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Merit-based Incentive Payment System (MIPS) 2020 – Year 4
Key Changes and Highlights

Eligibility

Eligible Clinician Types: The Center for Medicare and Medicaid Services (CMS) did not make any changes to the eligible clinician (EC) types in 2020. The EC types continue to include: Physicians *, Chiropractors, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Qualified Audiologists, Clinical Psychologists, and Registered Dieticians or Nutrition Professionals.

Low Volume Threshold (LVT): In Year 4 of the Quality Payment Program (QPP), the LVT which determines a clinician's eligibility in MIPS remains unchanged. To be excluded from MIPS, clinicians or groups need to meet one or more (but not all 3) of the following 3 criteria:

- Bill $90,000 or less in Medicare Part B allowed charges for covered professional services OR
- Provide care for 200 or fewer Part B Beneficiaries, OR
- Deliver 200 or fewer covered professional services under the Physician Fee Schedule (PFS)

The LVT applies to the two MIPS determination periods:

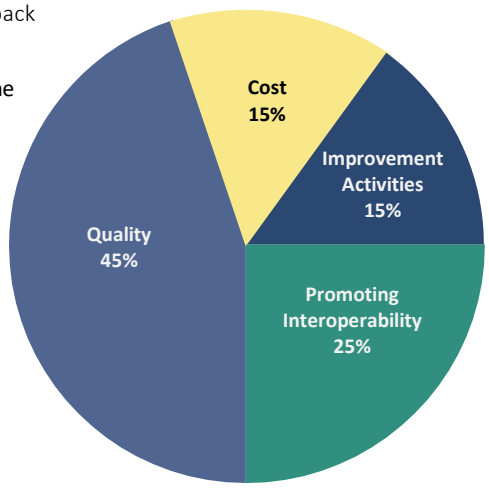
- October 1, 2018 to September 30, 2019
- October 1, 2019 to September 30, 2020

Clinicians must look up their own MIPS participation status using the MIPS Participation Status Tool on the QPP website at: https://qpp.cms.gov/participation-lookup

Opt-In to MIPS

Clinicians or groups can continue to opt-in to MIPS, if they meet or exceed at least one, but not all three of the LVT criteria. The decision to opt in remains irrevocable and clinicians are eligible for payment adjustment (positive, neutral or negative).
There is no change to the ability to voluntarily report measure and data to MIPS for feedback reports only.

The biggest changes to MIPS in 2020 are in the areas of scoring, payment adjustments and the elements of each of the performance categories.



Scoring

- Payment adjustment will range between -9% to +9% (up from -7% to +7%)
- The performance threshold is set at:
  - 45 points to receive a neutral payment adjustment (up from 30 points)
  - 46 to 100 points to receive a positive payment adjustment
  - Greater than 85 points to receive an exceptional bonus adjustment (up from 75 points)
- The category weights did not change for performance year 2020 from 2019.
  - Quality 45%
  - Promoting Interoperability 25%
  - Improvement Activities 15%
  - Cost 15%
- 6 bonus points will continue be added to the numerator of the Quality performance category for small practices (15 or fewer ECs).

Quality: 45% of Final Score

- 12-month Performance Period is required: January 1, 2020 to December 31, 2020.
- **Data completeness increases to 70% of all payor claims,** up from 60% in 2019. This means all reported Quality measures will need to be reported on at least 70% of eligible cases for both Medicare and non-Medicare patients for the entire year.
  - Reported measures that **fall below the threshold will receive 0 points (a big change from 2019), except for small practices (15 or less in TIN) that will continue to earn 3 points.**
- Maintains 3-point floor for measures scored against benchmark.
  - Measures that don't have a benchmark or don't meet the 20 case minimum will continue to earn 3 points (Must still meet data completeness of 70%).
- Quality measures can be reported (submitted) using multiple collection types (MIPS CQM, eCQM, QCDR and claims). **Only Small practices (15 or fewer in TIN) can submit quality measures via claims**.
- 6 bonus points will be added to the numerator for small practices that submit data on at least 1 Quality measure.

Quality (cont'd)

- Established a flat percentage benchmarks for limited cases where CMS determines that the measure's benchmark could potentially incentivize inappropriate treatment for some patients (e.g., MIPS #1 – Diabetes: HbA1c poor control (<9%); MIPS #236 – Controlling High Blood Pressure).

Promoting Interoperability (PI): 25% of Final Score

- At least 90 consecutive days reporting is required. Th last performance period to star would be 10/3/20-12/31/20.
- Clinicians/groups must continue to use 2015 Certified Electronic Health Record Technology (CEHRT).
- *Removal of the Verify Opioid Treatment Measure* bonus measure.
- *Query of Prescription Drug Monitoring Program (PDMP)* optional measure has been changed to a Yes/No response.
- Redistribute the points for the *Support Electronic Referral Loops by Sending Health Information* measure to the *Provide Patient Electronic Access to their Health Information* Measure, if an exclusion is claimed.
- Definition of hospital-based group has been changed, reducing the number of hospital-based clinicians to more than 75% of individual clinicians in a group being hospital based for the group to be considered hospital based. PI weight reduces to 0% and quality weighting increases to 60%.:
- PI measures include:
  - *E-Prescribing*
    - Bonus: Query of PDMP
  - *Health Information Exchange* (Two measures - Sending and receiving health information)
  - *Provider to Patient Exchange* (Providing Patients with electronic Access to their health information)
  - *Public Health and Clinical Data Exchange* (Must report on 2 different public health or clinical data registries)
- Small practices may still receive a significant hardship exception to reweight this category to Quality.

Improvement Activities (IAs): 15% of Final Score

- At least 90 consecutive days reporting is required.
- CMS has increased the participation threshold for group reporting from 1 clinician in a group to at least 50% of clinicians to fulfilling the same improvement activity any 90-day period.
- Added 2 new activities; modified 7 existing activities; and removed 15 existing activities.
- Just as in 2019, MIPS eligible clinicians must achieve a score of 40 points in order to achieve the full 15% for the IA performance category.
  - Medium-weighted activities are worth 10 points and high-weighted activities are worth 20 points for individuals and group with more than 15 clinicians.
  - Clinicians in small practices (15 or less in the TIN) will receive 20 point for medium weighted activities and 40 points for high-weighted activities

Cost: 15% of Final Score

- 12-month Performance Period is required: January 1, 2019 to December 31, 2019.
- CMS calculates the Cost performance category score using Medicare claims data. There is no need to submit any data.
- Medicare Spending per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) will be joined by 10 new episode-based measures (with case minimums for each measure) for a total of 18 episode-based measures.
- Just as in 2019, If the case minimums are not met for the measures, CMS will reweight the Cost performance category weight (15%) to the Quality performance category.

CMS QPP Resources - https://qpp.cms.gov/

- Participation Lookup Tool
- QPP Resource Library
- QPP Sign In & Reporting Portal
- HCQIS Access Roles and Profile (HARP). Manage access and credentials for QPP related activities for a practice.

*CMS defines a "physician" as a Doctor of medicine, osteopathy (including osteopathic practitioners), dental surgery, dental medicine, podiatric medicine, and optometry.

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