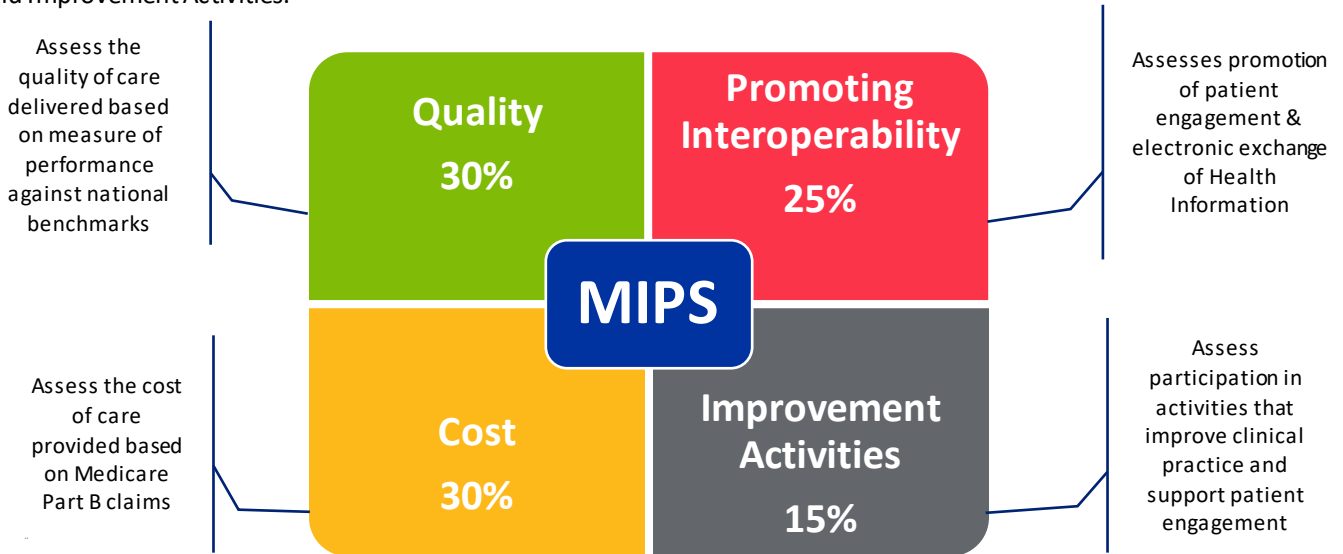# QPP Year 7: 2023 MIPS (Merit-Based Incentive Payment System) Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is the legislative act passed by Congress creating the Quality Payment Program or QPP. This program is designed to provide a coordinated framework for clinicians to participate in transitioning from a fee-for-service industry to a value-based industry. Through this program, CMS rewards value in 1 of 2 ways: through participation in MIPS (Merit-Based Incentive Payment System) or via Advanced APMs (Advanced Alternative Payment Models). MIPS Participants, deemed Eligible Clinicians, are subject to a performance-based payment adjustment. Participants in Advanced APMs deemed Qualifying Participants are excluded from MIPS participation. New for PY2023, MIPS Value Pathways (MVPs) is a more focused approach to aligning measures relevant to the scope of a clinician's practice that is meaningful to care. Participation in MVPs is voluntary at this time and can replace or be in addition to Tranditional MIPS reporting.

MIPS 2023 Performance Category Highlights

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). The program is the mechanism by which CMS reimburses MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes. Under MIPS, CMS evaluates clinician and/or group performance across 4 main categories that lead to improved outcomes & experiences, reduce costs, and value in healthcare: Quality, Promoting Interoperability, Cost, and Improvement Activities.

Assess the quality of care delivered based on measure of performance against national benchmarks

Quality 30%	**Promoting Interoperability 25%**
Cost 30%	**Improvement Activities 15%**

MIPS

Assesses promotion of patient engagement & electronic exchange of Health Information

Assess the cost of care provided based on Medicare Part B claims

Assess participation in activities that improve clinical practice and support patient engagement

MIPS Reporting Levels: Collection & Submission of MIPS Data

Individual Eligible Clinicians or ECs: an NPI tied to a single TIN
Group: Unique Tax Identification Number (TIN) composed of multiple NPIs
Virtual Group: 2 + TINs forming a group for MIPS reporting purposes
APM Entity: MIPS APM ECs

Programmatic Threshold Changes						
Program Year: 2017	2018	2019	2020	2021	2022	2023
Penalty Avoidance: 3 points	15 points	30 points	45 points	60 points	75 points	75 points
Exceptional Performer: 70 points	70 points	75 points	85 points	85 points	89 points	Discontinued
Payment Year: 2019	2020	2021	2022	2023	2024	2025

MIPS 2023 Performance Category Reporting Overview

Quality	Cost	Improvement Activities	Promoting Interoperability
• Select +6 measures for monitoring & submission • Collect data for 12-mo performance period • 1/1-12/31 • Requires JSON or QRDA-3 data file for submission • 60 total category pts	• Calculated based on claims submitted to CMS duing performance period • Must meet case minimums to trigger measures • Real-time benchmarking; feedback available AFTER close of performance year	• Attestation of 2-4 activities • 40 total category pts • Medium weighted - 10 pts • High weighted - 20 pts • Special Statuses may be applied that allow for more favorable scoring	• Required minimum 2015 CEHRT Cures Act • Submit 90-continuous day performance period • 4 Main objectives & corresponding measures • Must pass measures include: Annual SRA, SAFER Guides Attestation, Public Reporting, and HIE

Traditional MIPS Reporting & Scoring Highlights

➢ Submit data for Quality, Improvement Activities (IA) and Promoting Interoperability (PI) categories.
  o Submission via QPP portal January 1, 2024-March 31, 2024 for PY 2023
  o Special Statuses provide flexibilities related to category reporting requirements or re-weighting policies
  o Removal of CMS Web Interface submission mechanism for PY 2023 for Traditional MIPS
➢ Data may be submitted at the individual EC and/or Group-levels.
  o CMS will take the highest score across submission methods for each category & across levels of reporting and apply it to the MIPS EC's Final Score calculation.
➢ Each MIPS Category has a specific % weighting, that when combined, results in a Final MIPS Score ranging from 0-100 pts.
  o This Final MIPS score determines whether the TIN (group) and/or individual Eligible Clinician receives a negative, neutral or positive payment adjustment.
  o ECs and Groups may be eligible for Complex Patient Bonus Scoring. This is applied to the final MIPS score and can be valued at up to 10pts. Scoring methodology has been updated in 2023 to reflect medical and social complexity.
➢ Maximum +/- 2023 Payment Adjustment is 9%; 2023 payment adjustments are reflected in Medicare Part B payments and covered professional services beginning January 1, 2025.
➢ Performance Feedback & Final Payment adjustment determinations for the 2023 performance year will be available in the summer of 2024

CMS Path to Value

Value in healthcare can be defined as the proportional relationship between the overall quality of care and patient outcomes vs. the total cost of care. Managing and reducing costs and improving patient outcomes and perceptions of care delivery systems is a primary aim of the QPP. CMS has created a progressive pathway for clinicians and groups to shift from fee-for-service reimbursement to fully dual-sided risk. Traditional MIPS is the initial entry point to begin this journey of pay-for-performance with the ultimate goal for practices and providers to be engaged in payment models such as Advanced APMs balancing high quality care at lower costs.

Fee-For-Service/Volume MIPS MVPs APMs Advanced APMs *Value-Based Care*
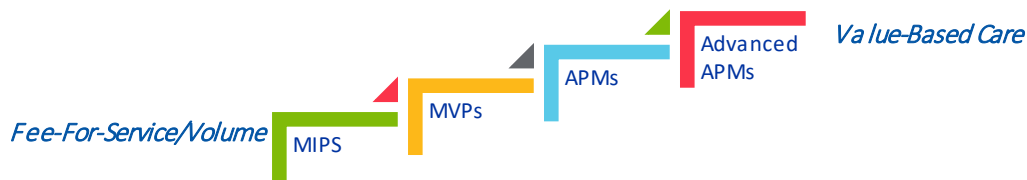
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