Your Participation

Grab Tab – Click orange arrow to open/close Control Panel.

Please continue to submit your text questions and comments using the Questions Panel.

**Note:** Today’s presentation is being recorded and will be available on the GIQuIC website in approximately two weeks.

If you have questions, please contact info@giubic.org.
This presentation provides information about the GIQuIC 2023 Qualified Clinical Data Registry (QCDR) as a reporting mechanism for the Merit-Based Incentive Payment System (MIPS) for the 2023 performance year. This is the second installment of a two-part presentation.

Part 1 (Action Plan) addressed assembling the basic information and resources you need to support gastroenterologists in successful reporting, if done via the GIQuIC 2023 QCDR.

Part 2 (Planning and Execution) will address MIPS reporting requirements and how they can be fulfilled by reporting via the GIQuIC 2023 QCDR.

**Important Note:** To report via the GIQuIC 2023 QCDR a site must be registered and actively participating in GIQuIC (submitting data, generating reports) *no later than June 30, 2023.*
1. Understand the Quality Payment Program
   • Merit-based Incentive Payment System (MIPS)
2. Assemble the reporting team
3. Determine the goal
   • MIPS eligibility status
4. Evaluate options for reporting
   • individual clinician or group reporting
   • data submission mechanisms
5. Create a plan and monitor your progress
I. Describe the Merit-based Incentive Payment System (MIPS)

II. Discuss MIPS performance categories requirements and scoring

III. Discuss how the GIQuIC 2023 QCDR meets reporting requirements

IV. Review upcoming activities in the GIQuIC 2023 QCDR reporting timeline
Simple Agenda

Who: MIPS-eligible clinicians

covered in detail during the April 13 Action Plan webinar

What: Quality Payment Program, MIPS, MIPS performance categories

Why: To avoid a negative payment adjustment in 2025
To potentially earn a positive payment adjustment

How: There are multiple mechanisms through which data submission can be made, including GIQuIC

When/Where: We will focus on reporting via the GIQuIC 2023 QCDR.
What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

- **MIPS** - Merit-based Incentive Payment System
  - If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

- **Advanced APMs** - Advanced Alternative Payment Models
  - If you participate in an Advanced APM and achieve QP status, you may be eligible for a 5% incentive payment and you will be excluded from MIPS.

Note: If you participate in an Advanced APM and don’t achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.
MIPS Eligibility

It is recommended you bookmark this page.
## Merit-based Incentive Payment System

**Performance Threshold & Payment Adjustments**

### 2022 Final

<table>
<thead>
<tr>
<th>Final Score 2022</th>
<th>Payment Adjustment 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;89 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Eligible for additional payment for exceptional performance—minimum of additional 0.5%</td>
</tr>
<tr>
<td>75.01-88.99 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>• Not eligible for additional payment for exceptional performance</td>
</tr>
<tr>
<td>75 points</td>
<td>• Neutral payment adjustment</td>
</tr>
<tr>
<td>18.76-74.99 points</td>
<td>• Negative payment adjustment between -9% and 0%</td>
</tr>
<tr>
<td>0-18.75 points</td>
<td>• Negative payment adjustment of -9%</td>
</tr>
</tbody>
</table>

### 2023 Final

<table>
<thead>
<tr>
<th>Final Score 2023</th>
<th>Payment Adjustment 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>75.01-100 points</td>
<td>• Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>0-18.75 points</td>
<td>• Negative payment adjustment of -9%</td>
</tr>
</tbody>
</table>

---

The 2022 performance year/2024 MIPS payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.
Merit-based Incentive Payment System

What is the Merit-based Incentive Payment System (MIPS)?

MIPS is one way to participate in QPP. Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

- **Quality**: Assesses the quality of care you deliver based on measures of performance.
- **Improvement Activities**: Assesses your participation in activities that improve clinical practice and support patient engagement.
- **Promoting Interoperability**: Assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT).
- **Cost**: Assesses the cost of the care you provide based on your Medicare Part B claims.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2023 Traditional MIPS</th>
<th>2023 Traditional MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individuals, Groups, Virtual Groups</td>
<td>no change for 2022</td>
</tr>
<tr>
<td>Quality</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

For a high-level overview and actionable steps of MIPS, review the [2023 MIPS Quick Start Guide](#).
Quality Improvement Registry
Quality assessment/improvement registries (QI registries) seek to use systematic data collection and other tools to improve quality of care.

Qualified Clinical Data Registry
A QCDR is an entity that collects medical or clinical data for the purposes of patient and disease tracking to foster improvement in the quality of care provided and that has self-nominated, successfully completed a qualification process, and been approved by CMS as a reporting mechanism.
*Centers for Medicare & Medicaid Services*
<table>
<thead>
<tr>
<th>CMS Requirement</th>
<th>GIQuIC 2023 QCDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report data from January 1 – December 31, 2023</td>
<td>Only GIQuIC participants registered and <strong>actively</strong> submitting data to the registry by June 30, 2023, may consider reporting via the GIQuIC 2023 QCDR.</td>
</tr>
<tr>
<td></td>
<td>For units that registered and started submitting data after January 1, 2023, data from January 1 onward must be entered (and in some cases manually) into the registry. The data in the registry must be for the entire reporting period regardless of the unit’s start date with GIQuIC.</td>
</tr>
<tr>
<td>CMS Requirement</td>
<td>GIQuIC 2023 QCDR</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| **Data Completeness Requirement**  
Report on 70% of cases to which measure applies across all places of service regardless of payer; submission must include at least one Medicare patient | To participate in GIQuIC a provider must upload 100% of colonoscopy cases done at the participating site(s) - all payers, not just Medicare.  
**Variable depending upon provider**  
Are at least 70% of the provider’s procedures captured in GIQuIC?  
• Look at the cases that qualify for each measure denominator.  
• Consider the volume the provider does at each place of service. |
# Quality Performance Category

<table>
<thead>
<tr>
<th>CMS Requirement</th>
<th>GIQuIC 2023 QCDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report at least 6 individual measures Measures can be reported to CMS via multiple mechanisms. CMS will pick the six measures with the highest scores for the purposes of determining points earned and payment adjustment.</td>
<td>The GIQuIC QCDR includes 8 measures • 7 colonoscopy • 1 EGD</td>
</tr>
<tr>
<td>One outcome measure required (or one high-priority measure if outcome measure is not available)</td>
<td>The GIQuIC QCDR includes 2 outcome and 6 high-priority measures</td>
</tr>
<tr>
<td>CMS automatically calculates and scores individuals, groups, and virtual groups on select administrative claims measures when the individual or group meets the case minimum and clinician requirement for the measures</td>
<td>No action for reporting is required</td>
</tr>
</tbody>
</table>
Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Quality performance category of the Merit-Based Incentive Payment System (MIPS) via the GIQuIC Qualified Clinical Data Registry (QCDR) for the 2023 program year. Additional detail on GIQuIC’s QCDR measures available for public reporting follows on the subsequent pages.

The GIQuIC 2023 QCDR has been approved to support individual eligible clinician, group, and virtual group reporting to the Quality, Improvement Activities, and Promoting Interoperability performance categories.

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Title</th>
<th>Outcome/High-Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIQIC25</td>
<td>Screening Colonoscopy Adenoma Detection Rate - Female</td>
<td>Outcome</td>
</tr>
<tr>
<td>GIQIC24</td>
<td>Screening Colonoscopy Adenoma Detection Rate - Male</td>
<td>Outcome</td>
</tr>
<tr>
<td>GIQIC23</td>
<td>Appropriate follow-up interval based on pathology findings in screening colonoscopy</td>
<td>High-Priority</td>
</tr>
<tr>
<td>NHCR4</td>
<td>Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation</td>
<td>High-Priority</td>
</tr>
<tr>
<td>QPP185</td>
<td>Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use</td>
<td>High-Priority</td>
</tr>
<tr>
<td>QPP320</td>
<td>Appropriate follow-up interval for normal colonoscopy in average risk patients</td>
<td>High-Priority</td>
</tr>
<tr>
<td>QPP439</td>
<td>Age Appropriate Screening Colonoscopy</td>
<td>High-Priority</td>
</tr>
<tr>
<td>GIQIC10</td>
<td>Appropriate management of anticoagulation in the peri-procedural period rate – EGD</td>
<td>High-Priority</td>
</tr>
</tbody>
</table>
Quality measures submitted for the 2023 performance period will receive between 0 and 10 measure achievement points.

Quality measures fall into one of three categories for scoring:

1. The measure meets the data completeness criteria, has a benchmark, and the volume of cases is sufficient (>20 cases for most measures)
   - These measures continue to receive between 1 to 10 points based on performance compared to the benchmark

2. The measure meets the data completeness criteria but either (1) doesn’t have a benchmark and/or (2) the volume of cases you’ve submitted is insufficient (<20 cases for most measures)
   - These measures receive 0 point, except for small practices, which would continue to receive 3 measure achievement points*

3. The measure doesn’t meet the data completeness criteria
   - These measures receive 0 point, except for small practices, which would continue to receive 3 measure achievement points*

* These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims-based measures.
**MIPS Scoring**

Scoring Basics in 2023

- **Class 4 Measures:**
  - The measure meets the data completeness criteria, the volume of cases is sufficient but does not have a benchmark
    - Newly introduced measures will receive a score of 7 points
      - If a performance year benchmark can be established a score of 7 – 10 will be awarded (floor of 7 points)
    - Second year measures will receive a score of 5 points
      - If a performance year benchmark can be established a score of 5 – 10 will be awarded (floor of 5 points)*

*These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims-based measures.
**MIPS Scoring**

**Benchmarks**

*How are the benchmarks established?*

- When you submit measures for MIPS, each one is assessed against a benchmark to determine how many points the measure earns.

- We establish quality performance benchmarks either:
  - Prior to the reporting period for which they apply (*historical benchmarks* based off data from two years prior); or
  - From data submitted for that performance period
Quality Performance Category Scoring

MIPS Scoring
Benchmarks

How are benchmarks converted to points?

- Each measure you submit is assessed against its collection-type specific benchmark to see how many points are earned based on your quality performance.

- Each quality measure is scored on a **10-point** scale:
  - Except for the topped-out MIPS quality measures finalized with a 7-point scale,
  - Measures that don’t meet data completeness criteria, and
  - Measures that either don’t have a benchmark and/or the volume of cases you’ve submitted is insufficient.

- Performance is broken down into “deciles,” with each decile corresponding to a value between 1 and 10 points.

- There is a 1-point floor for measures that can be reliably scored based on performance for the 2023 MIPS performance period. As a result, measures in the lowest deciles cannot get less than 1 measure achievement points.

- We compare your performance on a quality measure to the performance levels in the national performance (benchmarks).

- The points you earn are based on the decile range that matches your performance level.
Quality Performance Category Scoring

MIPS Scoring

Benchmarks

- Quality measure that can’t be reliably scored against a benchmark, or quality measures without a benchmark, will receive 1 point (assuming the measure meets data completeness) unless a benchmark can be established with performance period data.
  - *What does “reliably scored” mean?*
    - A national benchmark exists.
    - Sufficient case volume has been met (>20 cases for most measures).
    - Data completeness criteria has been met (meaning at least 70% of possible data is submitted).
- This applies to measures across all collection types except for CMS Web Interface measures and administrative claims measures.
### GIQuIC 2023 QCDR Measure Set - Scoring

- Assuming data completeness + case minimum requirements met
- Historical benchmarks available as of April 11, 2023.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Points Available as of April 11, 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIQIC25 Screening Colonoscopy ADR female</td>
<td>5 points, possible benchmarks post reporting</td>
</tr>
<tr>
<td>GIQIC24 Screening Colonoscopy ADR male</td>
<td>5 points, possible benchmarks post reporting</td>
</tr>
<tr>
<td>GIQIC23 Appropriate Follow-Up Screens</td>
<td>From 1 to 10 points can be earned</td>
</tr>
<tr>
<td>NHCR4 Repeat Screen Inadequate Prep</td>
<td>From 1 to 10 points can be earned</td>
</tr>
<tr>
<td>QPP320 Appropriate F/U Negative Screen</td>
<td>From 1 to 7 points can be earned</td>
</tr>
<tr>
<td>QPP185 Colo Interval Pts w History</td>
<td>From 1 to 7 points can be earned</td>
</tr>
<tr>
<td>QPP439 Age Appropriate Screens</td>
<td>From 1 to 10 points can be earned</td>
</tr>
<tr>
<td>GIQIC10 Manage Anticoag - EGD</td>
<td>0 points, possible benchmarks post reporting</td>
</tr>
</tbody>
</table>
**Quality Performance Category Scoring**

**MIPS Scoring**

**Bonus Points**

*Small Practice Bonus in 2023 performance year:*
- Small practice bonus will continue in the 2023 at the quality performance category,
- 6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.

*Quality Improvement Bonus in 2023 performance year:*
- You can earn up to 10 percentage points based on the rate of your improvement in the quality performance category for the year before.
What is the MIPS Improvement Activities Performance Category?

The improvement activities performance category assesses your participation in clinical activities that support the improvement of clinical practice, care delivery, and outcomes. With over 100 activities to choose from, you can select from the 2023 Improvement Activities Inventory to find those that best fit your practice and support the needs of your patients by improving patient engagement, care coordination, patient safety, and other areas in patient care.

For a high-level overview and practical information about data collection and submission for the 2023 MIPS improvement activities performance category, review the [2023 Improvement Activities Quick Start Guide](https://www.cms.gov/Improvement-Activity-Performance-Category).
Improvement Activities Category

Full Resource Library

Search

Performance Year  QPP Reporting Track  Performance Category  Resource Type
2023  MIPS  Improvement Act  All

9 Resources

2023 MIPS Improvement Activities User Guide

Updated 03/23/2023

A guide to help clinicians participating in the improvement activities performance category of the Merit-based Incentive Payment System (MIPS) during the 2023 performance period.
2023 MIPS Data Validation Criteria

ZIP 2MB | PY 2023 | MIPS, APMs | Technical Guides and User Guides

Lists the 2023 criteria used to audit and validate data submitted for the Merit-based Incentive Payment System (MIPS) performance categories.
## Improvement Activities Inventory

<table>
<thead>
<tr>
<th>ID</th>
<th>Subcategory Name</th>
<th>Category</th>
<th>Activity Name</th>
<th>Activity Description</th>
</tr>
</thead>
</table>
| IA_EPA_1 | Expanded Practice Access               |          | Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who have Real-Time Access to Patient’s Medical Record | - Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one of the following:  
  - Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);  
  - Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers);  
  - Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management. |
| IA_PSPA_18 | Patient Safety & Practice Assessment | Measurement and improvement at the practice and panel level | Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecard that could include one or more of the following:  
  - Regularly review measures of quality, utilization, patient satisfaction and other measures; and/or  
  - Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels.  
MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities. |
## Improvement Activities Category - Scoring

### Scoring
- High-weighted activity = 20 points
- Medium-weighted activity = 10 points

### For maximum score, complete:
- 4 medium-weight or
- 2 high-weight activities or
- 1 high-weighted and 2 medium-weighted activities

### Small practices and practices in rural areas:
- Complete 2 medium-weight activities or 1 high-weight activity for maximum score

### Groups can attest:
- Groups can attest to an improvement activity when **at least 50% of the clinicians in the group perform the same activity** during any continuous 90-day period within the same performance period.
**Improvement Activities Inventory**

**September 29, 2023**, is the last day to initiate an improvement activity that will count towards 2023 performance year reporting.

<table>
<thead>
<tr>
<th>ID</th>
<th>Subcategory Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
<th>Objective &amp; Validation Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:</td>
<td>High</td>
<td>Objective: Increase patient access to MIPS eligible clinicians who provide care in an outpatient setting with the goal of reducing unnecessary emergency department visits. Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded patient care, patient's electronic health record (EHR), or that patients received urgent care in a timely way. Expanded Business Hours are defined as hours of operation. Include at least one of the following elements: 1) Patient record in EHR - A patient record in an EHR with date and timestamp indicating services provided outside of the practice's normal hours of operation. 2) Patient encounter/medical record/claim - Patient encounter/medical record/claim indicating patient was seen or received services from an eligible clinician, including use of telehealth visits, or that the services were provided at an alternative location (e.g., senior center, or agency on aging). 3) Same or next day patient encounter/medical record/claim - Patient encounter/medical record/claim indicating patient was seen for urgent care or transition management.</td>
<td></td>
</tr>
</tbody>
</table>

Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures, and/or • Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels. MIPS eligible clinicians can apply the measurement and quality improvement to address inequalities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities. Examples: • Obtain diagnostic imaging Center of Excellence (DIICE) designation • Participate in Endoscopy Unit Recognition Program (EURP) • Participate in Simulation Education Courses approved by the American Society of Anesthesiologists Simulation Education Network • Use the Centers for Medicare & Medicaid Services' Disparities Impact Statement tool to fulfill this activity and address inequities in populations Information: • Toolkit for Implementing Culturally and Linguistically Appropriate Services Standards: [https://www.cms.gov/About-CMS/Agency-Information/Disparities](https://www.cms.gov/About-CMS/Agency-Information/Disparities)
<table>
<thead>
<tr>
<th>ID</th>
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</tr>
</thead>
<tbody>
<tr>
<td>IA_EPA_1</td>
<td>Expanded Practice Access</td>
<td>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinicians and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:</td>
<td>High</td>
<td>Objective: Increase patient access to eligible clinicians who work in an outpatient setting with the goal of reducing unnecessary emergency visits. Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded practice hours (e.g., expanded hours in evenings and weekends with access to the patient medical record) and/or use of alternatives to increase access to care by MIPS eligible clinicians and groups, such as clinic, phone visits, group meetings, home visits and alternate locations (e.g., senior centers and assisted living facilities).</td>
<td></td>
</tr>
<tr>
<td>IA_PSPA_18</td>
<td>Patient Safety &amp; Practice Improvement</td>
<td>Measurement and Improvement at the practice level</td>
<td>Medium</td>
<td>Objective: Enhance the measurement of the quality of care, making quality data relevant at practice and panel levels, and use those scores to improve quality. Validation Documentation: Evidence of quality measurement and improvement for populations at the practice and panel level or for populations with disabilities, racial and gender minorities, individuals with certain chronic conditions and/or individuals in rural areas.</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- **IA Validation Criteria:**
  - 2023 IA Validation Criteria
  - 2023 IA Changes
  - 2023 Deleted IA
  - 2023 PI Criteria
  - 2023 PI Changes
  - Version History

---

**Read Column F**
What is the MIPS Promoting Interoperability Performance Category?

- Interoperability, or the use of technology to exchange and make use of information, makes communicating patient information less burdensome and improves outcomes. The MIPS Promoting Interoperability performance category emphasizes the electronic exchange of health information using certified electronic health record technology (CEHRT) to improve:
  
  - Patient access to their health information;
  - The exchange of information between clinicians and pharmacies; and
  - The systematic collection, analysis, and interpretation of healthcare data.
Promoting Interoperability Performance Category
2023 MIPS Finalized Policy

Reweighting

<table>
<thead>
<tr>
<th>2022 Final</th>
<th>2023 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automatic reweighting applies to following clinician types:</td>
<td>Continuing automatic reweighting for following clinician types in 2023:</td>
</tr>
<tr>
<td>- Nurse practitioners</td>
<td>- Clinical social workers</td>
</tr>
<tr>
<td>- Physician assistants</td>
<td>- Physical therapists</td>
</tr>
<tr>
<td>- Certified registered nurse anesthetists</td>
<td>- Occupational therapists</td>
</tr>
<tr>
<td>- Clinical nurse specialists</td>
<td>- Qualified speech-language pathologists</td>
</tr>
<tr>
<td>- Clinical social workers</td>
<td>- Qualified audiologists</td>
</tr>
<tr>
<td>- Physical therapists</td>
<td>- Clinical psychologists, and</td>
</tr>
<tr>
<td>- Occupational therapists</td>
<td>- Registered dieticians or nutrition professionals</td>
</tr>
<tr>
<td>- Qualified speech-language pathologists</td>
<td></td>
</tr>
<tr>
<td>- Qualified audiologists</td>
<td></td>
</tr>
<tr>
<td>- Clinical psychologists, and</td>
<td></td>
</tr>
<tr>
<td>- Registered dieticians or nutrition professionals</td>
<td></td>
</tr>
</tbody>
</table>

Automatic reweighting applies to MIPS eligible clinicians, groups and virtual groups with following special statuses:
- Ambulatory Surgical Center (ASC)-based
- Hospital-based
- Non-patient facing
- Small practices

Basics:
- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points
# Promoting Interoperability Performance Category

## 2023 MIPS Finalized Policy

### Basics:
- Adjust measure points

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Prescribing</strong></td>
<td>e-Prescribing</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Query of PDMP</td>
<td>10 points*</td>
</tr>
<tr>
<td><strong>Health Information Exchange</strong></td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>15 points*</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Reconciling Health Information</td>
<td>15 points*</td>
</tr>
<tr>
<td></td>
<td>Health Information Exchange Bi-Directional Exchange*</td>
<td>30 points*</td>
</tr>
<tr>
<td></td>
<td>Enabling Exchange under TEFCA</td>
<td>30 points*</td>
</tr>
<tr>
<td><strong>Provider to Patient Exchange</strong></td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>25 points*</td>
</tr>
</tbody>
</table>
| **Public Health and Clinical Data Exchange** | Report the following 2 measures:  
- Immunization Registry Reporting  
- Electronic Case Reporting  | 25 points*     |
|                                    | Report one of the following measures:  
- Syndromic Surveillance Reporting  
- Public Health Registry Reporting  
- Clinical Data Registry Reporting | 5 points (bonus)* |

*indicates change from previous policy
<table>
<thead>
<tr>
<th>ID</th>
<th>2023 Promoting Interoperability Measure</th>
<th>2023 Promoting Interoperability Measure Description</th>
<th>2023 Promoting Interoperability Reporting Requirement (Yes/No Statement or Numerator/Denominator)</th>
<th>2023 Promoting Interoperability Validation (during performance period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>e-Prescribing</td>
<td>At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically using CEHRT.</td>
<td>Required</td>
<td>At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically via CEHRT.</td>
</tr>
<tr>
<td>6</td>
<td>e-Prescribing Exclusion</td>
<td>Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.</td>
<td>Required only if submitting an exclusion for the e-Prescribing measure. Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history.</td>
<td>Required</td>
<td>Uses data from CEHRT to conduct a query of a PDMP for prescription drug history prior to electronically prescribing a patient a Schedule II opioid, Schedule III drug, or Schedule IV drug using CEHRT. The 2018 QPP final rule finalized removing the numerator and denominator previously established and instead requires a “yes/no” response beginning with the 2019 performance period.</td>
</tr>
<tr>
<td>8</td>
<td>Query of Prescription Drug Monitoring Program (PDMP) Exclusion 1</td>
<td>MIPS eligible clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period.</td>
<td>Required only if submitting an exclusion for the Query of Prescription Drug Monitoring Program measure. Yes</td>
<td>The 2023 QPP final rule finalized an exclusion for the Query of PDMP measure for any MIPS eligible clinician that is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. The submission of a “yes” for the Query of PDMP measure will void the exclusion.</td>
</tr>
<tr>
<td>8</td>
<td>Query of Prescription Drug Monitoring Program (PDMP) Exclusion 2</td>
<td>MIPS eligible clinician writes fewer than 100 permissible prescriptions during the performance period.</td>
<td>Required only if submitting an exclusion for the Query of Prescription Drug Monitoring Program measure. Yes</td>
<td>The 2023 QPP final rule finalized an exclusion for the Query of PDMP measure for any MIPS eligible clinician that writes fewer than 100 permissible to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period. In order to submit an exclusion for this measure, MIPS eligible clinicians must select the exclusion for this measure. The submission of a “yes” for the Query of PDMP measure will void the exclusion.</td>
</tr>
</tbody>
</table>

Note: Updated from previous date to 2023 PI Criteria.

*Additional details can be found in the high priority practices guide SAFER guide.*
CMS Webinars

Webinar Library

Upcoming Webinars and Programs

No upcoming webinars. Check back periodically for updates.

Full Webinar Library

Search

Performance Year: All
QPP Reporting Track: All
Performance Category: All
Webinar Type: All

192 Webinars

2023 MIPS Overview
PY 2023 | MIPS, APMs | General

Recorded 05/10/2023
Merit-Based Incentive Payment System

What is the Merit-based Incentive Payment System (MIPS)?

MIPS is one way to participate in the QPP. The program describes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

- **Quality**: Assesses the quality of care you deliver based on measures of performance.
- **Improvement Activities**: Assesses your participation in activities that improve clinical practice and support patient engagement.
- **Promoting Interoperability**: Assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT).
- **Cost**: Assesses the cost of the care you provide based on your Medicare Part B claims.

For a high-level overview and actionable steps to understand your 2022 MIPS eligibility and participation requirements, review the [2022 MIPS Eligibility and Participation Quick Start Guide](#).
Small Practice Flexibilities

- 3 points for Quality measures that do not meet data completeness requirements
- Reduced Improvement Activity requirements
- PI hardship exception
- 6 bonus points added to Quality Category performance

**Small Practice Defined:**
15 or fewer eligible clinicians
- physician
- PA, NP, CNS
- CRNA
- certified nurse-midwife
- clinical social worker
- clinical psychologist
- registered dietitian/nutritional professional
- physical or occupational therapist
- qualified speech-language pathologist
- qualified audiologist
We understand that there may be circumstances out of your control that make it difficult for you to meet program requirements. To reduce this burden, we provide the opportunity to apply for exceptions to meeting Merit-based Incentive Payment System (MIPS) program requirements. In certain circumstances, these exceptions may be applied automatically. QPP exception guidelines may change each performance year due to policy changes.

**Performance Year**

Select your performance year.

There are 2 exception applications available to clinicians:

- The [MIPS Extreme and Uncontrollable Circumstances (EUC) Exception](http://example.com) application allows you to request reweighting for any or all performance categories if you encounter an extreme and uncontrollable circumstance that’s outside of your control.

- The [MIPS Promoting Interoperability Performance Category Hardship Exception](http://example.com) application allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of the reasons identified below.
Care Compare: Doctors and Clinicians Initiative

The Centers for Medicare & Medicaid Services (CMS) publicly reports Quality Payment Program (QPP) performance information for doctors, clinicians, groups, and Accountable Care Organizations (ACOs) on Medicare Care Compare Doctors and Clinicians profile pages and in the Provider Data Catalog (PDC). The performance information was previously reported on Physician Compare profile pages and in the Physician Compare Downloadable Database.

Spotlight and Announcements

2021 Quality Payment Program (QPP) Performance Information Now Available on Care Compare

The Centers for Medicare & Medicaid Services (CMS) added new 2021 Quality Payment Program (QPP) performance information for doctors, clinicians, groups, virtual groups, and Accountable Care Organizations (ACOs) to the Doctors and Clinicians section of Medicare Care Compare and in the Provider Data Catalog (PDC). CMS is required to report MIPS eligible clinicians’ final scores, MIPS eligible clinicians’ performances under each MIPS performance category, names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs. Performance information for doctors and clinicians is displayed using measure-level star ratings, percent performance scores, and checkmarks.
2023 Performance Period Timeline

Merit-based Incentive Payment System Timeline

The MIPS program has distinct phases that span several calendar years as shown below.

Performance Year
- Jan. 1 – Dec. 31, 2023
  - Clinicians care for patients and record data.
  - Check initial eligibility (January 2023)
  - Select a reporting option
  - Choose a participation option
  - Collect quality measure data (January - December)
  - Perform improvement activities (generally 90 days)
  - Collect Promoting Interoperability data (90+ days)
  - Check final eligibility (December 2023)

Data Submission
- Jan. 2 – April 1, 2024
  - Submit data collected in the performance year
  - Get a HARP account and OPP access (November 2023)
  - Sign in to the OPP website (January – March 2024) to
  - Attest to performing improvement activities and Promoting Interoperability measures
  - Upload your quality measure file or view data submitted on your behalf
  - View any Medicare Part B claims measures you reported throughout 2023

Performance Feedback
- Late Summer 2024
  - Review final score and payment adjustment
  - Sign in to the OPP website to view your performance feedback and payment adjustment information
  - Submit a targeted review request if you find any scoring errors (you have 60 days to do this once final performance feedback is released)

Payment Adjustment
- Jan. 1 – Dec. 31, 2025
  - Payment adjustments applied
  - MIPS eligible clinicians will receive a positive, negative, or neutral adjustment in the 2025 payment year based on their 2023 MIPS final score.
  - MIPS payment adjustments are applied on a claim-by-claim basis to covered professional services billed under the Physician Fee Schedule.

Keep in mind GIQuIC submission deadlines are in advance of CMS deadlines to ensure successful reporting for all participants wishing to report via the GIQuIC 2023 QCDR.
• January 1, 2023 - December 31, 2023, is the performance period for 2025 payment.
• Data must be submitted by the vendor by April 1, 2024.
  – Keep in mind vendors such as GIQuIC typically have deadlines in advance of this final submission deadline to CMS.
  – If reporting via the GIQuIC 2023 QCDR, you must adhere to GIQuIC deadlines.
2023 Performance Period Timeline

• **Mid June 2023:** Data Release Consent Form (DRCF) and CMS Form 1500 Upload processes along with the 2023 MIPS Dashboard open (IA and PI categories)

• **Mid July 2023:** Deadline to submit DRCF and upload CMS Form 1500

Reminder: To report via the GIQuIC 2023 QCDR a site must be registered and actively participating in GIQuIC (submitting data, generating reports) **no later than June 30, 2023**.

Subsequent steps and associated deadlines to be published soon.
Questions?

Your Participation

Grab Tab – Click orange arrow to open/close Control Panel.

Please continue to submit your text questions and comments using the Questions Panel.

**Note:** Today’s presentation is being recorded and will be available on the GIQuIC website in approximately two weeks.

If you have questions, please contact info@giquic.org.
Additional Questions

- Quality Payment Program
  https://qpp.cms.gov/
  qpp@cms.hhs.gov

- GIQuIC
  Anna Chareon, GIQuIC Registration only
  achareon@gi.org or info@giquic.org

Any Questions
Open a new ticket in **Service Desk** by logging into the registry at **giquicregistry.org** and select one of the **MIPS-related options** in **Ticket Category**.