MIPS - A complete guidebook for 2023 changes

Introduction:

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established new payment models for physicians and other eligible clinicians to transition from traditional fee-for-service to value-based care. One of the payment models established under MACRA is the Merit-Based Incentive Payment System (MIPS). MIPS is a program that combines and replaces three previous programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program. This white paper provides an overview of MIPS and its impact on healthcare providers.

MIPS Overview:

MIPS is a quality payment program that adjusts Medicare Part B payments based on performance in four categories: Quality, Improvement Activities, Promoting Interoperability, and Cost. The program is designed to encourage healthcare providers to focus on quality and value of care, and to promote the use of electronic health records. Providers earn a composite performance score (CPS) based on their performance in each category, which is used to determine payment adjustments.

Purpose:

1. Our signature consulting program helps practices meet and exceed MIPS requirements. We offer a range of plans, from setting you on the right path to doing it all for you.
2. We help you manage your practice's MIPS submission by checking your clinicians' past scores and eligibility and providing resources on how to meet each measure.
3. Our experts provide on-site, and remote consulting services tailored to help you get the most out of your EHR and other IT systems.
4. Leverage our team of experts to help with the most challenging IT tasks for healthcare. Whether you are a health system, hospital, vendor, or insurer, we have a solution for you.

On November 1st, 2022, the Centers for Medicare and Medicaid Services (CMS) released its Medicare Physician Fee Schedule (PFS) Final Rule which makes changes to the Quality Payment Program (QPP) for 2023 and future performance years. The rule provides policy updates to the traditional Merit-based Incentive Payment System (MIPS) program, the new MIPS Values Pathway (MVPs) framework, Alternative Payment Models (APMs), and Accountable Care Organizations (ACOs). This article provides a summary of the key provisions in the Final Rule.

Changes to Traditional MIPS

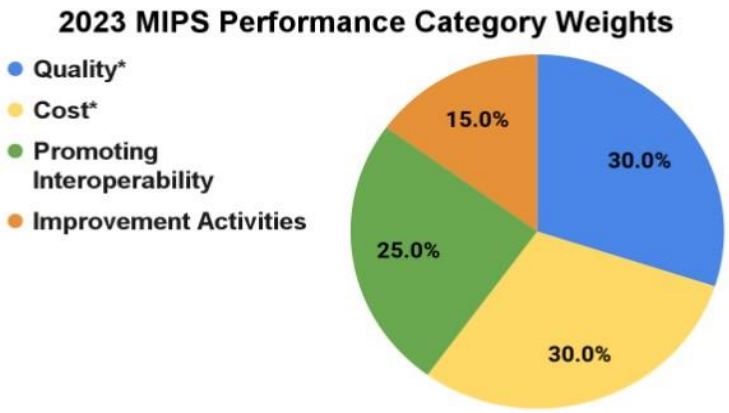
Traditional MIPS is the original framework available to MIPS eligible clinicians for collecting and reporting data to MIPS. MIPS scores for clinicians and groups are determined based on their

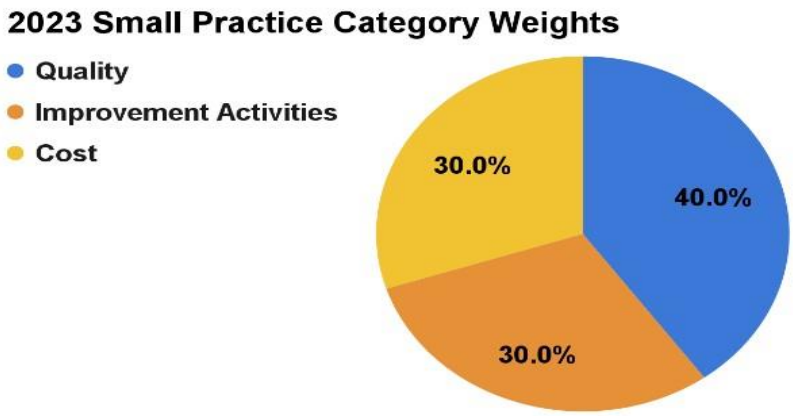
overall performance in each of the four MIPS categories (Quality, Improvement Activities, Promoting Interoperability, and Cost) compared to the CMS performance threshold score for a given year.

The Final Rule established a minimum performance threshold of 75 MIPS points for the 2023 performance year. CMS continues to use the mean final score from the 2017 performance year to establish the performance threshold. **This means clinicians and groups must reach 75 MIPS points again in 2023 to avoid a negative payment adjustment in the 2025 payment year.**

As finalized in the 2022 MIPS Final Rule, there will no longer be an additional performance threshold for exceptional performance in 2023. The 2022 performance year is the last year where clinicians can earn an exceptional performance bonus.

CMS made no changes to the MIPS performance category weights in 2023 and is maintaining the performance category redistribution policies for small practices (15 or fewer clinicians). The points from each category are added together to give a MIPS final score.





CMS will continue to automatically reweigh the Promoting Interoperability performance category and more heavily weight the Improvement Activities performance category for small practices. When both Cost and Promoting Interoperability are reweighted, Quality and Improvement Activities will each be weighted at 50%.

The payment adjustments for 2025 outlined in the table below reflect the removal of the additional adjustment for exceptional performance. MIPS scores at or below 18.75 points would earn the full -9 percent penalty.

Final Score 2023	Payment Adjustment 2025
75.01 - 100 points	Positive MIPS payment adjustment greater than 0% on a linear sliding scale
75 points	0% MIPS payment adjustment
18.76 -74.99 points	Negative MIPS payment adjustment between -9% and 0% on a linear sliding scale
0 - 18.75 points	Negative MIPS payment adjustment of -9%

Quality Category Updates

CMS is maintaining the current data completeness requirements for the 2023 performance year, so clinicians will report at least 70% of eligible encounters for the quality measures they report, regardless of insurance type. **However, this threshold increases to 75% for the 2024 and 2025 performance years.**

There are a few quality measure changes, including expansion of the definition of "high priority measure" to include health equity-related quality measures. CMS finalized a total of 198 quality measures for the 2023 performance period which reflect:

- Substantive changes to 76 existing quality measures
- The addition of 9 new quality measures (which includes one new administrative claims measure)
- Removal of 11 quality measures
- Addition/removal of quality measures from multiple specialty sets

Measures that have been added to or removed from the 2023 quality measure inventory, along with their collection types, are outlined in the tables below.

New Quality Measures	Collection Type
#485 Psoriasis – Improvement in Patient-Reported Itch Severity	MIPS Clinical Quality Measure (CQM)
#486 Dermatitis – Improvement in Patient-Reported Itch Severity	MIPS CQM
#487 Screening for Social Drivers of Health	MIPS CQM
#488 Kidney Health Evaluation	Electronic CQM (eCQM) and MIPS CQM
#489 Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	MIPS CQM
#490 Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	MIPS CQM
#491 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma	MIPS CQM
#492 Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	Administrative Claims*
#493 Adult Immunization Status	MIPS CQM

**CMS will use performance period benchmarks exclusively for scoring administrative claims measures.*

Retired Quality Measures	Collection Type
#76 Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	Medicare Part B Claims, MIPS CQM
#119 Diabetes: Medical Attention for Nephropathy	eCQM, MIPS CQMs
#258 Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	MIPS CQM
#265 Biopsy Follow-Up	MIPS CQM
#323 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	MIPS CQM
#375 Functional Status Assessment for Total Knee Replacement	eCQM
#425 Photodocumentation of Cecal Intubation	MIPS CQM
#455 Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)	MIPS CQM
#460 Back Pain After Lumbar Fusion	MIPS CQM
#469 Functional Status After Lumbar Fusion	MIPS CQM
#473 Leg Pain After Lumbar Fusion	MIPS CQM

Quality Measures Removed from Traditional MIPS*	Collection Type
#110: Preventive Care and Screening: Influenza Immunization	Medicare Part B Claims, eCQM, MIPS CQM
#111: Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims, eCQM, MIPS CQM

**These measures will still be available for MVP reporting. Measure #110 will also be retained for MSSP ACO reporting through the APP.* When reporting under traditional MIPS, a new Adult Immunization Status measure will include influenza and pneumococcal vaccination, as well as Td/Tdap and Zoster vaccination.

Previously Finalized Quality Updates for 2023:

In the 2022 MIPS Final Rule, several policy changes were adopted that go into effect beginning with the 2023 performance period:

- **Measures with a benchmark** - The 3-point floor is removed for measures that can be scored against a benchmark. These measures will receive 1-10 points. (This does not apply to new measures in the first 2 performance periods available for reporting.)
- **Measures without a benchmark** - The 3-point floor is removed for measures without a benchmark (except small practices). These measures will receive 0 points (small practices will continue to earn 3 points). (This does not apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures.)
- **Measures that don't meet case minimum requirements (20 cases)** - The 3point floor is removed (except small practices). These measures will earn 0 points (small practices will continue to earn 3 points). (This does not apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum is not met.)

Improvement Activities Category Updates

There are no major changes to the MIPS Improvement Activities (IA) category other than updates to the IA inventory. CMS is adding four new activities, modifying five current activities, and

removing five existing improvement activities from the IA inventory as outlined in the following table.

New Improvement Activities	Retired Improvement Activities
IA_AHE_10 Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data (Medium)	IA_BE_7 Participation in a QCDR, that promotes use of patient engagement tools
IA_AHE_11 Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients (High)	IA_BE_8 Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive
IA_EPA_6 Create and Implement a Language Access Plan (High)	IA_PM_7 Use of QCDR for feedback reports that incorporate population health
IA_ERP_6 COVID-19 Vaccine Achievement for Practice Staff (Medium)	IA_PSPA_6 Consultation of the Prescription Drug Monitoring program
	IA_PSPA_20 Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
	IA_PSPA_30 PCI Bleeding Campaign

Promoting Interoperability Category Updates

CMS is making several changes to the Promoting Interoperability (PI) category. The updates include:

- Requiring and modifying the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure
- Expanding the Query of PDMP measure to include not only Schedule II opioids, but also Schedule III, and IV drugs.
- Adding a new Health Information Exchange (HIE) Objective option, the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure (requiring a yes/no response), as an optional alternative to fulfill the objective.
- Consolidating the current options from three to two levels of active engagement for the Public Health and Clinical Data Exchange Objective and require the reporting of active engagement for the measures under the objective.
- Continuing to reweight the PI category for certain types of non-physician practitioner MIPS eligible clinicians.

CMS is *discontinuing* automatic reweighting for the following clinician types beginning with the 2023 performance period:

- Nurse practitioners
- Physician assistants
- Certified registered nurse anesthetists
- Clinical nurse specialist

The agency will *continue* automatic reweighting for the following in the 2023 performance period:

- Clinical social workers
- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists, and
- Registered dieticians or nutrition professionals

When participating in MIPS at the APM Entity level (reporting the APP, traditional MIPS, or an MVP), CMS will allow APM Entities to report PI data at the APM Entity level. APM Entities will still have the option to report this performance category at the individual and group levels.

CMS is also updating PI scoring for each of the PI measures as follows:

PI Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Query of PDMP	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points
	OR	
	Health Information Exchange Bi-Directional Exchange*	30 points
	OR	
	Participation in TEFCA	30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points
	Report the following 2 measures:	25 points

PI Objective	Measure	Maximum Points
	• Immunization Registry Reporting • Electronic Case Reporting	
Public Health and Clinical Data Exchange	Report one of the following measures: • Syndromic Surveillance Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)

Cost Category Updates

A maximum cost improvement score of one percentage point out of 100 percentage points is established for the Cost performance category. It will be retroactively applied to start with the current 2022 performance period.

Complex Patient Bonus

CMS finalized that a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they don't submit data for at least one MIPS performance category.

MIPS Value Pathways (MVPs)

As previously finalized in the 2022 MIPS final rule, CMS will make MVPs available for reporting beginning with the 2023 performance year:

- 2023, 2024, and 2025 performance years - Individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM Entities can report MVPs.

- 2026 performance year and for future years - Individual clinicians, single specialty groups, subgroups, and APM Entities can report MVPs. Multispecialty groups will be required to form subgroups to report MVPs.

CMS continues to focus on the development of MVPs and subgroup reporting and has finalized a total of 12 MVPs for the 2023 performance year.

MVPs	
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP	Improving Care for Lower Extremity Joint Repair MVP
Advancing Cancer Care	Optimal Care for Kidney Health
Advancing Care for Heart Disease MVP	Optimizing Chronic Disease Management MVP
Advancing Rheumatology Patient Care MVP	Patient Safety and Support of Positive Experiences with Anesthesia MVP
Optimal Care for Patients with Episodic Neurological Conditions	Promoting Wellness
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP	Supportive Care for Neurodegenerative Conditions

Subgroup Registration

Clinicians who choose to participate in a subgroup to report an MVP must register as a subgroup between April 1 and November 30 of the performance year. In addition to the required MVP registration information, the subgroup registration must include:

- A list of Taxpayer Identification Numbers (TINs)/National Provider Identifiers (NPIs) in the subgroup
- A plain language name for the subgroup (which will be used for public reporting)

- A description of the composition of the subgroup, which may be selected from a list or described in a narrative.

Clinicians (identified by NPI) may register for one subgroup per TIN.

Subgroup Eligibility
CMS will use the first segment of the MIPS determination period to determine the eligibility of clinicians intending to participate and register as a subgroup. As previously finalized, each subgroup must include at least one MIPS eligible clinician.

Subgroup Scoring
CMS will calculate and score administrative claims measures at the TIN level, not at the subgroup level:

- **Foundational Layer (MVP Agnostic)** - For each selected population health measure in an MVP, subgroups would be assigned the affiliated group's score, if available. For instances where a group score is not available, each such measure would be excluded from the subgroup's final score.
- **Quality Performance Category** - For each selected outcomes-based administrative claims measure in an MVP, subgroups would be assigned the affiliated group's score, if available. For instances where a group score is not available, each such measure would be assigned a zero score.
- **Cost Performance Category** - Subgroups would be assigned the affiliated group's cost score, if available for the cost performance category in an MVP. For instances where a group score is not available, each such measure would be excluded from the subgroup's final score.

Subgroup Final Score
CMS will not assign a score for a subgroup that registers but does not submit data as a subgroup.

Advanced APMs

CMS finalized the following policies to encourage participation in Alternative Payment Models (APMs):

- Makes permanent the 8% minimum on the Generally Applicable Nominal Risk standard for Advanced APMs.
- Applies the 50-clinician limit to the APM Entity participating in the Medical Home Model. CMS will identify the clinicians in the APM Entity by using the TIN/NPIs on the participation

list of the APM Entity on each of the three QP determination dates (March 31, June 30, and August 31). This policy would become effective in the performance year 2023.

Impact on Healthcare Providers:
MIPS has a significant impact on healthcare providers, particularly those in small and rural practices. Providers must invest in technology, staff, and processes to collect and report data on quality measures, improvement activities, and interoperability measures. Failure to meet reporting requirements can result in negative payment adjustments, which can have a significant financial impact on small practices. Additionally, providers must demonstrate a commitment to quality and value-based care, which can require significant changes in practice patterns and patient engagement.

Conclusion:
Closing gaps in care on time is still a challenge for most providers and payers, and data has shown that adhering to the quality measures and implementing them on time helps in closing the gaps in care and improving the quality of care.

We at Tietoevry enable healthcare organizations to manage their regulatory reporting requirements while driving improvement in quality scores for programs like HEDIS, MIPS and CQM's and ECQM's. We provide insight-driven quality improvement and provider engagement across multiple regulatory programs. We provide solutions to get real-time compliance updates and make it highly configurable automated workflows for improved efficiency and focused measure prioritization.

We help our customers develop solutions that will empower quality and care management teams to:

- Drive CQM, eCqm, HEDIS, Star and state regulatory needs through a unified platform
- Prioritize and accelerate gap closure
- Leverage advanced analytics (including AI/ML) across populations and value-based program
- Improve efficiencies across HEDIS compliance and Medical Record Review

This information has been collated by our experts – Shridhar Rajanna & Shridhar Purohit, Healthcare Services, EVRY India. For queries and other details on our offerings, please contact – info.usa@tietoevry.com

Sources:

- *https://qpp.cms.gov/*
- *https://www.cms.gov/*
- *MIPS Value Pathways (MVPs) - The Future of MIPS | MDinteractive*
- *Federal Register*