HEALTHCARE REGULATORY ROUND-UP #71

MIPS 101: A Refresher

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Introductions

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Today's Agenda

1. Quality Payment Program Overview
2. Merit-Based Incentive Payment System
3. MIPS APMs and Advanced APMs

1. Quality Payment Program (QPP) Overview

Image Source: Shutterstock

Medicare Access and CHIP Reauthorization Act of 2015

- Created the Quality Payment Program (QPP) launched Jan 1, 2017
- Ended the Sustainable Growth Rate (SGR) formula for determining Medicare payments
- Intended to reward health care providers for value not volume
  - Gave CMS the ability to reward high-value, high-quality Medicare clinicians with payment increases – while reducing payments to those clinicians who weren't meeting performance standards
- Created two new tracks for determining payment to Providers for Medicare Part B-covered professional services

Quality Payment Program (QPP)

https://qpp.cms.gov/about/qpp-overview

QPP Goals

- To improve beneficiary population health
- To improve the care received by Medicare beneficiaries
- To **lower costs** to the Medicare program through **improvement of care and health**
- To advance the use of healthcare information between allied providers and patients
- To maximize QPP participation with a flexible and transparent design, and easy to use program tools
- **To expand Alternative Payment Model participation**
- To provide accurate, timely, and actionable performance data to clinicians, patients and other stakeholders

https://qpp.cms.gov/about/qpp-overview

2. Merit-Based Incentive Payment System (MIPS)

Image Source: Shutterstock

Eligibility - Basics

- Based on Taxpayer Identification Number/National Provider Identifier (TIN/NPI)
- Providers can have multiple TIN/NPI combinations
- Must exceed three low-volume thresholds:
  - Bill more than $90,000 for Medicare Part B covered professional services, and
  - See more than 200 Medicare Part B patients, and
  - Provide more than 200 covered professional services to Medicare Part B patients.
- During two 12-month segments
  - Except solely based on segment 2 data when a TIN or TIN/NPI is newly established during segment 2
  - Example: For performance year 2024,

    Segment 1 = October 1, 2022 – September 30, 2023

    Segment 2 = October 1, 2023 – September 30, 2024

Eligibility – Clinician Types

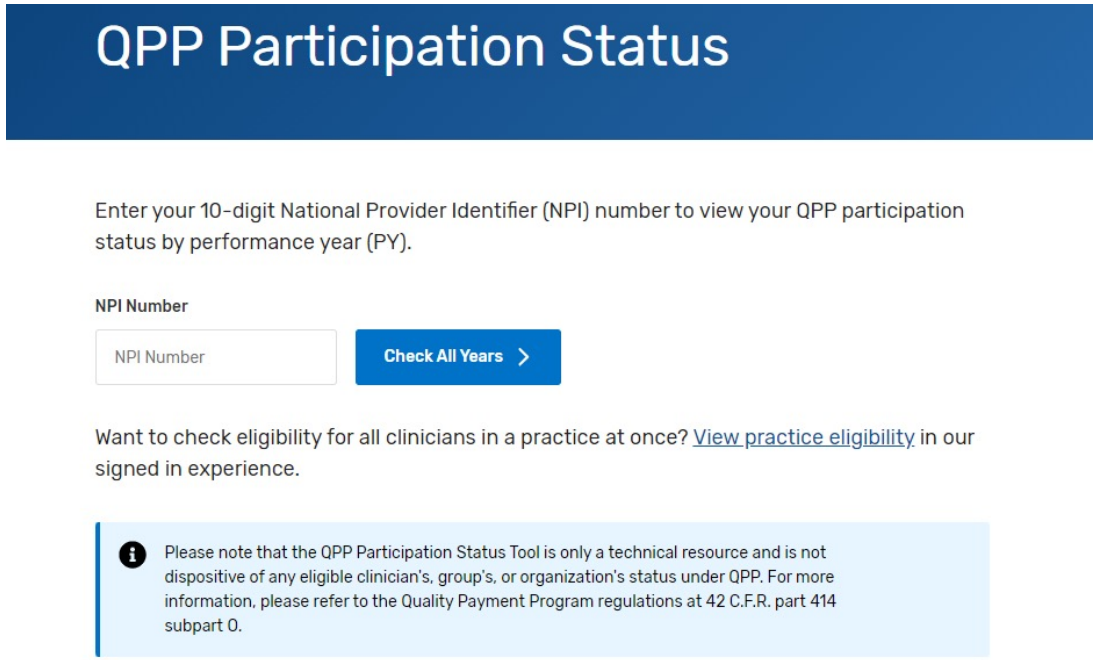
- Physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry)
- Osteopathic practitioners
- Chiropractors
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical therapists
- Occupational therapists
- Clinical psychologists
- Qualified speech-language pathologists
- Qualified audiologists
- Registered dietitians/nutrition professionals
- Clinical social workers
- Certified nurse midwives

Eligibility – Potential Changes

- Joining a New Practice or APM Entity
- Changing provider type/specialty code from segment to segment
- Billing data for Segment 1 but not Segment 2
- Falling below Low-Volume thresholds in Segment 2
- Dropping out of an APM Entity during the performance year
- Changing Qualifying Provider (QP) status (APM)

Confirming Eligibility

- Designated representatives can obtain a roster status for all clinicians in a practice by logging in to QPP
- Individual look up is available via NPI



https://qpp.cms.gov/participation-lookup

Confirming Eligibility

MIPS Eligibility:

INDIVIDUAL GROUP

Clinician Level Information

Exceeds low volume threshold	No
Medicare patients for this clinician	Does not exceed 200
Allowed charges for this clinician	Does not exceed $90,000
Covered services for this clinician	Does not exceed 200
MIPS eligible clinician type	Yes
Enrolled in Medicare before January 1, 2024	Yes

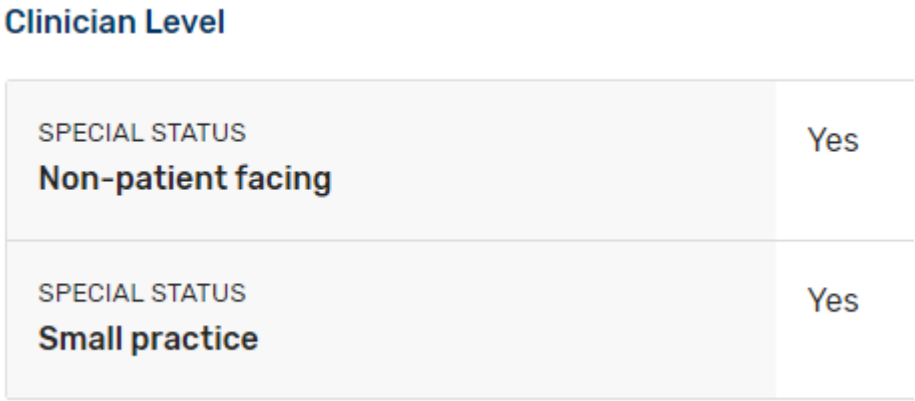
Practice Level Information

Exceeds low volume threshold	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Exceeds $90,000
Covered services at this practice	Exceeds 200

https://qpp.cms.gov/participation-lookup

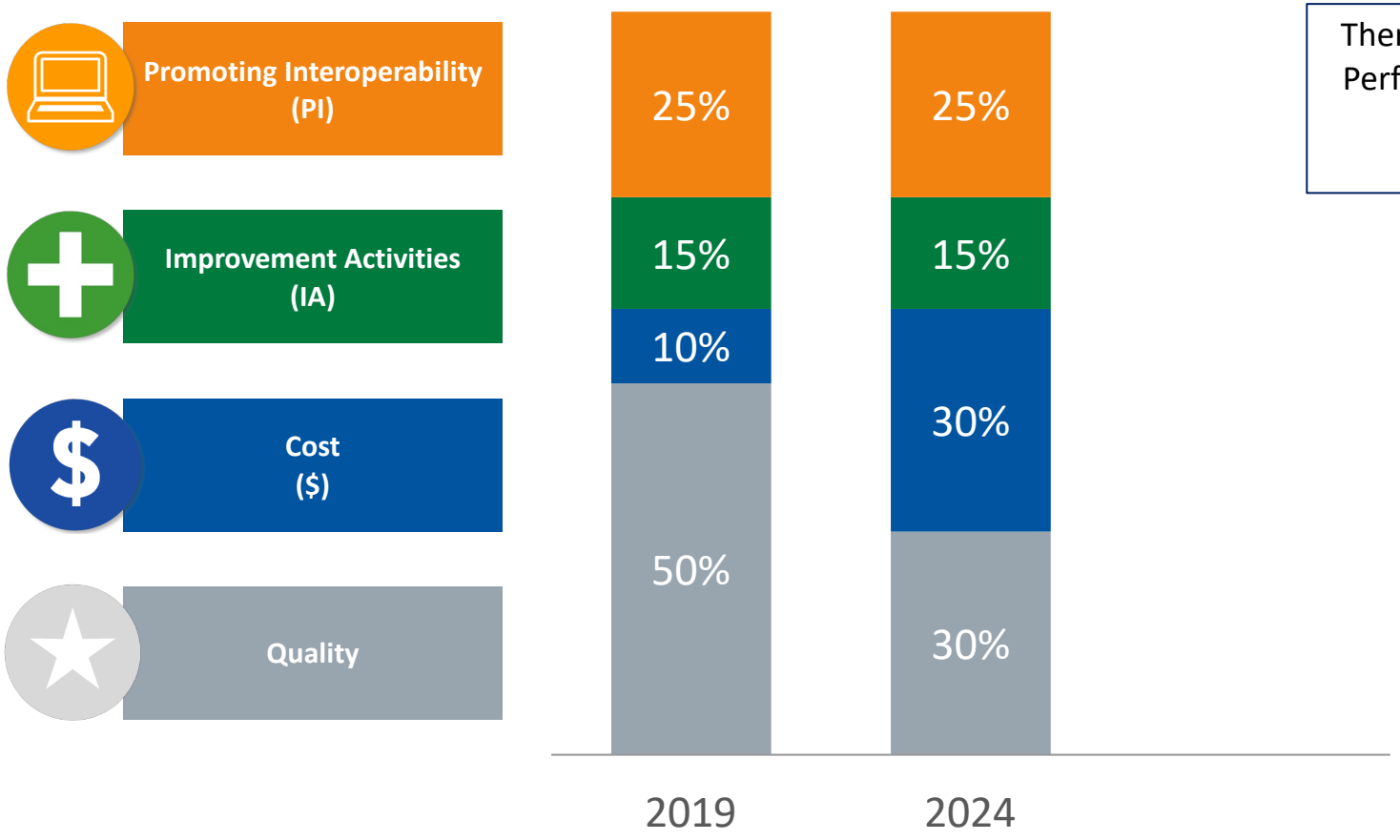
Special Statuses

- Special status is afforded to the following providers:
  - Ambulatory surgery centers (ASCs)
  - Hospital-based
  - Facility-based
  - Non-patient facing
  - Small practice
  - Health professional shortage area (HPSA)
  - Rural



Visit https://qpp.cms.gov/mips/special-statuses?py=2024 to learn more.

Composite Score Components



There is a 2-year lag between Performance Year (2024) and Payment Year (2026).

Scoring

Your 2024 Final Score	Payment Impact for MIPS Eligible Clinicians for the 2026 MIPS Payment Year
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (between -9% and 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) As a reminder, the 2022 performance year/2024 payment year was the last year for the additional positive payment adjustment for exceptional performance.

Quality

- Performance Period: January 1 – December 31, 2024
- Collection Types:
  - Electronic Clinical Quality Measures (eCQMs)
  - MIPS Clinical Quality Measures (CQMs)
  - Qualified Clinical Data Registry (QCDR) Measures
  - Medicare Part B Claims Measures and
  - The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey
- Data completeness – all payers/all patients
  - 2024 and 2025 – 75% as finalized in the 2023 MPFS
  - 2026 – finalized to hold at 75%

Quality

- Must report on 6 quality measures including one outcome/high-priority measure or a complete specialty measure set
  - If specialty measure set has less than 6 measures, you must submit on all measures in the set
- Can select from approximately 198 quality measures
  - Additions/deletions and edits occur each year
- CMS also scores four administrative measures based on claims data
  - Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Eligible Groups
  - Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for MIPS
  - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
  - Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure under MIPS

Quality Scoring

- Measures are scored against published benchmarks
- Bonus points (+6) are available for small practices (practice with less than 15 providers) who submit at least one measure
- Can earn up to 10 additional percentage points based on improvement in the quality category from the previous year
- Facility-based scoring is available if a provider is identified as facility-based, attributed to a facility with a FY 2025 Hospital Value-Based Purchasing Program Score, and if this methodology results in a higher final score than without the facility-based measure

Cost

- Calculated by CMS based on administrative claims
- 29 cost-based measures available for 2024 performance period
  - Includes episode-based measures and population-based measures
- If entity/provider doesn’t meet case minimum for any measure, category is automatically weighted to zero and 30% is redistributed to other categories
- Maximum of 1 percentage point is available for cost improvement scoring
- Facility-based scoring mimics quality

Promoting Interoperability

- Performance period – 180 continuous days or more during CY 2024
- Required to use electronic health record that meets certification criteria at 45 CFR 170.315
- Must be able to reply “yes” to certain attestations related to information blocking, security risk analysis and Safety Assurance Factors for EHR Resilience (SAFER) Guides.
- Automatic reweighting to other categories for clinical social workers, ambulatory surgical center (ASC)-based, hospital-based, or non-patient facing providers, and small practices
  - Certain other provider types were previously reweighted but this ended with Performance Year 2023

Promoting Interoperability

- Scoring
  - Numerator / Denominator = performance rate x total points available for measure
  - If measure requires a yes/no answer, full points awarded for “yes”
  - Full points for Public Health and Clinical Data Exchange if a yes is submitted or one yes and one exclusion
  - Must report on all required measures or score will default to zero
- Bonus Points
  - Can earn 5 bonus points for submitting “yes” for one of the optional Public Health and Clinical Data Exchange measures
    - Public Health Registry Reporting
    - Clinical Data Registry Reporting
    - Syndromic Surveillance Reporting

Improvement Activities

- Performance period – 90 continuous days or more during CY 2024
- Activities can use different 90-day periods
- 106 Improvement Activities available to choose from
- Generally requires performance of
  - 2 high-weighted activities
  - 1 high-weighted and 2 medium-weighted activities
  - 4 medium-weighted activities
  - Special statuses may impact this requirement
- For group reporting – activity must be performed by at least 50% of clinicians in the group

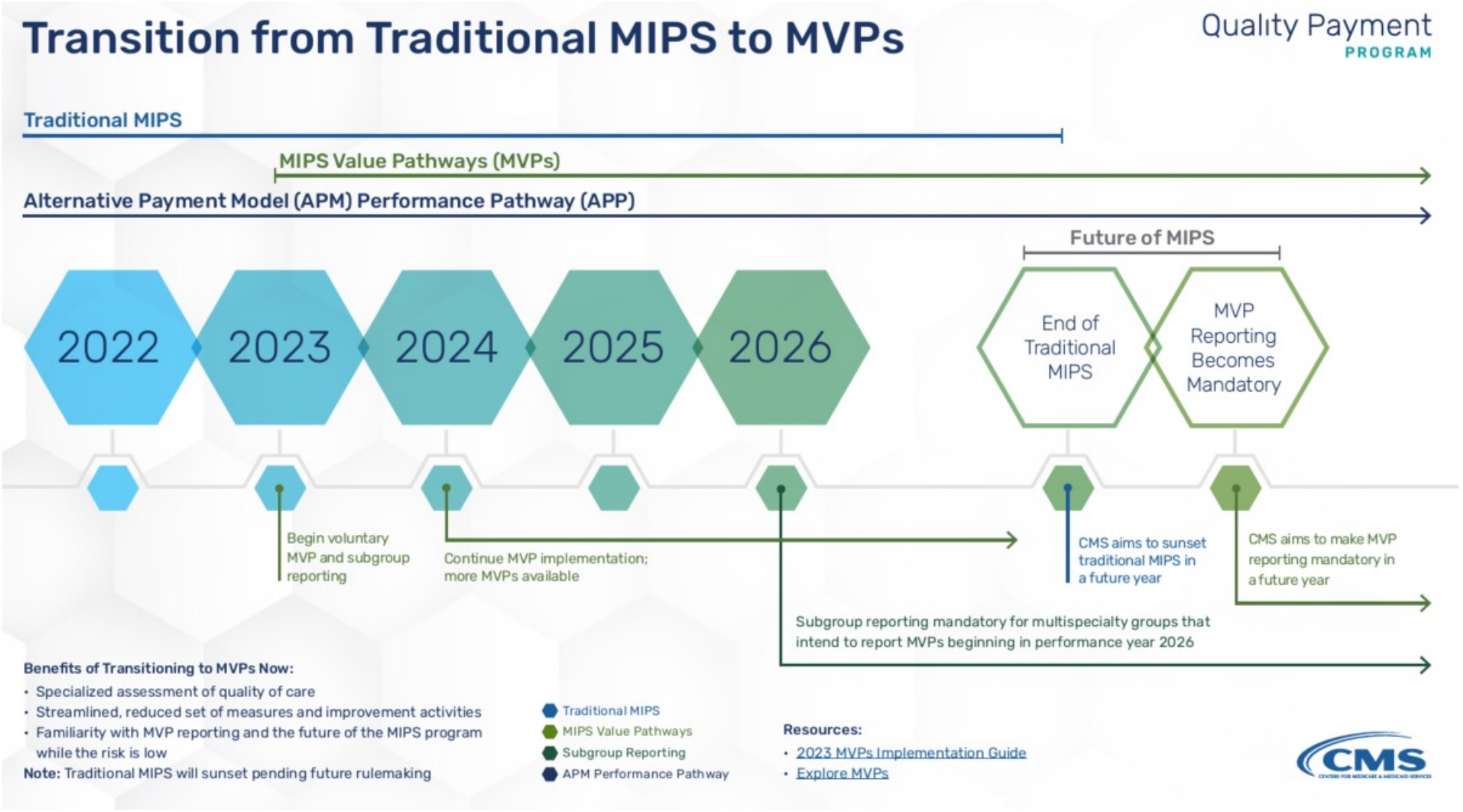
MIPS EUC Exception

- Extreme and Uncontrollable Circumstances (EUC)
- Applications available until 8p ET on December 31, 2024
- EUCs - rare events entirely outside of your control and the control of the facility in which you practice
- Note: CMS notes that the COVID-19 public health emergency ended in 2023 and will not accept a COVID-19 related exception request for 2024.
- Applications can be submitted through Health Care Quality Information System (HCQIS) Access Roles and Profile (HARP)
- If apply and accepted, and subsequently submit data, then data will be scored on a category-by-category basis
- EUCs are *automatically* applied when clinicians in a CMS-designated region have been affected by an EUC (wildfire, hurricane, earthquake, etc.)

MIPS Promoting Interoperability Exception

- Applications available until 8p ET on December 31, 2024
- Hardship exceptions are available for the following specified reasons:
  - You have decertified EHR technology (must be decertified under the Office of the National Coordinator for Health Information Technology's (ONC) Health IT Certification Program)
  - You have insufficient internet connectivity
  - You face extreme and uncontrollable circumstances such as a disaster, practice closure, severe financial distress, or vendor issues
  - You lack control over the availability of CEHRT
- Lacking the required CEHRT alone doesn't count
- PI Category is reweighted to other categories

MIPS Value Pathways (MVPs)



https://qpp.cms.gov/resources/resource-library

MVP Registration

- **Register between April 1 and December 2, 2024**
  - Must register by June 30 if using CAHPS for MIPS Survey – deadline approaching
  - Can make changes until November 30, 2024
  - Select MVP intend to report and one population health measure included in the MVP, as well as any outcomes-based administrative claims measure on which the participant intends to be scored, if available within the MVP
  - Cannot report on an MVP that was not registered for
  - Subgroup registration
    - A list of TIN/NPIs in the subgroup
    - Plain language name for the subgroup (public reporting)
    - Description of the composition of the subgroup
    - Clinician (NPI) only allowed to register for one subgroup per TIN
    - Use the initial 12-month segment of 24-months MIPS determination period to determine eligibility

Available MVPs

- Focusing on Women's Health
- Quality Care for the Treatment of Ear, Nose and Throat Disorders
- Prevention and Treatment of Infectious Disorders including Hep C and HIV
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support for Musculoskeletal Care
- Emergency Medicine
- Advancing Cancer Care
- Heart Disease
- Rheumatology
- Stroke Care
- Lower Extremity Joint Repair
- Kidney Health
- Episodic Neurological Conditions
- Anesthesia
- Neurodegenerative Conditions
- Value in Primary Care (combination of Chronic Disease Mgmt and Promoting Wellness)

MVP Reporting Requirements

Quality Performance Category

- 4 quality measures
- 1 must be an outcome measure (or a high priority measure if an outcome is not available or applicable)
- This can include an outcome measure calculated by CMS through administrative claims, if available in the MVP

IA Performance Category

- 2 medium-weighted improvement activities OR one high-weighted improvement activity OR IA_PCMH.

Cost Performance Category

- CMS calculate performance exclusively on the cost measures that are included in the MVP using administrative claims data.

Foundational Layer

Population Health Measures

- MVP Participants must select 1 population health measure at the time of registration. CMS will calculate these measures through administrative claims and add the results to the quality score.
- For the 2024 performance period, select from:
  - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups
  - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Promoting Interoperability Performance Category

- Must submit the same Promoting Interoperability measures required under traditional MIPS, unless Participant qualifies for reweighting of the Promoting Interoperability performance category.

MVP – Promoting Interoperability

Promoting Interoperability
• Security Risk Analysis • High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) • e-Prescribing • Query of Prescription Drug Monitoring Program (PDMP) • Provide Patients Electronic Access to Their Health Information • Support Electronic Referral Loops By Sending Health Information AND • Support Electronic Referral Loops By Receiving and Reconciling Health Information OR • Health Information Exchange (HIE) Bi-Directional Exchange OR • Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) • Immunization Registry Reporting • Syndromic Surveillance Reporting (Optional) • Electronic Case Reporting • Public Health Registry Reporting (Optional) • Clinical Data Registry Reporting (Optional) • Actions to Limit or Restrict Compatibility or Interoperability of CEHRT • ONC Direct Review Attestation

3. MIPS APMS and Advanced APMs

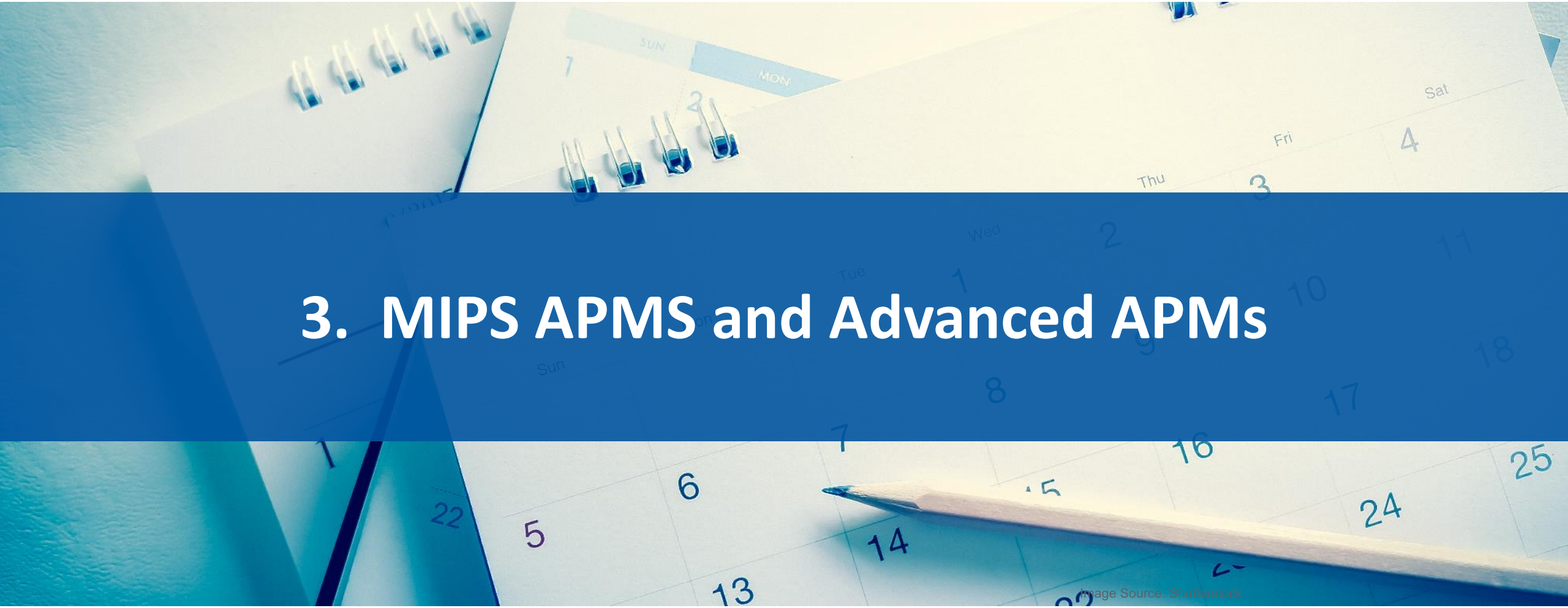
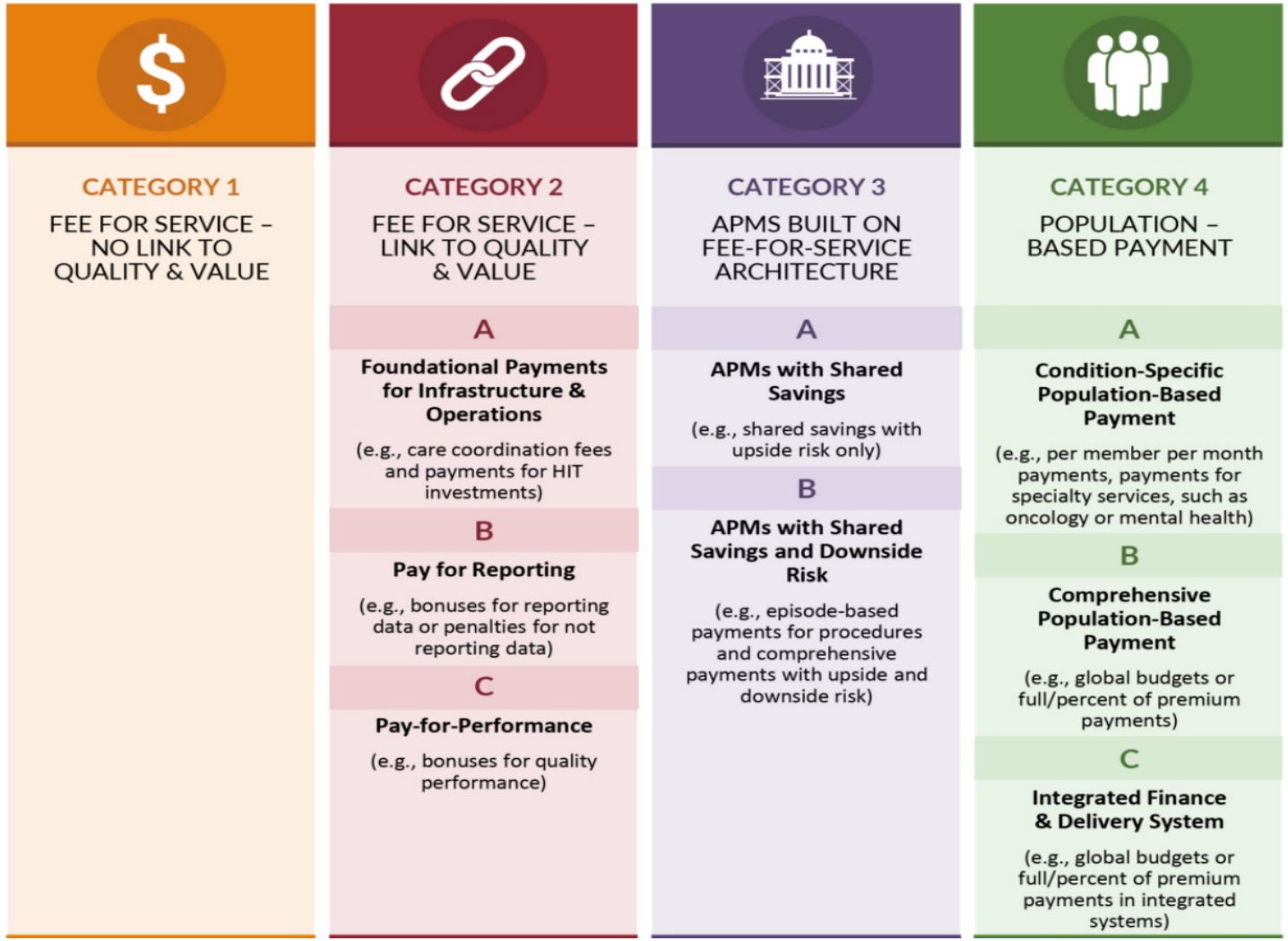


Image Source: Shutterstock

Alternative Payment Models (APMs)



https://hcp-lan.org/apm-framework/

MIPS APM vs. Advanced APM

- MIPS APMs
  - Hold their participants accountable for cost and quality of care provided to Medicare beneficiaries
  - Complete list available at https://qpp.cms.gov/apms/mips-apms
  - Participants still subject to MIPS payment adjustments
  - MIPS score calculated using APM Performance Pathway
    - Participants may elect to report traditional/MVP MIPS; will receive higher score
- Advanced APMs
  - Subset of MIPS APMs + other payer APMs recognized by CMS
    - Use of certified EHR, payment based on quality measures, financial risk
  - Qualifying APM Participants (QPs)
    - Do not have to report traditional/MVP MIPS
    - Receive Advanced APM payment adjustment (in place of MIPS payment adjustment)
  - Partial Qualifying APM Participants (Partial QPs)
    - MIPS participation optional

MIPS APMs

- Includes Medicare Shared Savings Program – BASIC Track Levels A-D
- MIPS Eligible Clinician who participates in MIPS APM may elect APM Entity's MIPS score calculated using APM Performance Pathway
  - NPI must appear on MIPS APM's Participation List or Affiliated Practitioner List on at least one snapshot date (for 2024 – July, October, & December 2024, March 2025)
    - Check status at https://qpp.cms.gov/participation-lookup
  - If report traditional MIPS, will receive higher score
  - If NPI bills under multiple TINs, report traditional/MVP MIPS for TIN(s) not participating in MIPS APM
- APM Performance Pathway
  - Cost = 0%
  - Quality = 50%
    - Based on APM quality measure set reported through APM entity
  - Performance Improvement= 20% (automatically receive full credit)
  - Promoting Interoperability = 30%
    - Participants report in same manner as traditional MIPS; APM Entity's score derived from participants' scores

Advanced APMs

- Includes MSSP BASIC Track Level E, MSSP ENHANCED Track, BPCI, and ACO REACH
- Qualifying participant
  - Receive ≥ 75% of Medicare Part B payments or see ≥ 50% of Medicare patients through Advanced APM Entity during QP performance period (increasing in 2026)
    - Same snapshot periods MIPS APM participation
    - May also qualify thru All-Payer and Other Payer Option (Medicare + other non-Medicare payers)
  - Payment adjustments
    - PY 2024 = ~2.63% increase to Part B payments in 2026
    - PY 2025+ = higher conversion factor update (0.75% vs. 0.25%)
- Partial qualifying participant
  - Receive ≥ 40% of Medicare Part B payments or see ≥ 30% of Medicare patients through Advanced APM Entity during QP performance period (increasing in 2026)
    - May also qualify thru All-Payer and Other Payer Option
  - May opt-out of MIPS (no payment adjustment)

2024 MIPS Action Items

- Evaluate available options and determine your MIPS pathway for 2024.
- Continue leveraging your operational, clinical, quality and IS team members for best opportunity for success.
- If considering MVP, ensure your vendor can support MVP data aggregation and reporting.
    - Evaluate benefits/risks of early adoption
- Continue to evaluate APM options as available and ready.
- Evaluate your entity's MIPS strategy for the next 2-3 years.
- Review and comment on proposed rulemaking.

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June 19 – Healthcare Privacy Update

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