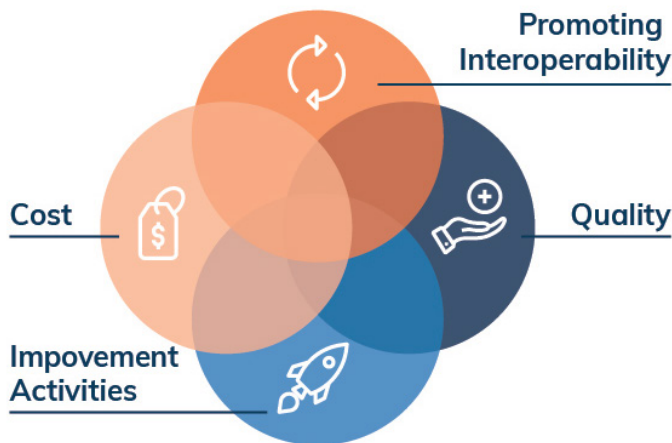


Breaking Down MIPS and Upcoming Changes

The Merit-based Incentive Payment System (MIPS) is a series of metrics that evaluate health outcomes and performance, and provide financial rewards for achieving certain thresholds. The MIPS program was authorized by the [Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#).

Clinicians are reimbursed for Medicare Part B services on a fee-for-service basis, with the Centers for Medicare and Medicaid (CMS) making adjustments based on their MIPS “score.” MIPS is one of two parts of a Medicare Part B performance-based payment system called Quality Payment Program (QPP).



Any Medicare Part B provider who satisfies the definition as a [MIPS-eligible provider](#), but chooses not to participate in MIPS will be subject to a negative payment adjustment on Medicare Part B reimbursements.

You can choose to participate in MIPS as an individual or as part of a group or virtual group. You are assessed across the four MIPS performance categories according to your participation status. Clinicians who qualify for MACRA’s Advanced Alternative Payment Model (AMP) are exempt from the MIPS payment adjustment.

MIPS combines three Medicare programs into a single payment program:

1.

Physician Quality Reporting System (PQRS)

2.

Value-based Payment Modifier (VM) Program

3.

Medicare Electronic Health Records Program—aka Meaningful Use

MIPS eligibility at-a-glance

There are several ways to determine eligibility for MIPS. If you qualify as a MIPS-eligible individual provider, you must report for MIPS. However, a MIPS-eligible practice can report all clinicians as a group, with individual providers receiving a score and payment adjustments based on the group reports. But, if you are part of a group and your individual score is higher than the group score, your adjustment will be based on the higher of the two.

As a Solo Practitioner	As Part of a Group (Including Virtual Groups*)	MIPS APM
<ul style="list-style-type: none"> Identified as a MIPS-eligible clinician on Medicare Part B claims Enrolled as a Medicare provider before 2021, Not a Qualifying Alternative Payment Model Participant (QP) Exceed the low-volume threshold as an individual 	<ul style="list-style-type: none"> Identified as a MIPS-eligible clinician on Medicare Part B claims Enrolled as a Medicare provider before 2021, Not a QP Participates in a practice that exceeds the low-volume threshold 	<ul style="list-style-type: none"> Effective with the 2021 performance year, APM participants and other MIPS-eligible clinicians will have the same eligibility rules.

*A virtual group is a combination of two or more Tax ID Numbers assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians. Providers can choose to form a virtual group regardless of their geographic location or specialty. There are no limits on the number of solo practitioners and groups that can come together to form a virtual group. However, you can only participate in one virtual group per performance year.

MIPS eligible clinicians include:

Physicians	Physicians Assistants	Nurse Practitioners	Clinical Nurse Specialists	Certified Registered Nurse Anesthetists
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Defining performance categories and weights

MIPS financial incentives are awarded based on how a provider or group scores against four performance measurements. Having multiple categories gives providers the flexibility to choose metrics that offer the greatest chance of success. As shown in this chart, the weight of the categories is subject to change from year to year.

Performance Category Weights	Performance Year Weight		
	2020	2021	2022
<p>Quality: Measures activities related to patient outcomes, appropriate use of medical resources, patient safety, efficiency, patient experience, and care coordination. Eligible clinicians must report on six measures for at least 70% of eligible patients for the entire year, with each measure being worth up to 10 points. At least one measure should assess if patient outcomes improved under your care. Bonus points are available.</p>	45%	40%	30%
<p>Cost: Measures the total Medicare payments made for care provided to patients. CMS calculates the Cost metric using claims data—providers aren't responsible for reporting this information.</p>	15%	20%	30%
<p>Promoting Interoperability: Measures patient engagement and the electronic exchange of information using 2015 edition Certified Electronic Health Record Technology (CEHRT) over a 90-day period a provider selects. Failure to report any of the required measures will result in a zero score for this category.</p>	25%	25%	25%
<p>Improvement Activities: Measures clinical practice improvement activities, such as care coordination, beneficiary engagement, and patient safety. Providers can choose to report two high-weighted activities of 20 points each, four medium-weighted activities of 10 points each, or a combination that reaches a total of 40 points. Practices of 15 clinicians or less can report one high-weighted activity or two medium-weighted activities, with activities being double-counted. Activities must be completed for 90 days and at least half of eligible providers in the practice must perform the same activity during the 90-day period.</p>	15%	15%	15%

How payment adjustments are calculated

There is a two-year lag between physician performance and Medicare Part B payment adjustments. For example, performance in 2021 will be reflected in 2023 reimbursements.

The minimum threshold for 2021 will be 60 points, up from 45 in 2020. This means you must achieve at least 60 MIPS final points in 2021 to avoid a MIPS penalty in 2023. The threshold for exceptional performance will remain at 85 points.

Performance Year	Payment Year	Minimum Threshold	Potential Payment Adjustment
2019	2021	30	±7%
2020	2022	45	±9%
2021	2023	60	±9%

MIPS-eligible providers who don't report MIPS in 2021 will experience a [-9% MIPS penalty](#) against their 2023 Medicare Part B payments.

It's important to note that MIPS is a budget-neutral program—the projected negative adjustments must be balanced by the projected positive adjustments. A modest positive payment adjustment would result from high participation rates combined with a high percentage of participating clinicians earning a final score above the minimum threshold. [Here](#) are the adjustments clinicians can expect in 2021, based on 2019 performance year results.

MIPS workflow



What else is new for 2021?

Here are other significant changes that take effect in 2021:

Sunsetting Web-Interface Reporting

CMS is eliminating the Web-Interface/Group Practice Reporting Option submission method for reporting Quality measures. This is a secure, internet-based submission system for [Accountable Care Organizations \(ACOs\)](#) and groups (including virtual groups) of 25 or more clinicians for reporting Quality data to the QPP. There will be a one-year transition period in 2021 during which ACOs can either:

- Continue to report via the CMS Web Interface; or
- Report the three [Electronic Clinic Quality Measures \(eCQMs\)](#) via a new [Alternative Payment Model \(APM\) Performance Pathway](#).

MIPS Value Pathway Delayed

The goal of the MIPS Value Pathway (MVP) is to coordinate and connect measures across the four performance categories (Quality, Cost, Promoting Interoperability, and Improvement Activities) for different specialties and health conditions. CMS will postpone adoption until 2022, and the MVP will align with the APM Performance Pathway when implemented.

Revisions to Quality Measures

For 2021, [CMS made changes](#) to 113 existing Quality measures, adding two new administrative claims measures, and removing 12 measures.

COVID-Related Bonuses

For the 2020 performance period, eligible providers can earn up to 10 bonus points (compared to five bonus points in 2019) due to the extra complexity of treating patients during the pandemic.

“MIPS Value Pathway (MVP) will align with the Alternative Payment Model (APM) Performance Pathway when implemented in 2022.”