MIPS Scoring for PT/OT/ST in 2020

PTs, OTs and SLPs who participate in MIPS in 2020 (the "performance year") will be subject to a payment adjustment to their Medicare Part B reimbursement in 2022 (the "payment year"). This payment adjustment can be positive, negative or neutral based on the individual clinician's or group's performance in the program.

For the 2022 payment year, the MIPS Performance Threshold is 45 points (out of 100). Individual clinicians and groups who achieve 45 total points will receive a neutral payment adjustment, below 45 receive a negative adjustment (penalty) and above 45, a positive one (incentive). Payment adjustments in 2022 can be as much as + or – 9%. (*NOTE*: Payment adjustments are "budget neutral," meaning the incentive pool is equal to the penalty pool. Incentives are earned by eligible clinicians/groups based on performance relative to those who receive penalties for substandard performance.)

The eligible clinician's or group's performance in the Quality and Improvement Activities categories will be weighted and added together to determine the total performance score out of 100. Having a general understanding of scoring in both categories will help clinicians make informed decisions about MIPS participation, measure selection and process implementation.

QUALITY

Quality Measures for MIPS in 2020 will receive 0 to 10 points per measure, known as "measure achievement points."

Each Quality Measure falls into 1 of 3 categories for scoring purposes:

1. The measure meets *data completeness criteria* (reported on at least 70% of all eligible patients), has a *benchmark* and the *volume of cases* is sufficient (≥ 20 cases for most measures)
   - These measures receive 3 – 10 points based on performance compared to the benchmark
2. The measure meets data completeness criteria, but either 1) does not have a benchmark, and/or 2) the volume of cases is insufficient (< 20 cases)
   - These measures receive 3 points
3. The measure does not meet data completeness criteria
   - These measures receive 0 points, except for small practices (≤ 15 eligible clinicians) which continue to receive 3 points

Historical benchmarks for 2020 are established using 2018 MIPS performance data. Since PTs, OTs and SLPs were not eligible to participate in MIPS in 2018, several "therapy-only" measures do not have determined benchmarks, while measures that apply to many different clinicians (i.e., MDs, NPs, etc.) do have established benchmarks. Performance for each measure with a benchmark is broken down into deciles (10 equally sized groups), with each decile assigned a value between 3 and 10. For example, with a non-inverse measure (better performance equals higher score), individual clinicians/groups who receive a score within the 1st or 2nd decile will receive 3 points; those within the 3rd decile will receive a score between 3 and 3.9; those in the 4th decile will receive a score between 4 and 4.9; etc.

"Topped Out" measures may be capped at 7 points. A topped out measure is one where performance is consistently high across providers such that meaningful distinctions and improvement in performance can no longer be made. In other words, almost everyone who submits a topped out measure does so successfully, with little to no room for further improvement.

CMS has published information on benchmarks and topped out measures for 2020 in the **Quality Payment Program Resource Library**.

- Topped out measures for PT/OT/ST in 2020 with a 7-point cap include:
  - 130, Documentation of Current Medications – Claims and Registry
  - 154, Falls: Risk Assessment – Claims and Registry
  - 155, Falls: Plan of Care – Claims only
  - 181, Elder Maltreatment Screen – Claims only
  - 182, Functional Outcome Assessment – Claims only
  - 282, Dementia: Functional Status Assessment – Registry only (*NOTE:* This measure is not available for claims reporting.)
- Measures with no benchmark (scored at 3 points):
  - 182, Functional Outcome Assessment – Registry only
  - FOTO measures 217-222, 478

The maximum number of achievement quality points a PT, OT or SLP may be awarded is 60 (i.e., 6 measures, each with maximum score of 10), whether reporting individually or as a group.

If an individual clinician or group submits fewer than 6 measures, they will be subject to the *Eligibility Measure Applicability (EMA) Process* if they submit measures from a given specialty set (e.g., the PT/OT Specialty Set, the SLP Specialty Set, or the Physical Medicine and Rehab Specialty Set). CMS uses the EMA process to determine if there are additional applicable measures that could be reported.

- If CMS finds no additional applicable measures, the clinician/group will not be held accountable for not submitting them, and the number of maximum points will be lowered for the Quality category (e.g., 50 points maximum for 5 available measures vs. 60).
- If, however, CMS determines that additional clinical-related measures could have been submitted, the maximum number of points will remain 60.

If an individual or group submits more than 6 measures, CMS will use the "top 6" (i.e., the 6 measures with the highest individual scores) to determine the overall quality score. The "6 measures" must be submitted per individual clinician, if participating in MIPS as an individual, or per group, if participating in MIPS as a group – *not per patient*. Once measures are selected, all patients eligible for a given measure are included in the denominator and should have the quality action completed and quality data reported. If a given patient is not eligible for a measure – maybe due to age, diagnosis, or impairment, then the measure will not be reported for that patient. For example, patients under the age of 65 are not eligible for the Falls measures (154 and 155).

The quality achievement points per measure are added together and then divided by the maximum number of quality points (i.e., 60) to get the quality performance percentage. This number is then multiplied by the category weight, 85% for PT/OT/ST in 2020, to obtain the total quality point contribution toward the final MIPS score.

PT EXAMPLE

A PT participating as an individual clinician reports 6 MIPS quality measures over the course of calendar year 2020 via the Casamba Qualified Registry, meeting both the data completeness (≥ 70% of all eligible patients, regardless of payer) and minimum case requirements (≥ 20 cases per measure):

Measure	Max Quality Performance Score per Measure	Clinician's Achievement Points per Measure
128 – BMI	10	7.1
130 – Current Medications	7 (topped out with cap)	6.5
154 – Falls: Risk Assessment	7 (topped out with cap)	5.5
155 – Falls: Plan of Care	10	5.7
182 – Functional Outcome Assessment	3 (no benchmark	3
218 – FOTO Hip PROM	3 (no benchmark)	3

The PT in this example achieved 30.8 total points. This number is divided by the maximum achievement quality points for a PT with 6 measures available (i.e., 60) to obtain the Quality Performance Percent Score:

30.8 / 60 = 51.3%

The Quality Performance Percent Score is calculated based on the maximum number of points that an individual PT, OT or SLP clinician or group could achieve – i.e., 60 points. It is not based on the maximum number of points available for the selected measures, 40 in this example due to capped, topped out measures and measures with no benchmark. Quality measure selection should be done carefully, considering the patient population, available measures per discipline, the reporting process (some measures are more cumbersome to capture and calculate than others), and the maximum number of points available per measure.

This quality percent score is then multiplied by the category weight (85% for PTs, OTs and SLPs) to obtain the total quality point contribution toward the PT's final MIPS score:

51.3% x 85% = 43.6 points

There are "bonus points" available in the quality category. Bonus points may be awarded for the following:

- Small practices – 6 bonus points will be added to the numerator of the Quality performance category for small practices (≤ 15 eligible clinicians)
- Improvement scoring – Improving quality score from one year to the next (*NOTE: PTs, OTs, SLPs may be eligible for this in 2020* if they participated in MIPS in 2019)
- End-to-end bonus – 1 point per quality measure for reporting quality data directly from certified electronic health record technology (CEHRT) without any manual manipulation (*NOTE:* Therapy-specific EMRs, like Casamba, do not qualify as a CEHRT and therefore, *this bonus is not applicable to most PTs, OTs and SLPs*.)
- Submitting additional outcome/high priority measures – 1 point for each additional high priority measure, 2 points for each additional outcome measure that meet data completeness and case volume requirements, up to a maximum of 6 bonus points (*NOTE:* PTs and OTs who successfully report more than 6 measures and select high priority or outcomes measures (e.g., more than one FOTO measure) as their "extra" measures, would be eligible for this bonus.)

IMPROVEMENT ACTIVITIES

Improvement Activities are designated by CMS as either high- or medium-weighted activities. High-weighted activities are worth 20 points; medium-weighted are worth 10 points.

To receive the maximum score in this category, eligible clinicians or groups must report activities totaling 40 points: 2 high-weighted OR 1 high- and 2 medium-weighted OR 4 medium-weighted activities. Small practices (≤ 15 eligible clinicians) receive "double points" per activity and can achieve the requisite 40 points via 1 high-weighted activity or 2 medium-weighted activities.

These activities must be completed for 90 consecutive days during the performance period (i.e., calendar year 2020). The individual clinician or group must attest to completing the selected activities by submitting the attestation directly to CMS through a Qualified Registry or Qualified Clinical Data Registry (QCDR) with this capability or logging in to the **Quality Payment Program** website and attesting to activity completion. If participating as a group, one individual can log in and attest on behalf of the group. (*Note:* Casamba's Qualified Registry does not support submitting the Improvement Activities attestation directly to CMS.)

CMS finalized two changes to the group reporting requirement for Improvement Activities in 2020:

1) At least 50% of the group (based on NPI) must perform Improvement Activities (vs. at least one member of the group as it was in 2019), and
2) At least 50% of the group's NPIs must perform the *same* activity for any continuous 90 days during the performance period (calendar year 2020).

A complete list of available Improvement Activities can be found in the **Quality Payment Program Resource Library** on the CMS QPP website. There are more than 100 activities to choose from, many of which are applicable to therapy providers.

Scoring is determined by dividing the total earned points for completed activities by 40 (the maximum points available), and then multiplying by the category weight, 15%.

PT EXAMPLE

The same PT participating in MIPS as an individual clinician attests to completing 30 points-worth of improvement activities during 2020. This adds 11.2 points to the total MIPS score:

30 / 40 = 75%, and then 75% x 15% = 11.2 points

FINAL MIPS SCORE

An individual clinician's or group's final MIPS score (between 0 and 100) is determined by adding the scores of the applicable categories together (Quality and Improvement Activities for PT/OT/ST).

In the PT example provided:

43.6 + 11.2 = 54.8 points

Since the Performance Threshold for the 2022 payment year is 45 points, this clinician would receive a positive payment adjustment (exact percentage to be determined by CMS based on a sliding scale) to all of the Medicare Part B services he/she bills in 2022.

REFERENCES:

Quality Payment Program Resource Library

2020 Medicare Physician Fee Schedule Final Rule