2023/2024 Quality Payment Program Overview & Updates

Altarum Quality Improvement Advisor Services

December 12th, 2023

Cheryl Budimir

Quality Improvement Advisor

Before joining Altarum in 2018, she served as a Practice Administrator in physician-owned and organization practices for more than 33 years. Ms. Budimir has an extensive background in ensuring compliance with all State and Federal regulations and insurance quality standards and implementing sustainable care delivery models by focusing on process mapping, Lean, Swim Lane, PDCA, patient satisfaction, and data utilization to drive quality improvement and monitor patient outcomes. She is dedicated to helping clinicians and their staff. Her focus is on guiding them through the complexities of payer incentive programs. She also works on streamlining workflows, incorporating both federal and commercial carriers' initiatives.

Agenda

- Review the 2023 QPP End-of-Year Considerations and Timeline
  - Eligible Providers vs Opt-In
  - MIPS Performance Threshold
  - Individual Reporting vs Group Reporting
- Exam the 2024 QPP Program Changes
  - CEHRT Requirements
  - Checking eligibility Status
- High-level review of the three reporting options: Traditional MIPS, MIPS Value Pathways (MVP), and Alternative Payment Model (APM)(REACH)
- Create a 2024 QPP “To Do List.”
- Questions and Answers

2023 QPP Performance Year

Traditional MIPS

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2023 QPP Participation Status

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

November 2023: Updated PY 2023 eligibility special status based on a review of claims and PECOS data: October 1, 2022 - September 30, 2023.

This status is FINAL unless your QP status changes due to the 3rd APM snapshot in December 2023.

Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (**snapshot data generally available July 2023, October 2023, and December 2023**)

On December 8, the Centers for Medicare & Medicaid Services (CMS) updated its Quality Payment Program Participation Status Tool based on the third snapshot of Alternative Payment Model (APM) data. The third snapshot includes data from Medicare Part B claims with dates of service between January 1, 2023, and August 31, 2023.

2023 MIPS Reporting Considerations

MIPS Eligible Clinicians exceed the low-volume threshold and are required to report for MIPS

Opt-in clinicians are not required to report because they do not exceed all three low-volume threshold elements but exceed one or two of them.

A group can report if they meet the low-volume threshold, but it is not mandatory.

Final Score	Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (greater than -9% and less than 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)

You will always want to consider scoring individually and in groups, as sometimes the groups will score better together, and Medicare will take the highest score.

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2023 MIPS Reporting Record Keeping

Quality Performance Category

1. Keep a list of the 6 MIPS quality measures for the 12-month performance period and the results:

   1 of these 6 must be an outcome measure OR another high-priority measure without an applicable outcome measure.
2. The CAHPS for MIPS Survey measure is 1 of the 6 measures for registered groups, virtual groups, and APM Entities. It can be counted as a high-priority measure if there aren't any applicable outcome measures.

https://qpp.cms.gov/mips/explore-measures

2023 MIPS Reporting Record Keeping

Promoting Interoperability Category: 90-day reporting period Automatically Reweighted for Small Practices

https://qpp.cms.gov/mips/promoting-interoperability

Objectives	Measures		Requirements
e-Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Query of Prescription Drug Monitoring Program (PDMP)		Required unless an exclusion is claimed
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 or option 3 is reported
		Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed or option 2 or option 3 is reported
	Option 2	HIE Bi-Directional Exchange	Required (no exclusion available), unless option 1 or option 3 is reported
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (no exclusion available), unless option 1 or option 2 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting		Required unless an exclusion(s) is claimed
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting		Optional measures (no exclusions available)

There are now 3 options for clinicians to meet the requirements of the Health Information Exchange objective.

You need to choose and report 1 of these 3 options.

When reporting the required measures in the Public Health and Clinical Data Exchange objective, you'll also need to submit your level of active engagement.

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2023 MIPS Reporting Record Keeping

Promoting Interoperability Category: 90-day reporting period Automatically Reweighted for Small Practices

https://qpp.cms.gov/mips/promoting-interoperability

In addition to reporting the previously listed measures, you must also:

- 2015 Edition Cures Update CEHRT to meet the measures above and collect your data (certified by the last day of your performance period)
- Submit a "yes" to the Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT Attestation (previously named the Prevention of Information Blocking attestation)
- Submit a "yes" to the ONC Direct Review Attestation
- Submit a "yes" that you have completed the Security Risk Analysis Attestation measure during 2023
- Submit a "yes" or "no" to completing the High Priority Practices Guide of the SAFER Guides Attestation measure during 2023
- Submit your EHR's CMS Certification ID from the Certified Health IT Product List.

If any of these requirements **aren't met**, you'll get **0 points** in the Promoting Interoperability performance category.

2023 Security Risk Assessment

https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

The Security Risk Assessment Tool-Overview for Small and Medium Practices

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2015 Cures Act Update EMR Requirement for 2023

2015 Edition Cures Update CEHRT to meet the measures above and collect your data (certified by the last day of your performance period, 12/31/2023)

- Transitions of Care
- Clinical Information Reconciliation and Incorporation
- Electronic Prescribing
- Care Plan
- Auditable Events and Tamper-Resistance
- Audit Reports
- Encrypt Authentication Credentials
- Multi-factor Authentication
- View, Download, and Transmit to 3rd Party
- Consolidated CDA Creation Performance
- Application Access-All Data Request
- Standardized API for Patient and Population Services

https://chpl.healthit.gov/#/search

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High Priority Practices Guide of the SAFER Guides Attestation

https://www.healthit.gov/topic/safety/safer-guides

Safer EHRs: An Introduction to the SAFER Guides

Foundational Guides	•High Priority Practices* •Organizational Responsibilities*
Infrastructure Guides	•Contingency Planning* •System Configuration* •System Interfaces*
Clinical Process Guides	•Patient Identification* •Computerized Provider Order Entry with Decision Support* •Test Results Reporting and Follow-Up* •Clinician Communication*

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2023 MIPS Reporting Record Keeping

Improvement Activity Category

2023 MIPS Data Validation Criteria

- Small Practice < 15 clinicians:
  - 1 High-Weighted Activity **OR**
  - 2 Medium-Weighted Activities
- Large Practice >15 clinicians
  - 2 High-Weighted Activities **OR**
  - 4 Medium-Weighted Activities **OR**
  - 1 High-Weighted **and**

    2 Medium-Weighted Activities

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2023 MIPS Reporting Record Keeping

Cost Performance Category

2023 MIPS Cost User Guide

- Clinicians and groups will only be scored on the measure if they're attributed beneficiary months for at least 20 patients.
- CMS will automatically evaluate and calculate data from administrative claims for measures meeting the case minimum requirement.
- Better care coordination and improving health outcomes will reduce cost
- Track: Admit, Discharge, and Transfer (ADT) notifications
- Call discharged patients and see them in follow-up in the office

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2023 MIPS Reporting Record Keeping

Cost Performance Category- 2023 MIPS Cost User Guide

Measure Name	Measure Type	Episode Window	This measure evaluates a clinician's risk-adjusted cost to Medicare for....	Measure can be triggered based on claims data from the following settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	Pre-Trigger Period= zero days Post-Trigger Period= 30 days	Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.	Ambulatory/office-based care centers, hospital outpatient departments (HOPDs), Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who receive an elective knee arthroplasty during the performance period.	Acute inpatient (IP) hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period.	ASCs, HOPDs and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	Pre-Trigger period=60 days Post-Trigger period=90 days	Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.	ASCs, ambulatory/office-based care, and HOPDs
Screening/Surveillance Colonoscopy	Procedural	Pre-Trigger Period= zero days Post-Trigger Period= 14 days	Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.	ASCs, ambulatory/office-based care, HOPDs

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2023 MIPS Cost Performance Category

Measure Name	Measure Type	Episode Window	This measure evaluates a clinician's risk-adjusted cost to Medicare for....	Measure can be triggered based on claims data from the following settings:
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Pre-Trigger Period= zero days Post-Trigger Period= 30 days	Patients who receive their first inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals
Elective Primary Hip Arthroplasty	Procedural	Pre- Trigger Period= 30 days Post-Trigger Period=90 days	Patients who receive an elective primary hip arthroplasty during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Femoral or Inguinal Hernia Repair	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Hemodialysis Access Creation	Procedural	Pre-Trigger Period= 60 days Post-Trigger Period=90 days	Patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period.	Ambulatory/office-based care centers, outpatient (OP) hospitals, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who undergo surgery for lumbar spine fusion during the performance period.	ASCs, HOPDs, and acute IP hospitals
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who undergo partial or total mastectomy for breast cancer during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, and ASCs
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Patients who undergo a non-emergent CABG procedure during the performance period.	Acute IP hospitals
Renal or Ureteral Stone Surgical Treatment	Procedural	Pre-Trigger Period= 90 days Post-Trigger Period=30 days	Patients who receive surgical treatment for renal or ureteral stones during the performance period.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs

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2023 MIPS Cost Performance Category

Measure Name	Measure Type	Episode Window	This measure evaluates a clinician's risk-adjusted cost to Medicare for….	Measure can be triggered based on claims data from the following settings:
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	Pre-Trigger Period= zero days Post-Trigger Period=90 days	Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.	Acute IP hospitals
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	Pre-Trigger Period= zero days Post-Trigger Period= 30 days	Patients who receive inpatient treatment for simple pneumonia during the performance period.	Acute IP hospitals
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	Pre-Trigger Period=zero days Post-Trigger Period= 30 days	Patients who present with ST-Elevation Myocardial Infarction indicating complete blockage of a coronary artery who emergently receive Percutaneous Coronary Intervention as treatment during the performance period.	Acute IP hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Pre-Trigger Period= zero days Post-Trigger Period= 60 days	Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.	Acute IP hospitals
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	Pre-Trigger Period= zero days Post-Tigger period=35 days	Patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period.	Acute IP hospitals
Melanoma Resection	Procedural	Pre-Trigger Window: 30 days Post-Trigger Window: 90 days	Patients who undergo an excision procedure to remove a cutaneous melanoma during the performance period.	ASCs, ambulatory/office-based care, and HOPDs.
Colon and Rectal Resection	Procedural	Pre-Trigger Window: 15 days Post-Trigger Window: 90 days	Patients who receive a colon or rectal resection for either benign or malignant indications during the performance period.	ASCs, HOPDs, and acute IP hospitals.
Sepsis	Acute inpatient medical condition	Pre-Trigger Window: 0 days Post-Trigger Window: 45 days	Patients who receive inpatient medical treatment for sepsis during the performance period.	Acute IP hospitals.

2023 MIPS Performance Category Weighting

2023 MIPS Performance Category Weights:
Individual, Group, Subgroup, and Virtual Group Participation

Quality	Promoting Interoperability	Improvement Activities	Cost
			
30% of MIPS Score	25% of MIPS Score	15% of MIPS Score	30% of MIPS Score

2023 MIPS Performance Category Weights:
APM Entity Participation Without meeting QP status

55% Quality	30% Promoting Interoperability	15% Improvement Activities	0% Cost

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2023 MIPS Qualifying APM Participant (QP) Status

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

- **QP status** clinicians have received at least **50%** of their Medicare Part P Payments or have seen at least **35%** of Medicare patients through an Advanced APM during the QP performance period (January 1, 2023 - August 31, 2023)

- Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (snapshot data generally available July 2023, October 2023, and **December 2023)**

- QPs receive a 5% APM Incentive Payment, equal to 5% of the estimated total payments for covered professional services during the calendar year before the payment year
  - QP Performance Year 2023 (January 1, 2023 – August 31, 2023) >Incentive Payment Base Year (January 1, 2024 – December 31, 2024) > Payment Year 2025

https://qpp.cms.gov/apms/advanced-apms

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2023 MIPS Partial Qualifying APM Participant Status (Partial QP)

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

- Not all clinicians achieve QP status; some may be eligible to become Partial QPs.
- Clinicians that reach **Partial QP status** received at least **40%** of their Medicare Part P Payments or have seen at least **25%** of Medicare patients through an Advanced APM during the QP performance period (January 1- August 31)
- The benefit of achieving **Partial QP status** includes choosing whether to participate in MIPS.
  - If clinicians choose not to report to MIPS:
    a. These clinicians will not receive an MIPS payment adjustment.
  - If clinicians choose to report to MIPS: (meet or exceed the 75-point threshold)
    a. These clinicians must fulfill all MIPS reporting requirements.
    b. These clinicians must complete a submission to MIPS by reporting either:
       i. APM Performance Pathway (APP)
       ii. Traditional MIPS

https://qpp.cms.gov/apms/advanced-apms

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2023 MIPS APM Participant Status- QP Status Not Met

- If a clinician is determined not to be a QP or a Partial QP, they must participate in MIPS and submit category data.
- Will be subject to MIPS Final Score and Payment Adjustment unless otherwise excluded
- CMS recommends working with your APM directly to see the requirements, as each APM differs.
- If the APM is not reporting on behalf of the provider, the provider will need to report MIPS if they are eligible

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

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

(2023 Learning Resources for QP Status and APM Incentive Payment)

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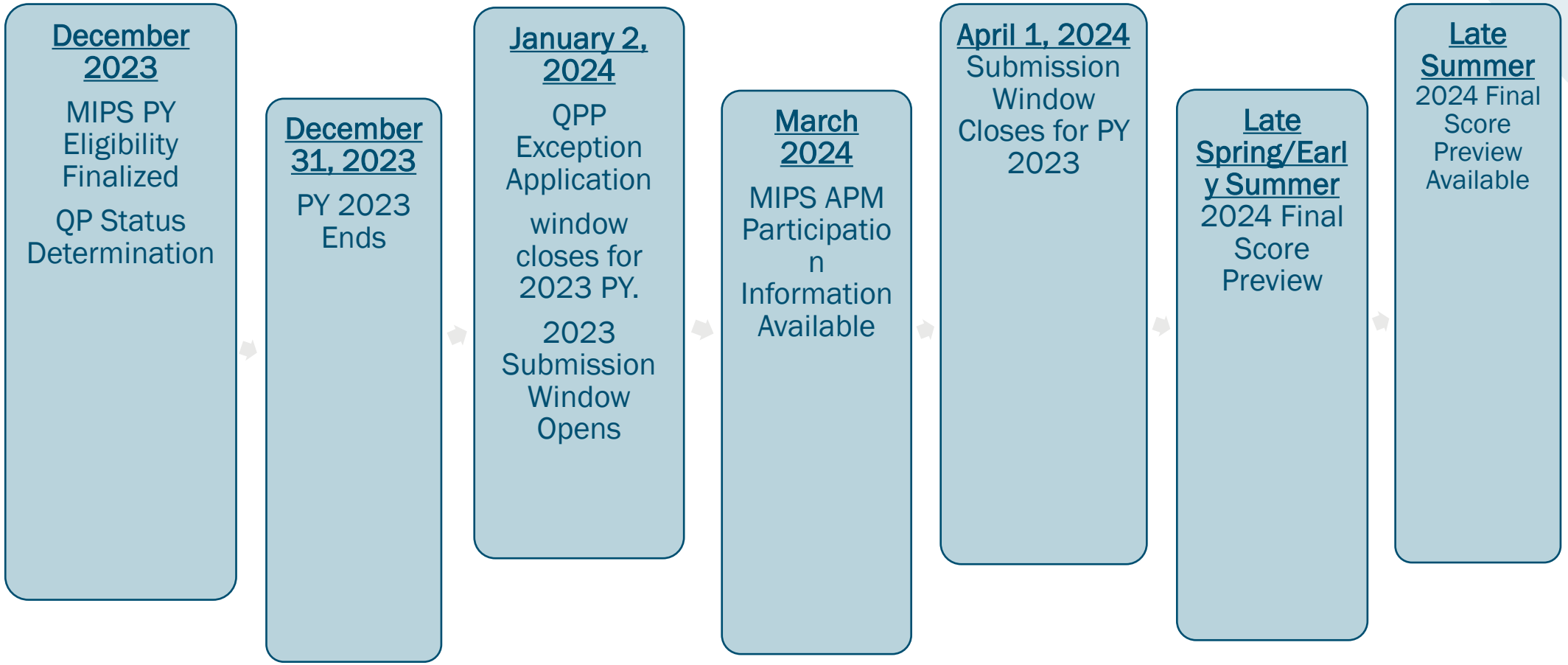
2023 MIPS Reporting Timeline



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2023 MIPS Audit File Checklist

In accordance with the federal False Claims Act you are encouraged to keep QPP documentation for up to six (6) years and, as stated in the QPP Final Rule, the Centers for Medicare and Medicaid Services (CMS) may request any records or data retained for MIPS purposes for six (6) years for each year of attestation. In the event you receive an audit, you will need to supply information to substantiate your MIPS participation. An Audit File should be kept in hard copy, and/or electronic copy, either locally or via cloud. If you receive an audit request from the Centers for Medicare & Medicaid Services (CMS), your initial response is required within ten (10) business days to acknowledge the request. From the date of the initial request, you will have forty-five (45) calendar days to complete data sharing as requested, or an alternative timeframe that is agreed upon by Centers for Medicare & Medicaid Services (CMS) and the MIPS-eligible Clinician or Group. Federal False Claims Act or https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf

EHR Vendor & Product Name	Recommended Content for EC's Audit File	Content in Audit File?
PROOF OF CERTIFIED EHR TECHNOLOGY (CEHRT): https://chpl.healthit.gov/#/search **CMS EHR Certification ID:**_____	A copy of the purchase agreement/contract with the vendor from whom the CEHRT was purchased identifying the vendor name, product name and product version used for attestation.	☐ **Yes** ☐ **No** ☐ **N/A**
EHR Vendor: _____ **EHR Product:** _____ **EHR Version:** _____	If EHR reporting is used to submit Quality measure data, documentation to show all measures reported are certified by the EHR vendor (s) and meet the most recent electronic specification.	☐ **Yes** ☐ **No** ☐ **N/A**

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2023 MIPS Audit File Checklist

Quality Category
List Quality Measures that were reported for MIPS Program Year 2022 Please refer to the 2022 MIPS Data Validation Criteria for suggested documentation details which can be found Here or at https://qpp.cms.gov/about/resource-library.

Quality Measure/Quality Measure ID	Documented on Quality Report?
1.	☐ Y | ☐ N
2.	☐ Y | ☐ N
3.	☐ Y | ☐ N
4.	☐ Y | ☐ N
5.	☐ Y | ☐ N
6.	☐ Y | ☐ N
Additional Quality measure reported:	☐ Y | ☐ N
Additional Quality measure reported:	☐ Y | ☐ N
Recommended Content for EC's Audit File	**Content in Audit File?**
If you report via EHR, print out your quality submission on the CMS Quality Payment Program website, which includes the category score, the list of all measure(s) reported, and any earned bonus points, and whether you uploaded a QRDA III file or the EHR vendor submitted your information.	☐ Yes ☐ No ☐ N/A

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2023 MIPS Audit File Checklist

If you report via registry, make sure to keep a paper or electronic copy of (document) the registry confirmation you receive stating your data was submitted to CMS. Request a performance scorecard from your registry (QCDR or Clinical Registry).	☐ Yes ☐ No ☐ N/A
CEHRT generated CQM reports from which attestation data was derived.	☐ Yes ☐ No ☐ N/A
CEHRT generated QRDA III files from which CQM attestation data was derived and where the file is being stored.	☐ Yes ☐ No ☐ N/A
If reporting as a group, a policy and/or other proof that shows quality data was submitted for all EC's in the TIN, including any individuals who may subsequently be excluded from MIPS payment adjustments (e.g., new Medicare Clinicians; Low Volume Clinicians).	☐ Yes ☐ No ☐ N/A
Evidence to support compliance with data completeness criteria, per specific data submission mechanism, such as, Medicare Part B claims, and/or reports of the QCDR Measures, MIPS CQMs, and eCQMs submitted. Maintain a copy of all aggregated data if reporting as a group, and proof that the data was submitted for all Eligible Clinician's in the TIN. (Example: copies of individual reports)	☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A
Documentation to support why fewer than six (6) measures, or no priority or outcome measure, was submitted, if applicable. Write a statement saying why there are less than six (6) quality measures (example: lack of clinical relevance) and have Eligible Clinician sign and date it.	☐ Yes ☐ No ☐ N/A

Questions?

2024 QPP Performance Year

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2024 QPP Participation Status

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

November 2023: Updated to reflect initial PY 2024 eligibility statuses based on claims analysis and PECOS data: October 1, 2022 - September 30, 2023.

Your PY 2024 eligibility status can be updated throughout the year based on the following:

Analysis of claims and PECOS data from October 1, 2023 - September 30, 2024 (available November 2024)

Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (**snapshot data generally available July 2024, October 2024, and December 2024**)

2024 MIPS Qualifying APM Participant (QP) Status-Change

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

- **QP status** clinicians have received at least 75% of their Medicare Part P Payments or have seen at least 50% of Medicare patients through an Advanced APM during the QP performance period (January 1, 2024 - August 31, 2024)

- Qualifying APM Participant (QP) determinations and eligibility to report to MIPS via the APM Performance Pathway (snapshot data generally available July 2024, October 2024, and December 2024)

https://qpp.cms.gov/apms/advanced-apms

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2024 MIPS Partial Qualifying APM Participant Status-Change (Partial QP)

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

- Not all clinicians achieve QP status; some may be eligible to become Partial QPs.
- Clinicians that reach **Partial QP status** received at least 50% of their Medicare Part P Payments or have seen at least 35% of Medicare patients through an Advanced APM during the QP performance period (January 1- August 31)
- The benefit of achieving **Partial QP status** includes choosing whether to participate in MIPS.
  - If clinicians choose not to report to MIPS:
    a. These clinicians will not receive an MIPS payment adjustment.
  - If clinicians choose to report to MIPS: (meet or exceed the 75-point threshold)
    a. These clinicians must fulfill all MIPS reporting requirements.
    b. These clinicians must complete a submission to MIPS by reporting either:
       i. APM Performance Pathway (APP)
       ii. Traditional MIPS

https://qpp.cms.gov/apms/advanced-apms

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2024 MIPS APM Conversion Factor-Change

- Beginning for the 2024 performance year/**2026 payment year**,
  - QPs will receive a higher Medicare Physician Fee Schedule (PFS) update ("qualifying APM conversion factor") than non-QPs.
- QPs will remain excluded from MIPS reporting and payment adjustments for the applicable year.
- For **payment years 2026 and beyond**, payment rates under the Medicare PFS for services furnished by the eligible clinician will be updated by the 0.75 percent qualifying

APM conversion factor. [2]

https://qpp.cms.gov/apms/advanced-apms

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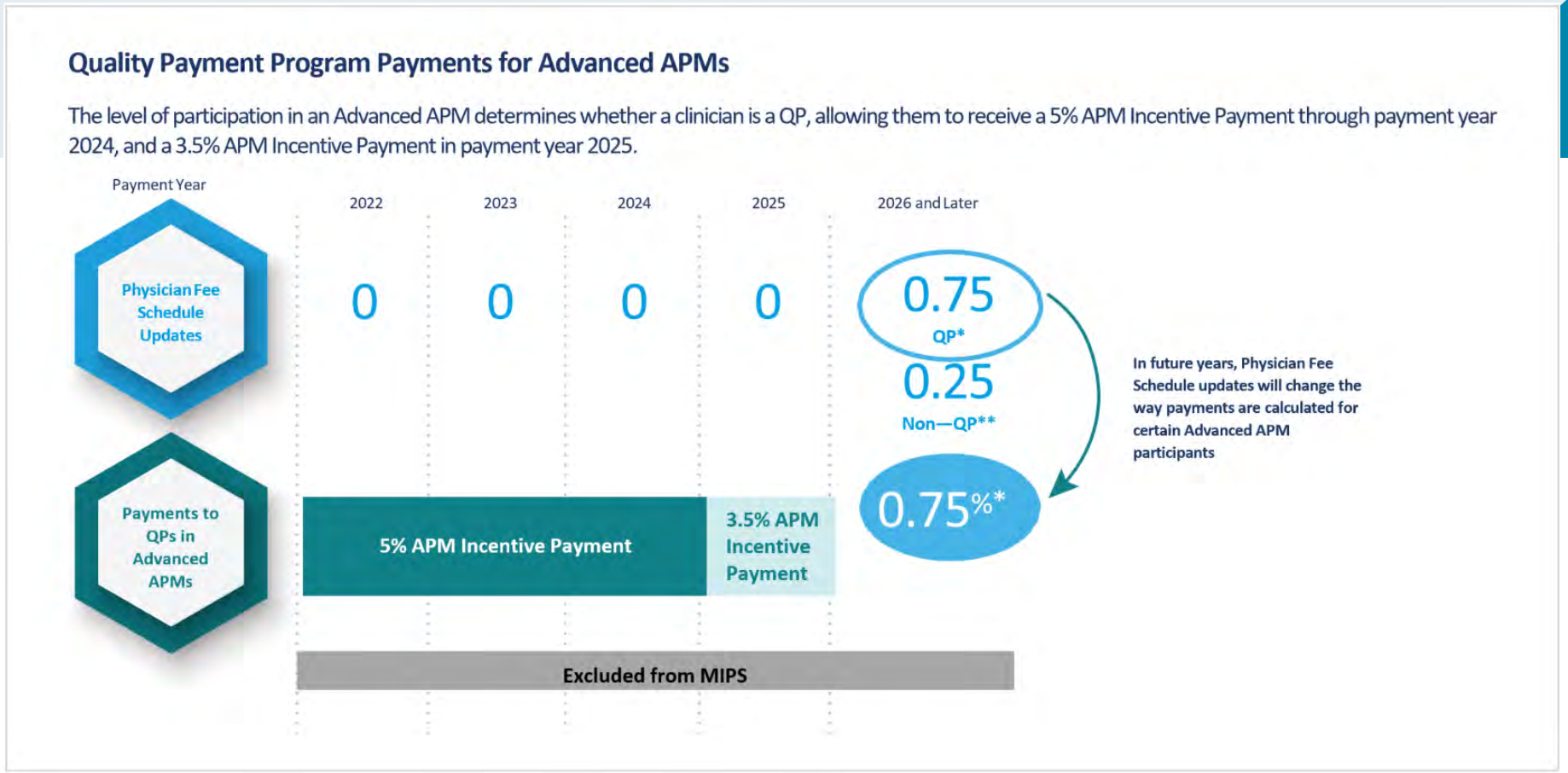
2024 MIPS APM Conversion Factor-Change



APM conversion factor. [2]

https://qpp.cms.gov/apms/advanced-apms

2024 MIPS Determination Period

MIPS Eligibility: ✔ INDIVIDUAL ✔ GROUP

MIPS Eligibility: ⊘ INDIVIDUAL ⊘ GROUP
Opt-in Option: Opt-in eligible as group

MIPS Eligibility: ⊘ INDIVIDUAL ⊘ GROUP

Low-Volume Thresholds:

Clinician Level

- Medicare Patients exceed 200
- Allowed charges exceed $90,000.
- Covered services exceed 200

Practice Level

- Medicare Patients exceed 200
- Allowed charges exceed $90,000.
- Covered services exceed 200

MIPS Eligible Clinicians exceed the low-volume threshold and are required to report for MIPS

Opt-in clinicians are not required to report because they do not exceed all three low-volume threshold elements but exceed one or two of them.

A group can report if they meet the low-volume threshold, but it is not mandatory.

You will always want to look at scoring both ways, individually and in groups, as sometimes the groups will score better together, and Medicare will take the highest score.

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2024 QPP Policy Changes

- The performance threshold remains at 75 points for the 2024 PY

2024 Performance Period	
2024 Final MIPS Score	**2026 MIPS Adjustment**
0.0-18.75	Negative 9%
18.76-74.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
75.0	0% adjustment
75.01-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00 This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality.

- Data Completeness is 75% in the 2024 PY

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2024 QPP Policy Changes

- Addition of 11 new Quality Measures:
- Removed the following 11 Quality Measures from MIPS:
- Three quality measures removed from traditional MIPS but still retained for MVP use only
  1. #112 Breast Cancer Screening
  2. #113 Colorectal Cancer Screening
  3. #128 Preventive Care & Screening BMI and Follow-up
- Substantive changes to 59 existing quality measures
- Five new Improvement Activities
- Removed three existing Improvement Activities:

IA_BMH_6	Implementation of co-location PCP and MH services	Medium / Behavioral and Mental Health
IA_BMH_13	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder	Medium / Behavioral and Mental Health
IA_ PSPA_29	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	High / Patient Safety and Practice Assessment

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

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2024 QPP Policy Changes

- Increased the performance period to 180 continuous days in the Promoting Interoperability
- Automatic Reweighting Promoting Interoperability for Clinical social workers
- No longer automatically reweighted Promoting Interoperability for the clinicians:
  - Physical Therapist, Occupational Therapist, Qualified speech-language pathologists, clinical psychologist, registered dietitians, or nutrition professionals
- PDMP Exclusion: “Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period.”
- A “Yes” response is required on the SAFER Guides Measure.
  - Clinicians only need to review the High Priority Practices SAFER Guide.

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

2015 Cures Act Update EMR Requirement for 2024

- Transitions of Care
- Clinical Information Reconciliation and Incorporation
- Electronic Prescribing
- Care Plan
- Auditable Events and Tamper-Resistance
- Audit Reports

- Encrypt Authentication Credentials
- Multi-factor Authentication
- View, Download, and Transmit to 3rd Party
- Consolidated CDA Creation Performance
- Application Access-All Data Request
- Standardized API for Patient and Population Services

https://chpl.healthit.gov/#/search

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2024 MIPS Performance Category Weighting-Placeholder

Quality	Promoting Interoperability	Improvement Activities	Cost
			
of MIPS Score	of MIPS Score	of MIPS Score	of MIPS Score
Quality	Promoting Interoperability	Improvement Activities	0% Cost

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Questions?

QPP reporting option: MIPS Value Pathways (MVP)

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2024 MVPs

Newly Finalized MVPs

TABLE A.1: FOCUSING ON WOMEN'S HEALTH MVP 5
TABLE A.2: QUALITY CARE FOR THE TREATMENT OF EAR, NOSE, AND THROAT DISORDERS MVP 8
TABLE A.3: PREVENTION AND TREATMENT OF INFECTIOUS DISORDERS INCLUDING HEPATITIS C AND HIV MVP 11
TABLE A.4: QUALITY CARE IN MENTAL HEALTH AND SUBSTANCE USE DISORDERS MVP 14
TABLE A.5: REHABILITATIVE SUPPORT FOR MUSCULOSKELETAL CARE MVP 17

Modifications to Previously Finalized MVPs

TABLE B.1: ADOPTING BEST PRACTICES AND PROMOTING PATIENT SAFETY WITHIN EMERGENCY MEDICINE MVP 20
TABLE B.2: ADVANCING CANCER CARE MVP 23
TABLE B.3: ADVANCING CARE FOR HEART DISEASE MVP 26
TABLE B.4: ADVANCING RHEUMATOLOGY PATIENT CARE MVP 30
TABLE B.5: COORDINATING STROKE CARE TO PROMOTE PREVENTION AND CULTIVATE POSITIVE OUTCOMES MVP 33
TABLE B.6: IMPROVING CARE FOR LOWER EXTREMITY JOINT REPAIR MVP 36
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TABLE B.11: VALUE IN PRIMARY CARE MVP 50

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2024 MVPs

Quality Performance Category

- Select and submit 4 quality measures.
- At least one measure 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.

Improvement Activities Performance Category

- Select and submit 2 medium-weighted improvement activities **OR** one high-weighted improvement activity **OR** IA_PCMH activity.

Cost Performance Category

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

Foundational Layer

Population Health Measures

- Must select one population health measure at the time of MVP registration. CMS will calculate these measures through administrative claims and will be scored as part of the quality performance category.
- For the 2024 performance period, there are 2 population health measures available for selection:
  - 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 you qualify for reweighting of the Promoting Interoperability performance category.

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2024 MVP Example

TABLE B.4: Advancing Rheumatology Patient Care MVP

Beginning with the CY 2024 MIPS Performance Period / 2026 MIPS Payment Year

As noted in the beginning of this resource, we're modifying the previously finalized Advancing Rheumatology Patient Care MVP within the quality performance category of this MVP to:

- Add 4 quality measures
- Remove 1 quality measure
- Add 4 improvement activities

Clinicians Who Practice in the Following Specialty May Want to Consider Reporting This MVP:

- Rheumatology
- Nurse practitioners
- Physician assistants

Measure Key

+	Additional quality measurers, improvement activities, and cost measures
^	New MIPS quality measures, improvement activities, and cost measures
*	Existing quality measures and improvement activities with revisions
!	High priority quality measures
!!	Outcome measures
~	Improvement activities that include a health equity component
%	Attestation to IA_PCMH provides full credit for the improvement activities performance category

Modifications to the Advancing Rheumatology Patient Care MVP

Quality	Improvement Activities	Cost
(!) Q130: Documentation of Current Medications in the Medical Record (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications)	(~) IA_AHE_3: Promote Use of Patient-Reported Outcome Tools (High)	Total Per Capita Cost (TPCC)
(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications)	(~) IA_BE_1: Use of Certified EHR to Capture Patient Reported Outcomes (Medium)	
Q176: Tuberculosis Screening Prior to First Course Biologic Therapy (Collection Type: MIPS CQMs Specifications)	IA_BE_4: Engagement of Patients through Implementation of Improvements in Patient Portal (Medium)	
Q177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity (Collection Type: MIPS CQMs Specifications)	(+) IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings (High)	
Q178: Rheumatoid Arthritis (RA): Functional Status Assessment (Collection Type: MIPS CQMs Specifications)	IA_BE_15: Engagement of Patients, Family and Caregivers in Developing a Plan of Care (Medium)	
	(+) IA_BE_24: Financial Navigation Program (Medium)	
	(+) IA_BE_25: Drug Cost Transparency	

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Quality	Improvement Activities	Cost
Q180: Rheumatoid Arthritis (RA): Glucocorticoid Management (Collection Type: MIPS CQMs Specifications)	(High)	
(+)(*)(!) Q487: Screening for Social Drivers of Health (Collection Type: MIPS CQMs Specifications)	IA_BMH_2: Tobacco Use (Medium)	
(*)(+) Q493: Adult Immunization Status (Collection Type: MIPS CQMs Specifications)	(~) IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (High)	
(^)(+)(!!) Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQMs Specifications)	(~) IA_EPA_2: Use of Telehealth Services that Expand Practice Access (Medium)	
ACR12: Disease Activity Measurements for Patients with PsA (Collection Type: QCDR)	(^)(+) IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways (High)	
(!!) ACR14: Gout Serum Urate Target (Collection Type: QCDR)	(%) IA_PCMH: Electronic Submission of Patient Centered Medical Home Accreditation	
(!) ACR15: Safe Hydroxychloroquine Dosing (Collection Type: QCDR)	IA_PM_16: Implementation of Medication Management Practice Improvements (Medium)	
(+)(!!) UREQA10: Ankylosing Spondylitis: Controlled Disease Or Improved Disease Function (Collection Type: QCDR)	IA_PSPA_28: Completion of an Accredited Safety or Quality Improvement Program (Medium)	

Foundational Layer

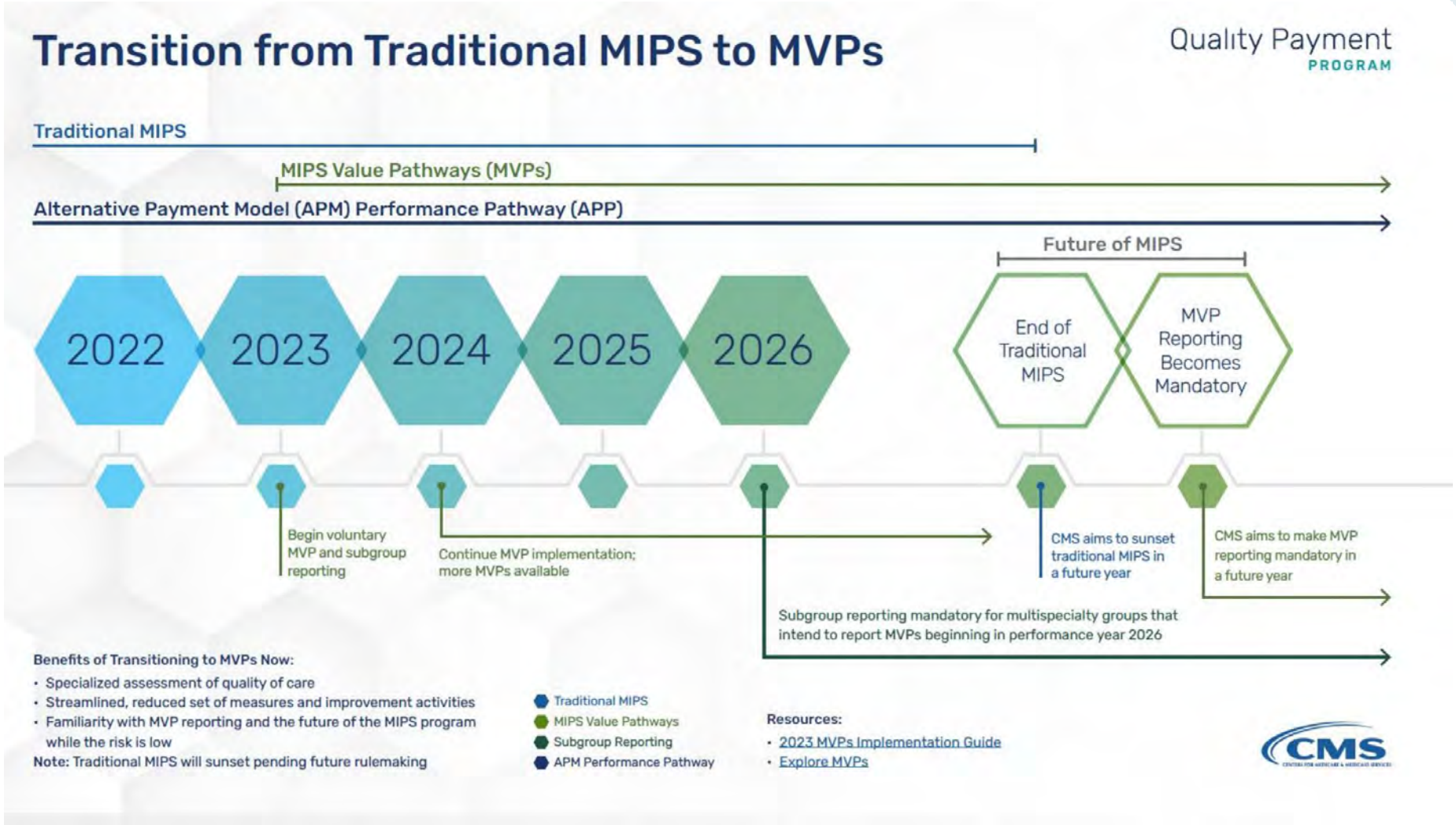
Population Health Measures	Promoting Interoperability
(!!) Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims)	• Security Risk Analysis • High Priority Practices 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
(!!) Q484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims)	

Foundational Layer

Population Health Measures	Promoting Interoperability
	• 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

MVPs Timeline

[MIPS Value Pathways (cms.gov)]



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2024 QPP To Do List

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2024 QPP To Do List	
	Sign Up for the QPP Small Practice Monthly Newsletter
	Sign Up for the CMS List serv
	Add the QPP Resource Library to your favorites and check often
	Add to favorites Small Practices PY 2023 (cms.gov) (2024 update pending)
	Contact your EMR Vendor, when will 2024 Quality Measures be available & what will be available
	Add to favorites: QPP Webinar Library
	Complete 2023 QPP Audit File Checklist (Cheryl B will share once available)
	Decide if an MVP is a better choice than Traditional MIPS MIPS Value Pathways (cms.gov)
	If you're not already in the APM, consider joining REACH ACO

Questions?

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Thank You!

Questions, please reach out to Cheryl.Budimir@altarum.org.

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