



MIPS reporting 2024

July 11, 2024



Presented by



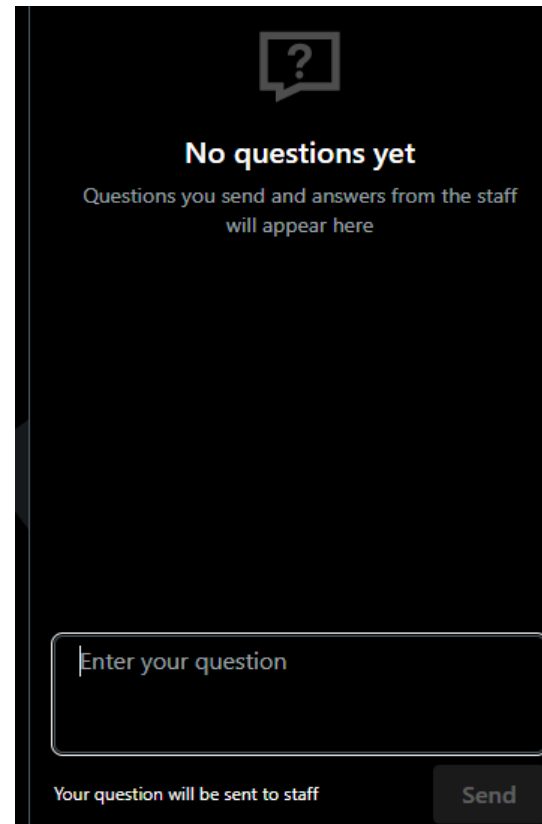
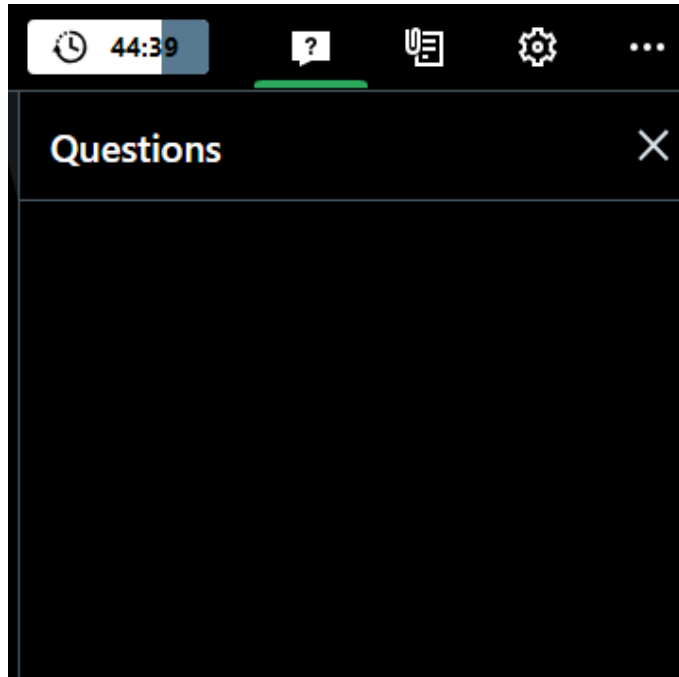
Debbie Belczyk
Account Manager



Stephanie Acheson
Technology Advisor

Handouts and questions

GoToWebinar widget



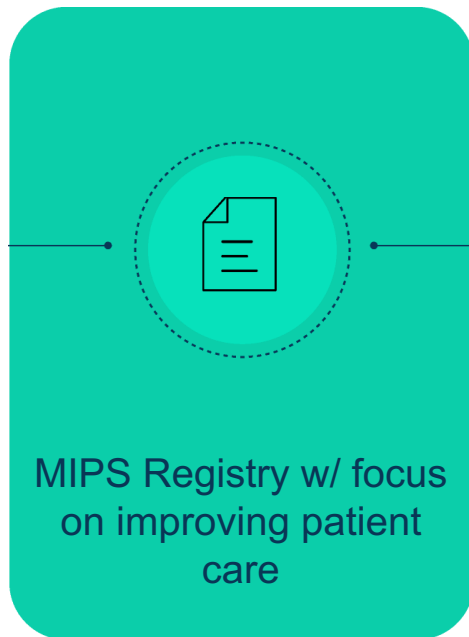
Questions can be submitted throughout via the **questions section** of the GoToWebinar widget.



Agenda

- Understanding MIPS
- 2024 MIPS requirements
- How to get started
- Navigate the system
- Timeline and submission deadlines

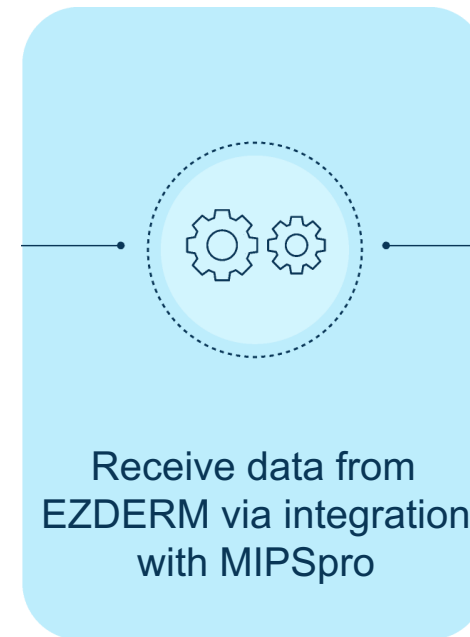
Partnership



MIPS Registry w/ focus on improving patient care



Partnership with EZDERM since 2017



Receive data from EZDERM via integration with MIPSpro

What is MIPS?

What is MIPS?

MIPS: The Merit-based Incentive Payment System

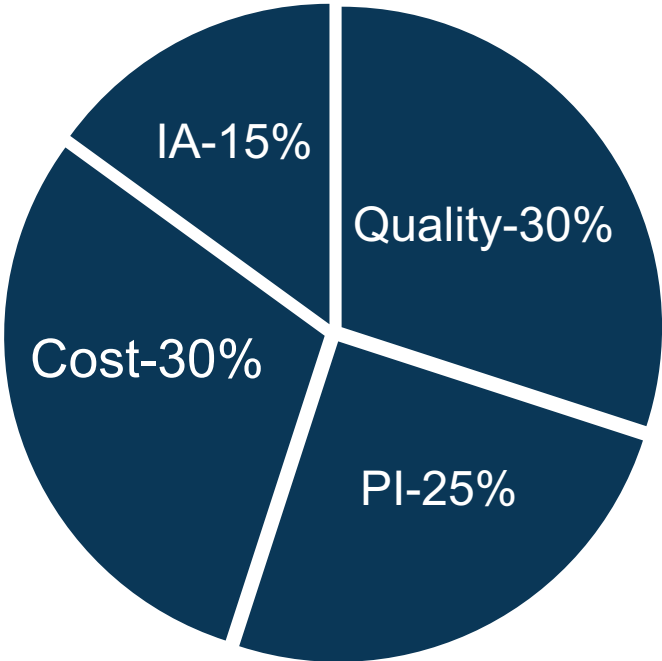
Quality: Assesses the value of care to ensure patients get the right care at the right time

Improvement Activities (IA): Gauges participation in activities that improve clinical practice

Promoting Interoperability (PI): Measures how well a clinician utilizes their EHR technology

Cost: Measures the cost of care

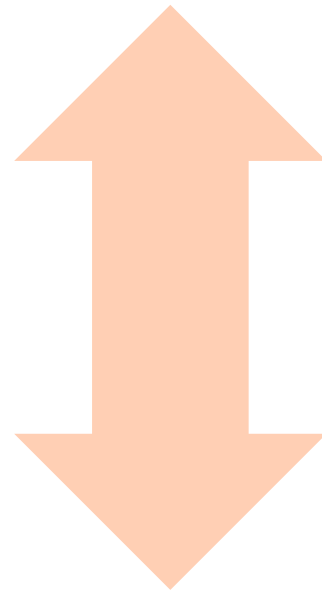
2024
MIPS reporting



MIPS 2024 numbers to know

Expected max incentive
plus-9%

Max penalty
minus-9%



Based on CMS calculations, there is up to a 9% incentive for the top performers. For those that don't participate at all, there will be a negative 9% adjustment on their Medicare revenue in 2025.

What changed and what stayed the same for 2024?



Changed

- Providers need to report at least 75% of eligible encounters for all quality measures.
- Promoting Interoperability:
 - Increase from 90 to 180 days
 - Need to attest “Yes” to SAFER Guides



Stayed the same

- Providers must reach 75 points to avoid the MIPS penalty.
- CMS will continue to reweight PI for small practices.
- Providers need to report at least 1 outcome or high-priority measure.
- There is a 20-case minimum per measure.



Eligibility

- \$90,000-plus in Medicare Part B charges
- 200-plus Medicare Part B patients
- 200-plus covered professional services

Quality category facts — small practices

Small practice = 15 providers or less

Bonus points

- Six bonus points are automatically added to the Quality.

Failure to meet data completeness

- Under 75% data completeness per measure will result in 3 points for the measure.

Measures that don't meet case minimum

- Measures that don't meet the case minimum (20 cases) will earn a maximum of 3 points.

Measures without a benchmark

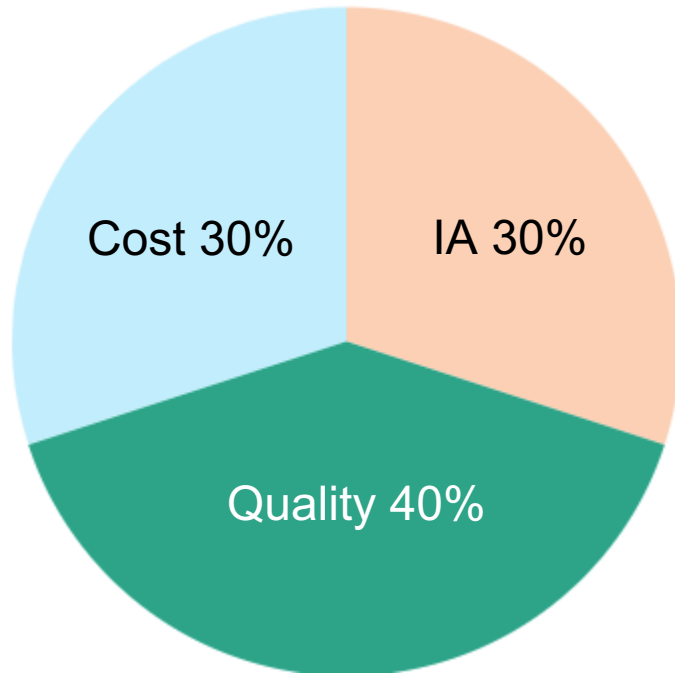
- Measures without a benchmark will earn a maximum of 3 points.

PI Exemption

- Promoting Interoperability automatically reweighted.

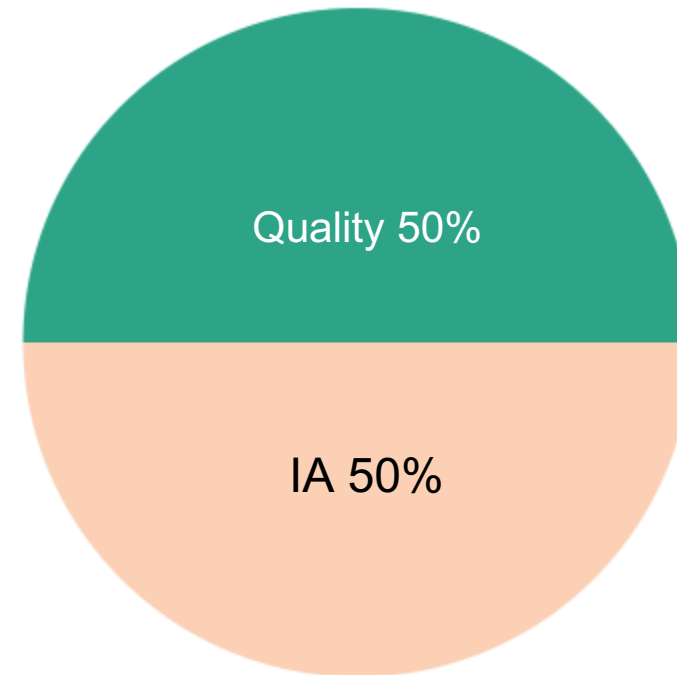
Performance category weights and reweighting – small practice (15 or fewer providers)

Standard weighting for small practices
(Promoting Interoperability automatically reweighted)



PI - 0% of MIPS score

Both the Cost and the Promoting Interoperability performance categories reweighted



Cost - 0% / PI-0%

Quality category facts – large practices

Large practice = 16 or more providers

Failure to meet data completeness

- Under 75% data completeness for each measure will result in 0 points for the measure.

Bonus points

- None

Measures that don't meet case minimum

- Measures that don't meet the case minimum (20 cases) will earn 0 points.

Measures without a benchmark

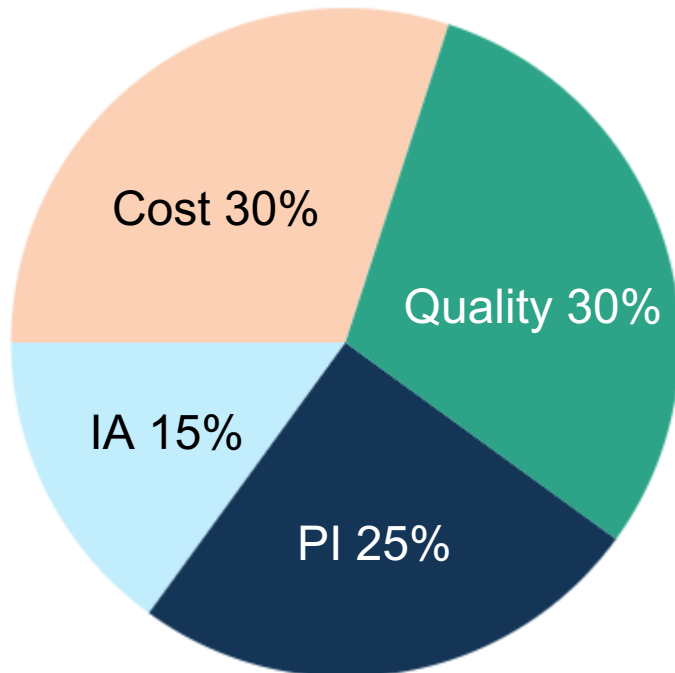
- Measures without a benchmark will earn 0 points.

Measures with a benchmark

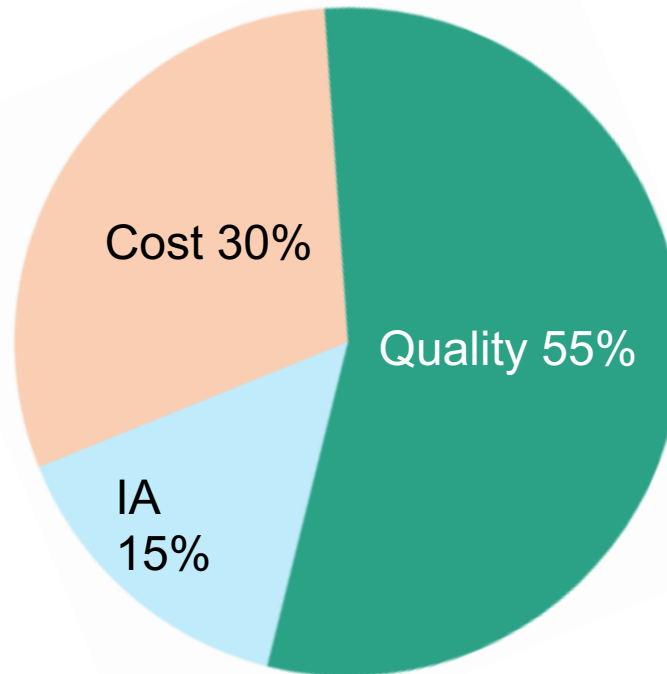
- Measures with a benchmark will earn 1-10 points. Highly topped-out measures will earn 1-7 points.

Performance category weights and reweighting – large practice

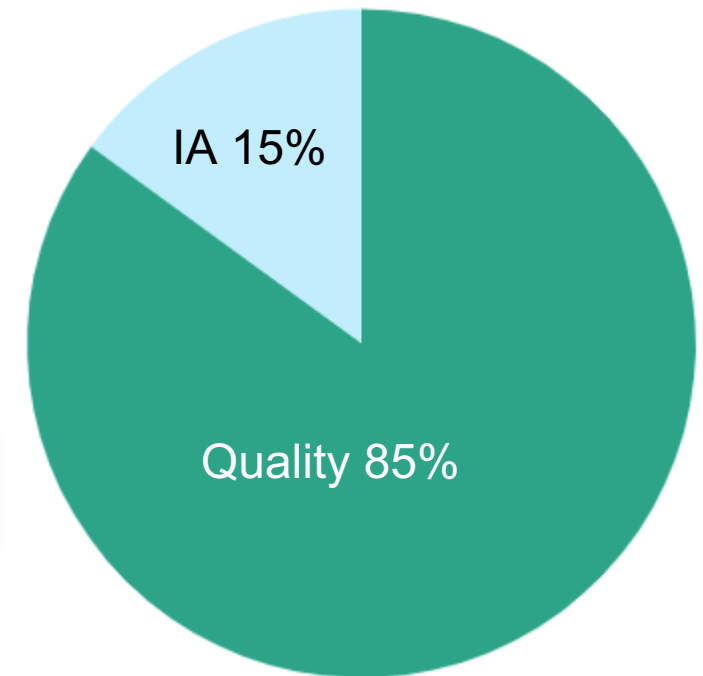
Standard weighting



PI exempt



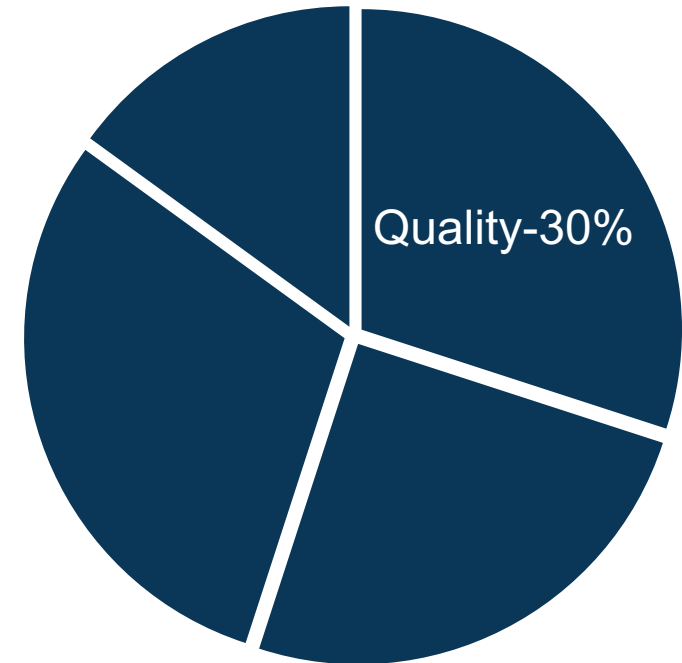
PI exempt and Cost reweighted



Quality category

- 6 measures to be scored
- 1 must be an outcome measures
- High-priority measure if outcome is unavailable

2024 MIPS reporting



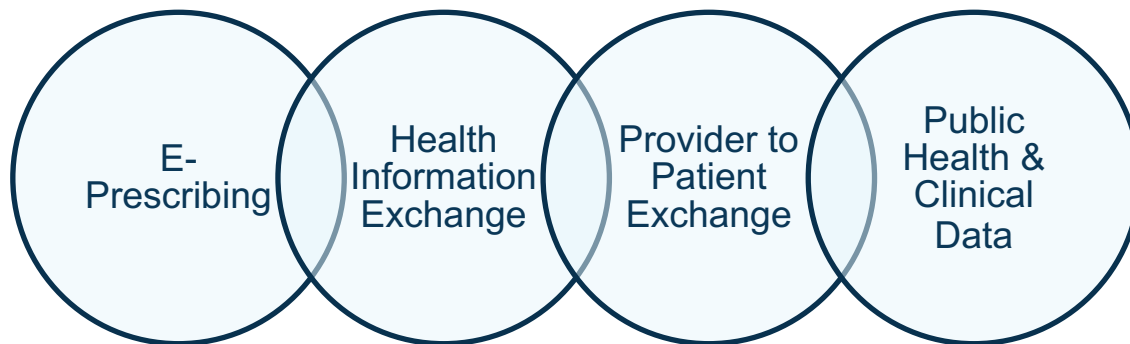
PI category

180 consecutive day reporting period

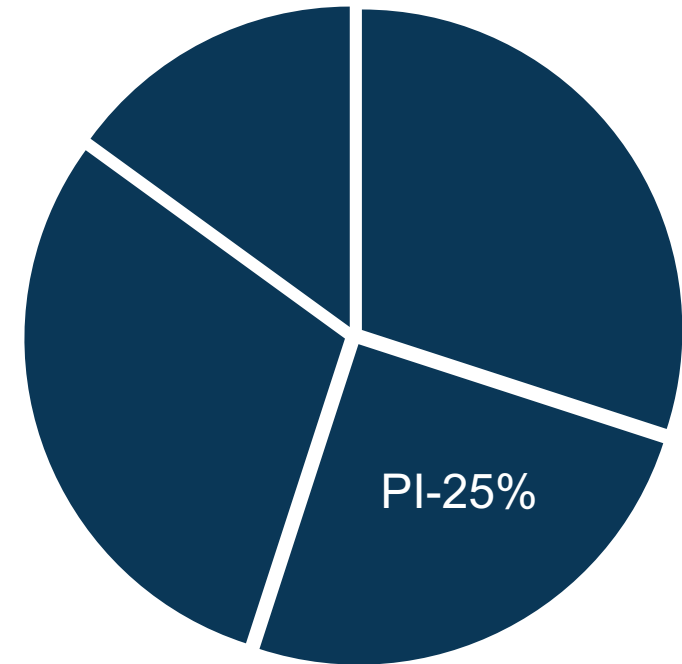
2 required attestations

- Security Risk Analysis
- Review of the 9 Safety Assurance Factors for EHR Resilience (SAFER) Guides measure - Must attest "Yes"

4 measure categories



**2024
MIPS reporting**

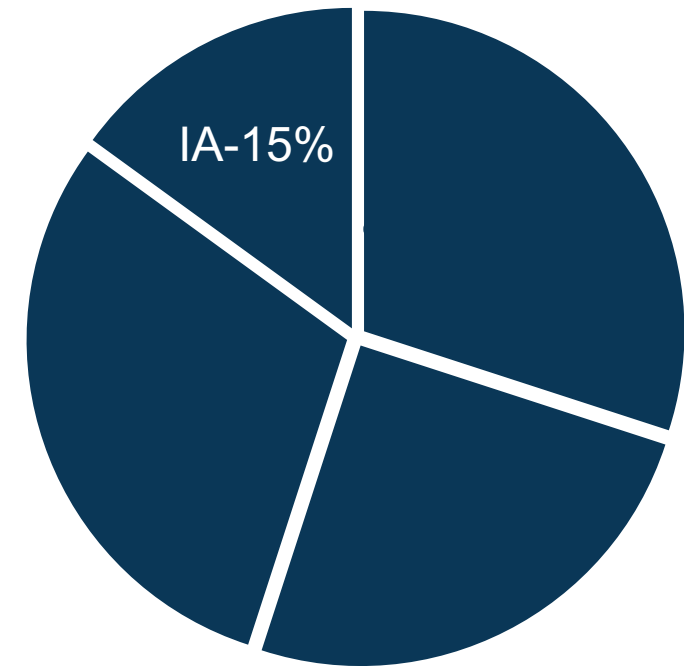


IA category

The IA category assesses your participation in clinical activities that support the improvement of clinical practice, care deliver, and outcomes.

- 90-day minimum reporting period for 50% of providers
- More than 100 improvement activities available
- 40 points total required through selection of high-weighted (20 point) and medium-weighted (10 point) activities
- 20 points required for rural, HPSAs, non-patient facing clinicians, small practices
- Improvement activities can be tracked and submitted in MIPSpro

2024
MIPS reporting



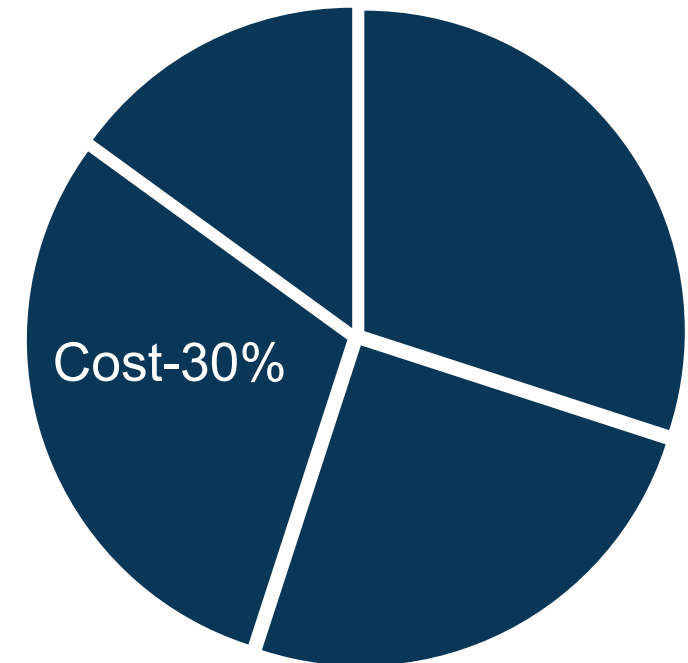
Cost category

The Cost category is automatically calculated from administrative claims data. The performance period is the calendar year.

Measures

- Total Per Capita Cost (TPCC) – total annual cost for patient care
- Medicare Spending Per Beneficiary (MSPB) – Total cost for each hospital episode
- 23 episode-based cost measures for those who qualify
 - Newer: Melanoma Resection measure

2024 MIPS reporting



MIPS tips and tricks



Report as a group and individual at the same time.

Example

20-provider group, MIPS group score of 89

Individual scoring

- Each provider gets own score
- Some will be below 89 and some will be above 89
- Hard to meet 20-patient minimum for some measures
- Can't take advantage of patients seeing multiple providers

Group scoring

- Everyone gets group score of 89
- Get pulled down by lower scores
- Issues with providers not carrying their weight

Both

- Providers that score better than 89 will get their individual score
- Providers that score less than 89 will get the group score
- Take advantage of 20-patient minimums, specialty providers within your group, and top performers



MIPS tips and tricks

Start tracking each MIPS category

- Track your performance in the Quality category.
- Complete your 180 days for PI and 90 days for IA so you can spend more time on Quality.
- Understand measure requirements so your workflows and documentation are correct.

Focus on performance improvement by attacking gaps in care

- Providers – determine if someone isn't carrying their weight.
- Patients – determine if there's a patient type that is causing your scores to suffer.
- Measures – determine what measures may have been overlooked.

Track more than 6 quality measures

- Choose all 8 measures and watch their performance.
- Start eliminating measures throughout the year to optimize your time.

Tracking performance in EZDERM

Profile pages

✔ Profile ✔ Small Practice Status ✔ PI Exempt ✔ Component Details ✔ TIN ✔ CMS Account ✔ BAA ✔ Waiver

Practice Profile

1.) Select Preferred Email Contact*
Select who should be contacted regarding account questions, issues, and updates.

Primary Admin (lpatrick@healthmonix.com)
 Secondary Admin(s)
[Select All](#) [Remove All](#)

1.) Administrator Name*

2.) Practice Address Line 1*

3.) Practice Address Line 2

4.) City*

5.) State*

Measures page

The screenshot displays a software interface for managing measures. At the top, a horizontal progress bar contains four stages: 'Measures' (highlighted in blue with a white checkmark), 'Data Entry' (with a refresh icon), 'Requirements' (with a refresh icon and a diamond symbol), and 'Ready To Submit' (with a lock icon). Below the progress bar is a light blue instruction box: 'Add the necessary measures and complete all pages to meet the measure selection requirements.' The main content area features two task cards. The first card, 'My Measures', includes a green checkmark icon, the text 'Select measures to report', and a 'My Measures' button. The second card, 'Electronic Reporting', includes a green checkmark icon, the text 'Determine CEHRT bonus points', and a 'Completed' button. Both task cards are highlighted with orange borders.

Measures selection

Measure Selection

Filters Showing 194 of 215 Measures [Select All Measures](#) | [Deselect All Measures](#) Measures Benchmarks | [View Selected Measures](#) Items per page: 50

Measure Title [+](#)

Measure Number [+](#)

Codes [+](#)

CMS Measure Set [+](#)

High Priority Measures [+](#)

Outcome Measures [+](#)

Provisional Measures [+](#)

Measures With Benchmarks [+](#)

Topped Out Benchmarks [+](#)

Measures Capped At 7 Pts [+](#)

[Reset](#) [Filter](#)

Selection Requirements

100% **Measures Selected: 8 of 6**
You must select at least 6 measures

100% **Outcome or HP measure: 3 of 1**
You must select at least 1 outcome or 1 high-priority (HP) measure

#1	Diabetes: Hemoglobin A1c Poor Control Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period High Priority: True Outcome: True Reporting Frequency: Once per patient per year Benchmarks Exist: Yes Topped Out: No	Select View Details
#5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Nepriylsin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge High Priority: False Outcome: False Reporting Frequency: 1: Once per patient/year; 2: Every Visit Benchmarks Exist: Yes Topped Out: Yes	Select View Details
#6	**Provisional** Coronary Artery Disease (CAD): Antiplatelet Therapy Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel High Priority: False Outcome: False Reporting Frequency: Once per patient per year Benchmarks Exist: Yes Topped Out: No	Select View Details
#7	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Select

Electronic reporting page

Electronic Reporting

Select Yes for the measures you've electronically reported end-to-end for this reporting year. Select No for the others.

CMS allows one bonus point for each measure under the quality performance category score, up to a maximum of 10 percent of the denominator of the quality performance category score if:

- The MIPS eligible clinician uses CEHRT to record the measure's demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not necessarily limited to the standards included in the CEHRT definition
- The MIPS eligible clinician exports and transmits measure data electronically to a third party using relevant standards or directly to us using a submission method; AND
- The third party intermediary (for example, this registry) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to us using a submission method

These requirements are referred to as "end-to-end electronic reporting." This bonus works in conjunction with the bonus points for reporting high priority measures. MIPS eligible clinicians are eligible for both this bonus option and the high priority bonus option with appropriate bonus caps for each option.

All measures qualify for CEHRT None of the measures qualify for CEHRT

Electronically Reported	Selected Measures	
Yes <input checked="" type="radio"/> No <input type="radio"/>	MIPS CQM #47	Advance Care Plan Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Yes <input checked="" type="radio"/> No <input type="radio"/>	MIPS CQM #110	Preventive Care and Screening: Influenza Immunization Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Yes <input checked="" type="radio"/> No <input type="radio"/>	MIPS CQM #111	Pneumococcal Vaccination Status for Older Adults Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

Completion threshold page

Complete this page after data has been imported from the interface.

Measures Data Entry **Requirements** Ready To Submit

Review and complete the following pages to confirm Quality reporting requirements.

✔ **Reporting Date Range**
Select a date range to report. [Go To Page](#)

✔ **Completion Threshold**
Enter total eligible instances to confirm 70% reporting rate needed per measure [Go To Page](#)

⚠ **Measures To Send To CMS**
Report that reflects CMS reporting requirement criteria [Go To Page](#)

Completion Threshold

To receive full decile and bonus points for a measure, you must report a minimum of 70% of all eligible patient instances (not just Medicare instances) for that measure. Complete this page to determine the completion threshold for each selected measure.

Instructions:

If you are entering all of the visit data associated with this TIN into MIPS/PRO, select "Yes" to the question below. The system will automatically calculate the completion threshold for each measure by dividing the "Completed" instances from the performance page by the "Total" instances from the performance page. The difference between these two numbers is the inclusion of incomplete instances that exist for that measure.

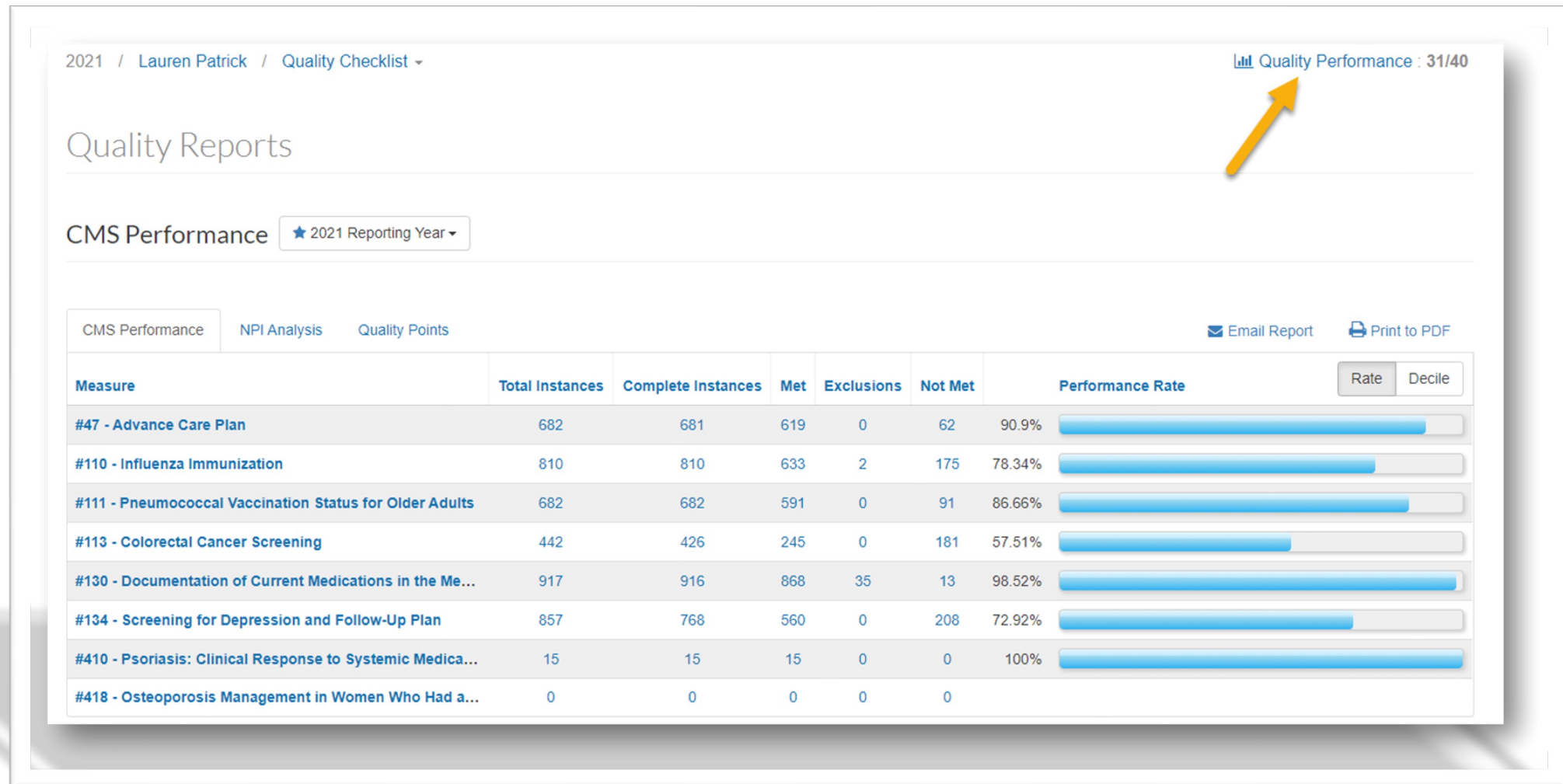
If you are entering less than 100% of the visit data associated with this TIN, you will need to manually enter the total instances for that measure as determined by your billing records and/or EHR reports.

Should you add or remove an instance for any measure after completing the page, the numerator will update for that measure. If the page is showing text fields and any measure has **more** than 100% reporting rate OR has an empty text field, the page will remain "Incomplete." Page must be complete before submission to CMS is allowed.

Yes Have you entered 100% of your 2021 reporting data into MIPS/PRO?
 No

Measure #	Reporting Frequency	Complete Instances (Numerator)	Total Instances (Denominator)	Reporting Rate
#47	Once per patient per year	681	682	99%
#110	Once per patient per year	810	810	100%
#111	Once per patient per year	682	682	100%

Quality performance



Quality performance

CMS Performance
NPI Analysis
Quality Points
FHIR to PDF

Actual
Predicted

"Actual" Quality Points: 47.78 / 60

Top 6 Actual Points: 47.78 ⓘ

Improvement bonus: Incomplete

ACR measure tracking is enabled. [Learn more](#)

"Actual" Top 6 measures with reporting completion rules

Compare actual vs predicted points for all selected measures in this section. Use the "20 instances" and "Completion Threshold" columns to determine why the actual and predicted points for each measure do (or do not) match.

Measure	Performance	20 Instances	Completion Threshold	Actual Points	Predicted Points	Total Possible Points	Top 6	Send To CMS Status
#47 - Advance Care Plan	100%	Yes (173)	Yes (100%)	10	10	10	Yes	Selected
#48 - Urinary Incontinence: Assessment of Presence or Absence of UI in Women Aged 65 Years and Older	100%	Yes (83)	Yes (100%)	10	10	10	Yes	Selected
#112 - Breast Cancer Screening	86.7%	Yes (196)	Yes (100%)	10	10	10	Yes	Selected
#374 - Closing the Referral Loop: Receipt of Specialist Report	93.3%	Yes (134)	Yes (100%)	10	10	10	Yes	Selected
#127 - DM: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	89.6%	Yes (309)	Yes (100%)	4.2	4.2	10	Yes	Selected
#331 - Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	61.8%	Yes (76)	Yes (100%)	3.58	3.58	10	Yes	Selected

Gaps in care report

Patients *View, add, and update patients*

Showing 997 of 997 Patient Records per page 25

Export to Excel Upload Patients Add Patient

Status	Patient Identifier	First Name	Last Name	Date of Birth	Last Updated Date	Quality Visits	Delete
●	1	joe	smith	1/1/1950	4/28/2021	0	Delete
●	1			5/31/1945	4/28/2021	9	Delete
●	5			8/13/1938	4/28/2021	2	Delete
●	5			7/22/1947	4/28/2021	2	Delete

Patient Identifier	Last Name	First Name	Date of Birth	Gender	DOS	DOS Time	DOS Modifier	NPI	Measure
XXX	Jane	Smith	05/31/1945	Female	1	04/13/202		1235111436	Documentation of Current Medications in the Medical Record
YYY	Cindy	Jones	05/31/1945	Female	1	02/17/202		1235111436	Documentation of Current Medications in the Medical Record
ZZZ	Jane	Doe	07/22/1947	Male	1	01/02/202		1235111436	Advance Care Plan

Promoting Interoperability

Select measures

2024 PI Measures

Select and review the PI measures you will be reporting

Measure ID	Required Measures	Points
PI_PPHI_1	Security Risk Analysis	0
PI_PPHI_2	High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides	0
PI_EP_1	e-Prescribing	10
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)	10
PI_PEA_1	Provide Patients Electronic Access to Their Health Information	25
PI_PHCDRR_1	Immunization Registry Reporting	12.5
PI_PHCDRR_3	Electronic Case Reporting	12.5

Required Measures

100% Measures selected: 7 of 7
Required measures are automatically selected.

HIE Measures

100% Measures selected: 2 of 2
You have selected to report HIE_1 and HIE_4

HIE Measures

For HIE measures, HIE_1 and HIE_4 are required but can be replaced by HIE_5 or HIE_6 as an alternative measure. Since they are mutually exclusive, only one set of them can be selected to report.

Note that HIE_1 and HIE_4 have exclusion possibilities and have numerator and denominator answers. This means a percentage of the total possible points of these two measures can be received. However, HIE_5 and HIE_6 are both all or nothing measures. In other words, if this group meets all the criteria for HIE_5, then all the points for the measure will be applied. If just one of the criteria is not met, then 0 points will be applied for this measure. To learn more about each measure, click the measure title for details.

If you wish to provide answers to all three measures and then compare the difference between PI score, you can select one set of measures, enter data and check the Track PI Measures page. Then return to this page and select another option, enter data, and compare results. Switching HIE measures will not remove or change data from any measure. Whatever option is selected here and appears on the track measures page once you choose to submit to CMS is the set of measures that will be submitted to CMS.

Measure ID	Measure Name	Points	HIE Selection
PI_HIE_1	Support Electronic Referral Loops by Sending Health Information	15	<input checked="" type="checkbox"/> Selected
PI_HIE_4	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15	<input type="checkbox"/>
PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	30	<input type="button" value="Select"/>
PI_HIE_6	Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)	30	<input type="button" value="Select"/>

Optional Bonus Measures

Measure ID	Optional Bonus Measures	Points	Select
PI_PHCDRR_2	Syndromic Surveillance Reporting	5	<input type="button" value="Add"/>
PI_PHCDRR_4	Public Health Registry Reporting	5	<input type="button" value="Add"/>
PI_PHCDRR_5	Clinical Data Registry Reporting	5	<input type="button" value="Add"/>

Promoting Interoperability

Track measures

MIPSpro ENTERPRISE GCDR

Help Administration Dashboard Admin Home dbelczyk@healthmonix.com

2022 / Michael Lewis / PI Checklist - PI Score : 25/25

Track 2022 PI Measures

Enter data for each measure and review the results.

Measure ID	Measure	Performance	Points Earned/Total	Status	Data Entry
PI_FPH_1	Security Risk Analysis	100%	Completed	Required	Update
PI_FPH_2	High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides	100%	Completed	Required	Update
PI_EP_1	e-Prescribing	67%	7 / 10	Required	Update
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)	100%	10 / 10	Required	Update
PI_HIE_1	Support Electronic Referral Loops by Sending Health Information	80%	16 / 20	Required	Update
PI_HIE_4	Support Electronic Referral Loops by Receiving and Reconciling Health Information	100%	20 / 20	Required	Update
PI_PEA_1	Provide Patients Electronic Access to Their Health Information	90%	36 / 40	Required	Update
PI_PHCDRR_1	Immunization Registry Reporting	Excluded	Excluded	Required	Update
PI_PHCDRR_3	Electronic Case Reporting	100%	10 / 10	Required	Update

Required Measures

● Complete

PI Points

99 / 100

PI Score

25 / 25

PI Reporting Date Range

The reporting date range for PI must be within the 2022 reporting year. The default range is 1/1/2022-12/31/2022, but any 90 day or greater range within the year is valid for 2022. The selected date range will be applied to all PI measures. The data entered for these measures should only fall within the following date range.

PI Start Date: [📅](#)

PI End Date: [📅](#)

[Update](#)

e-Prescribing (PI_EP_1)

Complete:

- This group writes fewer than 100 permissible prescriptions during the performance period in 2022 MIPS.
- None of the above

2. Numerator: Of the prescriptions defined by the denominator, enter the number of prescriptions generated and transmitted electronically using CEHRT.

Denominator: Enter the number of prescriptions written for drugs requiring a prescription to be dispensed (excluding controlled substances) during the performance period, or enter the number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period.

	Numerator	Denominator
Group Total:	<input type="text" value="10"/>	<input type="text" value="15"/>

Measure Details

Measure Title: e-Prescribing

Measure ID: PI_EP_1

Objective: e-Prescribing

Description

At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically using CEHRT.

Definitions

Improvement Activities

Select measures

Select Activities

Filters Showing 50 of 104 Activities

Activity Name Subcategory Activity Weight

Reset Filter

IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record Select View Details
Subcategory: Expanded Practice Access
Activity Weight: 20
Time Requirement: 90

IA_EPA_2: Use of telehealth services that expand practice access Select View Details
Subcategory: Expanded Practice Access
Activity Weight: 10
Time Requirement: 90

IA_EPA_3: Collection and use of patient experience and satisfaction data on access Select View Details
Subcategory: Expanded Practice Access
Activity Weight: 10


Selected Activities

Activities Added: 2
Points Selected: 40
Points Needed: 40 Continue

IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement x
Points :20

IA_BE_14: Engage Patients and Families to Guide Improvement in the System of Care x
Points :20

Improvement Activity Component - Attest

 **Congratulations!** Activity was attested on 4/28/2021

ACTIVITY: IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
ACTIVITY ID: IA_BE_6
SUBCATEGORY: Beneficiary Engagement
WEIGHT: 20 points
REQUIRED PARTICIPATION PERIOD: 90 days

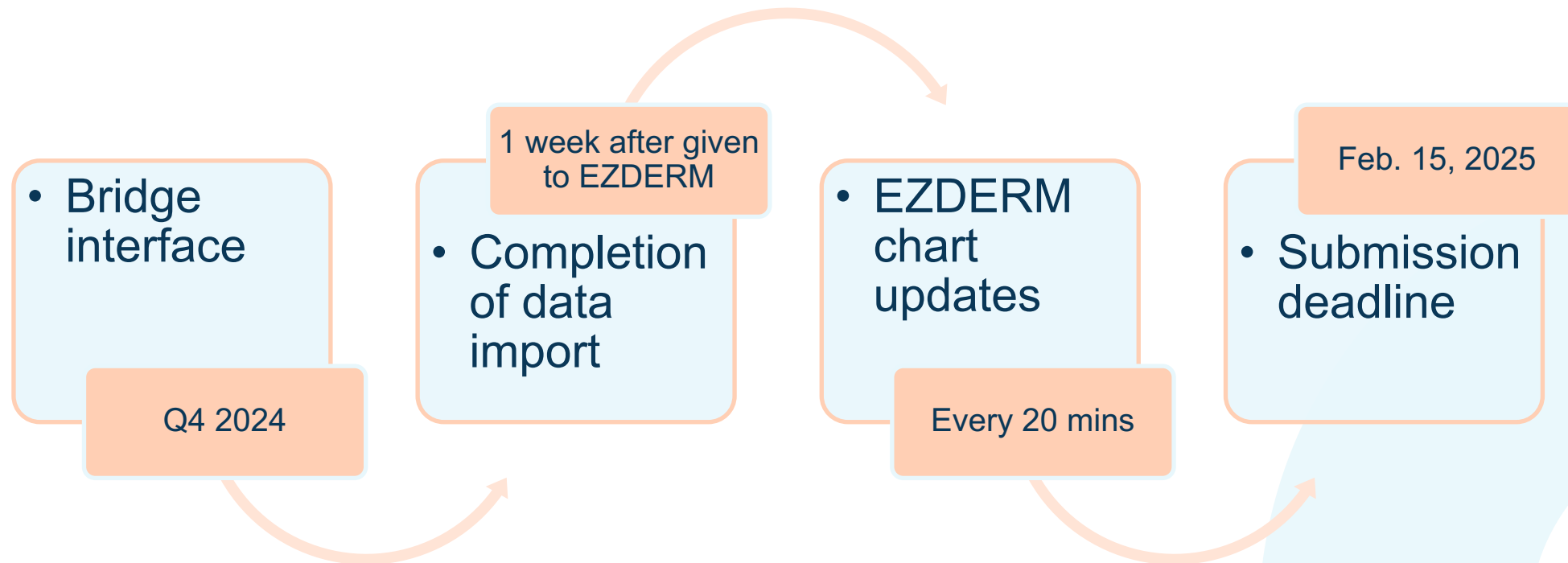
I attest that I have completed the above Improvement Activity as prescribed by the MIPS 2021 program.

Enter your initials.

Signature: First and last name

Date: 4/28/2021

Must knows!



Customer Support

Support options

Our experts are ready to provide timely help via live support and self-service materials.



610-590-2229, ext. 2

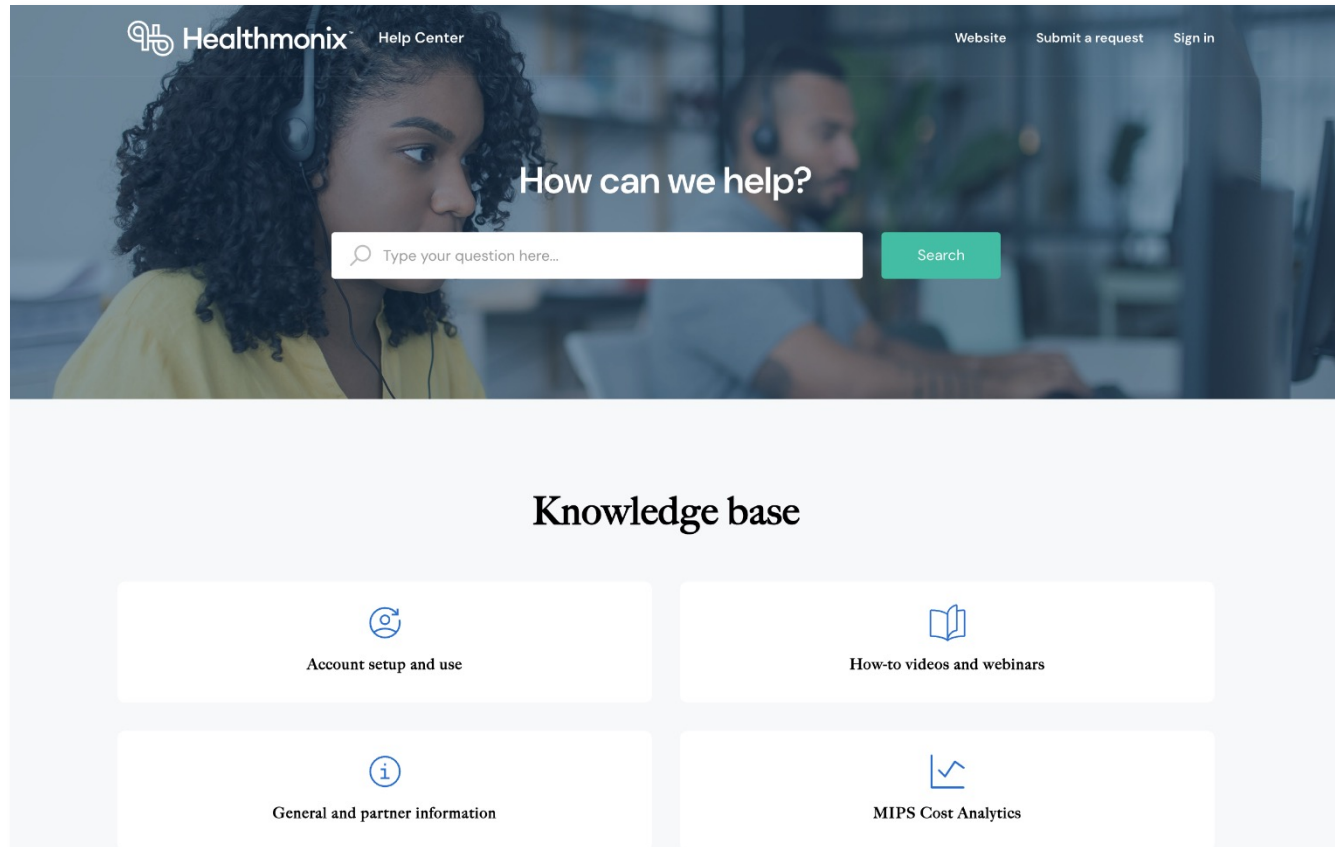


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Thank you

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