



# MIPS 2024: Final Rule Changes

Presented by:

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# Chirpy Bird - What We Do



Assigned regulatory expert

Monthly support using your EMR and/or registry to help you understand annual requirements for your specific practice and needs

Eligibility monitoring

Review quality measure selection with consideration for optimal scoring/decile restrictions

Provide guidance on quality data collection, workflow, reporting tools, and reporting support at year-end

Gain access to and review Quality reports for estimated scores and evaluate data completeness requirements.

Security Risk Assessment for PI

Advise on PI workflow and data collection strategies to meet measures.

Provide measure guidance and act as CEHRT liaison to help meet and monitor category performance

Perform “what if” scenarios to support the development of strategies leading to the highest possible MIPS scores.

Identify and document Improvement Activities (IA) category to meet data validation guidelines

SAFER documentation requirements for PI

Annual book of evidence for all category documentation

Attestation and submission of data

Applying for any applicable hardship, if needed

Provide guidance on current or proposed MIPS policy as it concerns existing efforts and strategy

Cost data review

**888-647-7247**

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# Agenda



- Rule Intent
- Eligibility
- Overall Score Thresholds
- Quality
- Promoting Interoperability
- Improvement Activities
- Cost
- MVPs
- Targeted Reviews
- Deadline Reminders
- References
- Q&A

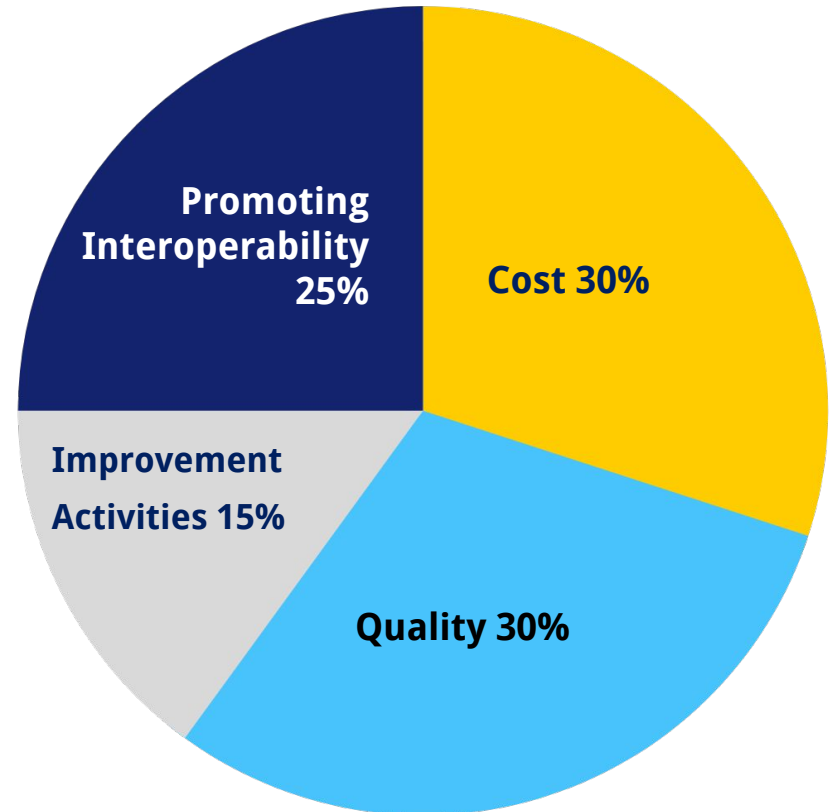
# Rule Intent for 2024

- Progress the Quality Payment Program (QPP).
- Focus on enhanced measurement efforts.
- Refine clinician participation for meaningful engagement.
- Aim: Continual improvement in healthcare quality for Medicare beneficiaries.
- Encourage ongoing improvement in clinician performance year-on-year.
- Drive better healthcare quality via payment policy.

# MIPS in a Minute

- 4 Categories
- Each has achievement points that correlate to program percentage points.
- Each year is a performance period
- Rules change annually
- MIPS Eligible Clinicians will be given a score of 0 to 100
- High scores are connected to an increase in reimbursement
- Low scores result in reimbursement reductions
- Results published online

**REVENUE AND REPUTATION ARE AT RISK**



# Eligibility remains the same; you are MIPS eligible if you are in the following categories:

- 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 or nutrition professionals
- Clinical social workers
- Certified nurse midwives

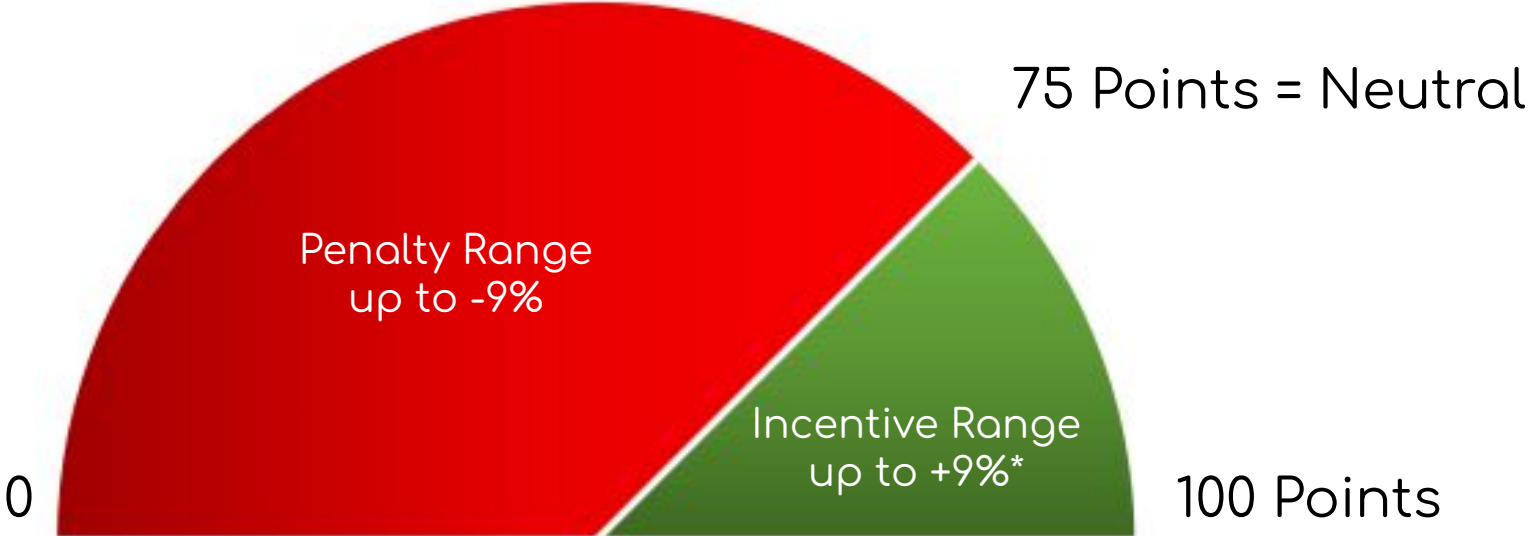


Are not participating in an APM and you exceed the low-volume threshold criteria:

**\$90k in allowable charge AND 200 patients AND 200 services**

But you are not in MIPS if you're in Medicare for the first time in 2023; or are a Qualifying APM Participant (QP) or Partial QP

# Annual Score Threshold & Payment Adjustments



**The FINAL threshold for the CY 2024 performance period/2026  
MIPS payment year is 75 points**

# Quality



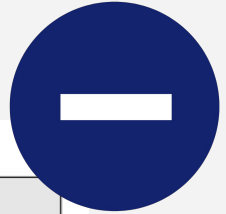
*Maintaining the data completeness criteria threshold to at least 75 percent for 2024, 2025, and 2026*

Establishing a measure set inventory of 198 MIPS quality measures.

- Lots of measure changes as usual. Measure changes would:
  - add 14 new MIPS quality measures
  - remove 11 MIPS quality measures
  - partially remove 3 MIPS quality measures from traditional MIPS but retained for use in MVPs
  - make substantive updates to 59 MIPS quality measures



# Derm Speciality Set Example - Removal



## B.9. Dermatology

PREVIOUSLY FINALIZED MEASURES PROPOSED FOR <b>REMOVAL</b> FROM THE DERMATOLOGY SPECIALTY SET										
Note: In this this proposed rule, we propose the removal of the following measure(s) below from this specific specialty measures set based upon review of updates made to existing quality measure specifications, the proposed addition of new measures for inclusion in MIPS, and the feedback provided by specialty societies.										
CBE # / eCQM CBE #				Quality #	CMS eCQM ID	Collection Type	Measure Type	Measure Title And Description	Measure Steward	Rationale for Removal
N/A / N/A				138	N/A	MIPS CQMs Specifications	Process	<b>Melanoma: Coordination of Care:</b> Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	American Academy of Dermatology	This measure is being proposed for removal beginning with the CY 2024 performance period/2026 MIPS payment year. See Table Group C of this Appendix for rationale.
N/A / N/A	402	N/A	MIPS CQMs Specifications	Process	<b>Tobacco Use and Help with Quitting Among Adolescents:</b> The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.			National Committee for Quality Assurance	This measure is being proposed for removal beginning with the CY 2024 performance period/2026 MIPS payment year. See Table Group C of this Appendix for rationale.	

# Derm Speciality Set Example - Addition



MEASURES PROPOSED FOR ADDITION TO THE DERMATOLOGY SPECIALTY SET								
Indicator	CBE # / eCQM CBE #	Quality #	CMS eCQMID	Collection Type	Measure Type	Measure Title And Description	Measure Steward	Rationale for Inclusion
! (Outcome)	N/A / N/A	TBD	N/A	MIPS CQMs Specifications	Patient-Reported Outcome-Based Performance Measure	<p><b>Gains in Patient Activation Measure (PAM®) Scores at 12 Months:</b> The Patient Activation Measure® (PAM®) is a 10 – or 13 – item questionnaire that assesses an individual’s knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM® performance measure (PAM®-PM) is the change in score on the PAM® from baseline to follow-up measurement.</p>	Insignia Health, LLC, a wholly owned subsidiary of Phreesia	<p>We propose to include this measure in the Dermatology specialty set as it would be clinically relevant to this clinician type. The addition of this measure to this specialty set would be feasible given its use through the continuum of care and across different clinical settings. This measure addresses chronic conditions and outcomes, both of which are high priority areas for measure consideration for MIPS. It’s utilized within the U.S. and internationally in research and has also been shown to be valid and reliable in different clinical settings and under different payment models. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2024 PFS final rule. See Table A.12 of this Appendix for rationale, including clinical evidence supporting the inclusion of this measure in MIPS.</p>

# Other 2024 Quality Measure Changes

## - **Measures Removed**

- 112 Breast Cancer Screening (still in MVPs)
- 113 Colorectal Cancer Screening (still in MVPs)
- 128 (BMI) Screening and Follow-up Plan (still in MVPs)

## - **Substantive changes include but not limited to:**

- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Coronary Artery Disease (CAD): Antiplatelet Therapy
- Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- **Many cardiac and other measures**

*See Full Fact Sheet Appendix for FULL LIST of measure changes!*

# Promoting Interoperability



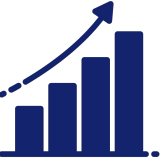
- ***The performance period for this category from 90 days to 180 days.***
- **Modifying** one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure for for clinicians who DO NOT prescribe schedule II, III, and IV drugs.
- Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to **require MIPS eligible clinicians to affirmatively attest to completion** of the self-assessment of their implementation of safety practices.

# Promoting Interoperability Reweighting



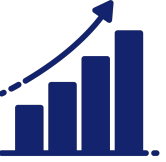
1. *CMS finalized continuation of automatic reweighting for the following clinician type in the 2024 performance period:*
  - **Clinical social workers**
2. *CMS **WILL NOT** continue automatic reweighting for physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitians or nutrition professionals for the 2024 performance period.*
3. *ASC-based, hospital-based, and non-patient facing clinicians and groups, along with clinicians in a small practice, **will continue to be automatically reweighted.***

# Improvement Activities



- Adding five new, modifying one existing, and removing three existing improvement activities from the Inventory.
  - Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
  - Practice-Wide Quality Improvement in MIPS Value Pathways
  - Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines
  - Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women
  - Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults

# Improvement Activities (cont.)



- **Removing** three activities to align with current clinical guidelines and practice and to eliminate duplication.
  - Implementation of co-location PCP and MH services
  - Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder
  - Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging
  
- **Modifications** to one
  - Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.

# Cost

- Adding five new episode-based measures to the cost performance category beginning with the CY 2024 performance period/2026 MIPS payment year. These include measures for:
  1. Depression
  2. Emergency Medicine
  3. Heart Failure
  4. Low Back Pain
  5. Psychoses and Related conditions.
- Removing the Simple Pneumonia with Hospitalization episode-based measure beginning with the CY 2024 performance period/2026 MIPS payment year.
- Procedural measure now requires a case minimum of 10 unless otherwise specified
- Up to 1 point cost Improvement maximum for YoY
- Updates to scoring policies, including a transition to a category-level cost improvement scoring method.

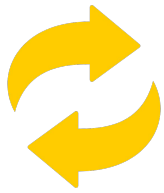


# MVPs

## Five new MVPs:

- Focusing on Women's Health
- Prevention and Treatment of Infectious Disease Including Hepatitis C and HIV
- Quality Care in Mental Health and Substance Use Disorder
- Quality Care for Ear, Nose, and Throat (ENT)
- Rehabilitative Support for Musculoskeletal Care

Consolidate old MVPs for Promoting Wellness AND Optimizing Chronic Disease Management into singular group known as “**Adult Universal Core Set**”



# MVP and Subgroup Reporting Changes

- **Facility based scoring for MVPs** - overlooked scoring for subgroups relative to facility association - fixing this going forward
- An MVP Participant that is a **subgroup** will receive the same reweighting that is applied to its affiliated group
- **Complex bonus for subgroups** - will get bonus from affiliated group since they cannot subtract the data specifically for a subgroup

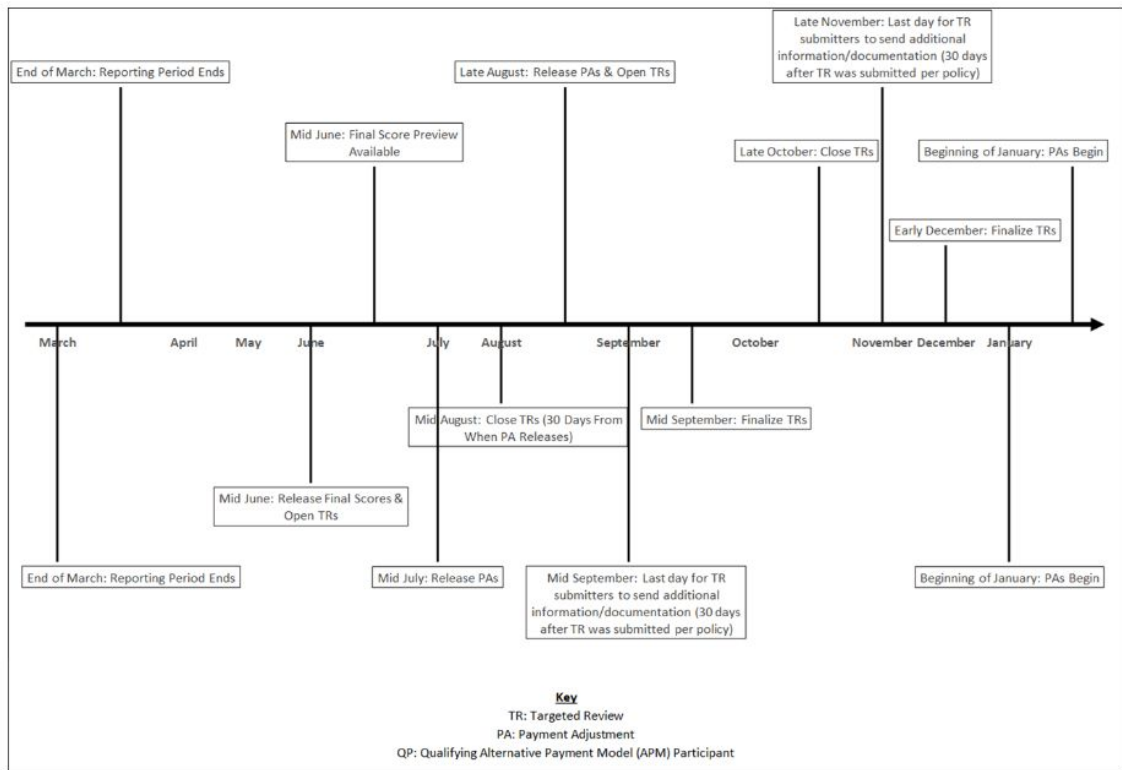


# Targeted Reviews

1. Beginning with the 2024 performance period, the targeted review submission period will open 30 days before payment adjustments are released AND 30 days after payment adjustments are released
2. Request to provide targeted review documentation will now be 15 days versus 30!
3. CMS will add virtual groups and subgroups to those eligible to submit a request for targeted review, as well as modifications to the timeline and requirements for this review.

# Targeted Review - Current vs Future Timing

**FIGURE 2: Current and Proposed Targeted Review Process**



# Estimated Payment Adjustments\*



- Maximum Penalty: -9%
- Over 54% of Clinicians and Practices Expected to Be Penalized -2.40%
  - This is an increase previously it was 36% that were penalized.
- *The rule reflects that the maximum positive payment adjustment could be as much as +8.82%\**

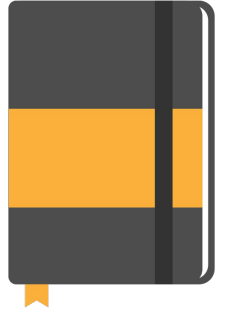
The case to do well is now stronger than ever!

# Other Policy Updates



- Providing additional procedure grouping flexibility for CMS to create clinically meaningful categories when one isn't available.
- Publicly reporting Medicare Advantage (MA) data, in addition to Medicare FFS utilization data counts, as appropriate and technically feasible, to address low volume counts and provide a more complete scope of a clinician's experience.
- Removing the policy to publicly report on the Provider Data Catalog (PDC), a subset of procedures from the Medicare Public Use File (PUF) and instead, providing a single downloadable dataset reflecting the same utilization data that would appear on clinician profile pages.

# References



**QPP 2024 Final Rule Resources - Full Fact Sheet and FAQ**

**2024 MVP Final Rule Resource Guide**

**eCFR Final Rule FULL Publication**

# Upcoming MIPS Deadlines



2024 MVP Registration Deadline - November 30th

2024 Virtual Group Election Deadline - December 31st

End of 2023 Performance Year - December 31st

EUC Deadline - January 2, 2024





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