (MVPs)

In an effort to further transform the MIPS program by empowering patients and simplifying MIPS to improve value and reduce burden, **CMS will begin to apply a new MIPS Value Pathway (MVP) framework beginning with the 2021 MIPS performance year** (the 2023 payment year). The MVP framework will 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.

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 Final Rule outlines the following changes to the MIPS Quality Measures for PTs and OTs in 2020:

The PT/OT Specialty Set (Appendix B.33):

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient w/ Knee Impairments using FOTO Patient Reported Outcome Measurement
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
134	Screening for Depression & Follow-up	221	...Shoulder Impairments using FOTO PROM
154	Falls: Risk Assessment	222	... Elbow/Wrist/Hand Impairments using FOTO PROM
155	Falls: Plan of Care	478	...Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen & Follow-up Plan	281	Dementia: Cognitive Assessment
182	Functional Outcome Assessment	282	Dementia: Functional Status Assessment
226	Tobacco Use: Screening & Cessation Intervention	288	Dementia: Education & Support of Caregivers for Patients with Dementia
		318	Falls: Screening for Future Fall Risk

The Physical Medicine Specialty Set measures applicable to PT/OT (Appendix B.15):

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
154	Falls: Risk Assessment	402	Tobacco Use and Help with Quitting Among Adolescents
155	Falls: Plan of Care	431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

The Final Rule lists the following measures in a new **specialty set for SLP** (Appendix B.43):

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

CMS finalized the removal of measures 131, Pain Assessment and Follow-up, and 223, Functional Status Change for Patients with General Orthopedic Impairments, from the MIPS program (from all measures sets) in 2020.

Note: Several measures have been revised for 2020 to include changes to the measure numerator and/or denominator and to therapy disciplines to which the measures apply. These modifications will be described in detail in the final measure specifications to be released by CMS prior to the end of the year.

For the 2022 payment year, CMS finalized the same 3-point floor for each quality measure that can be reliably scored against a benchmark based on a baseline period. (CMS states they will revisit this as they move toward MVPs.) Scoring remains essentially the same as for the 2021 payment year (the 2019 performance year), except for Class 3 measures, which currently receive 1 point – or 3 points for small practices.

TABLE 50: Quality Performance Category: 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 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 finalized modifications to the Improvement Activities inventory for 2020, including the removal, modification, and addition of activities. In addition, CMS finalized the adoption of improvement activity removal factors which reflect those established for quality measure removal in the CY 2019 Final Rule.

For performance year 2020, CMS finalized 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 any 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 finalize weighting of 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 finalized a performance threshold of 45 points for the 2022 payment year (the 2020 performance year), and 60 points for 2023. The “additional performance threshold” – or exceptional performance benchmark – will be 85 points for both payment years 2022 and 2023.

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

*Note: Table 60 in the Final 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 finalized 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. However, Qualified Registries and QCDRs that only represent MIPS eligible clinicians that are eligible for reweighting under the promoting interoperability category (for example, physical therapists) are not required to report this category. (Note: This means, that **beginning in CY (performance year) 2021, Casamba, as a Qualified Registry, must be able to submit both Quality and Improvement Activity data for our Registry clients.**)

In addition, CMS finalized 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

CMS clarified the following regarding these additional criteria: “In instances where a clinician or group is leaving a third-party intermediary on its own volition, a transition plan, while encouraged, is not required from a QCDR or qualified registry.” CMS’s proposal (i.e., the above-listed criteria) addresses the opposite scenario – if the QCDR or Registry discontinues services to their clinicians/groups/virtual groups during a performance period, then they must support the transition of their client to another entity. It is up to the intermediary to determine the strategy for the transition.

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 Final Rule Fact Sheet](#).

Access the [Quality Payment Program Resource Library](#).

Access the [CY 2020 Medicare Physician Fee Schedule Final Rule](#).