Service. Technology. Innovation.

MIPS Year 8 (2024) Basic Overview

This reference sheet focuses on the Traditional MIPS reporting option.

3 Reporting Options

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

- **Traditional MIPS**: Established in the 1st year of QPP.
- **Alternative Payment Model (APM) Performance Pathway (APP):** APP is designed to reduce reporting burden, create new scoring opportunities, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs):** The newest reporting option beginning in 2023. This offers clinicians a subset of measures and activities relevant to a specialty or medical condition.

Participation Options

Individual: Collect/submit data for an individual eligible clinician
Group: Collect/submit data for all clinicians in the group
Virtual Group: Virtual group elections are submitted to CMS prior to the performance year. The CMS-approved Virtual Group collects/submits data through the Traditional MIPS reporting only.
APM Entity: Collect/submit data for eligible clinicians identified as participating in an APM.

Eligibility Criteria

Eligibility factors are:

- Enrolled as a Medicare Provider for the first time before January 1st 2023
- Clinician Type
- Exceed the Low Volume Threshold

MIPS Eligible Clinician Types
Physicians (Doctor of Medicine, Osteopathy, Dental Surgery, Dental Medicine, Podiatric Medicine, and Optometry)
Osteopathic practitioners
Chiropractors
Physician assistants
Nurse practitioners
Clinical Nurse Specialists
Certified Registered Nurse Anesthetists
Physical Therapists
Occupational Therapists
Clinical Psychologists
Qualified Speech-Language Pathologist
Qualified Audiologists
Registered Dietitians or Nutrition Professionals
Clinical Social Workers
Certified Nurse Midwives

Low-Volume Threshold (LVT)
The LVT includes 3 aspects of covered professional services:

1. Allowed Charges – Bill more than $90,000 for Medicare Part B covered professional services under the Physician Fee Schedule (PFS).
2. # of Patients – Provide services to more than 200 Medicare Part B patients.
3. # Services provided – Provide more than 200 covered professional services to Medicare Part B patient.

Determination Period

This data will be used to determine clinician/practice exceeding the Low Volume Threshold, special status and update clinician lists for each practice.

Segment 1 (Preliminary Eligibility) – October 1, 2022 - September 30, 2023
Segment 2 (Final Eligibility) – October 1, 2023 - September 30, 2024.
Exception: Eligibility will be based solely on segment 2 data when a TIN or TIN/NPI combination is newly established during segment 2 of the MIPS determination period.

The following is based on the Low-Volume Threshold (LVT) analyses:

SEGMENT 1	SEGMENT 2		FINAL DETERMINATION
Below LVT	Below LVT	=	MIPS Exempt
Below LVT	Above LVT	=	MIPS Exempt
Above LVT	Below LVT	=	MIPS Exempt
Above LVT	Above LVT	=	MIPS Eligible

CMS will release your final eligibility determination from the 2 segments in December 2024.

Special Status

Those with a special status qualify for bonus points or reduced reporting requirements in certain performance categories.

- Practicing in a rural area or Health Professional Shortage Area (HPSA).
- Non-patient facing, hospital-based, facility-based, or ambulatory surgical center (ASC)-based.
- A Small practice.

Opt-in Policy
You can elect to opt-in to MIPS as an Individual if:

- You are identified as a MIPS eligible clinician type on Medicare Part B claims.
- Have enrolled as a Medicare provider before 2024.
- Exceed 1 or 2 of the 3 LVT criteria as an individual.

You can elect to opt-in to MIPS as a Group if the practice:
Has at least ONE clinician who:

- Is identified as a MIPS eligible clinician type on Medicare Part B claims.
- Enrolled as a Medicare provider before 2024.
- Exceeds 1 or 2 of the 3 LVT criteria at the group level.

Individuals and/or groups must elect to opt-in and will be held to the same requirements, thresholds, and payments adjustments.

MIPS Categories: Performance Periods and Weighted Value towards Final Score

Quality: 30%
- Full calendar year

Promoting Interoperability (PI): 25%
- Minimum of 180 consecutive days up to a full calendar year

Improvement Activities (IA): 15%
- Minimum of 90 days or as indicated by the measure.

Cost: 30%
- CMS will collect data on cost measures for a full calendar year

Redistribution Policy

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	30%	30%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability*	40%	30%	30%	0%
-No Quality	0%	30%	15%	55%
-No Improvement Activities	45%	30%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability*	50%	0%	50%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	70%	30%	0%	0%
-No Quality and no Improvement Activities	0%	30%	0%	70%

*The finalized redistribution policy specifically for MIPS eligible clinicians in small practices.

MIPS Threshold and Payment Adjustments

MIPS Threshold: 75 Points
Payment Adjustment: Positive, Negative or Neutral at 9% applied to payment year 2026
Clinicians that are eligible to report as an individual who fail to submit data will receive the maximum reduction by 9%

Key Points on MIPS Categories

Quality
Report on 6 quality measures. At least one must be an outcome or high priority measure.
Collect data for a full calendar year.
You can report measures thru multiple collection types.
Maximum category score = 60 points
Small Practice receives 6 bonus points.
To earn maximum point value for each measure:
- Case Volume = 20 cases
- Data Completeness = 75%
- Measure has a benchmark.

Promoting Interoperability
Maximum category score = 100 points
Collect data for a minimum of 180 continuous days.
Complete the following:
- Collect data in EHR technology with 2015 Edition Cures Update CEHRT functionality.
- Provide your EHR CMS identification code.
- Report "YES" to Actions to Limit or Restrict Interoperability of CEHRT
- Report "YES" to ONC Direct Review
- Report "YES" to completing Security Risk Analysis
- Report "Yes" or "No" to the SAFER Guide Assessment
- Report on 6 to 7 measures or claim their exclusion(s)

Failure to meet all reporting requirements will result in 0 points for the category.

Improvement Activities
Implement activities to receive maximum category score of 40 points.
Carry out activities for a minimum of 90 days unless stated otherwise by the activity.
Group reporting – 50% of the clinicians must perform the same activity to receive credit.
Attest "YES" to the activities performed.
Maintain supporting documentation for 6 years.

Cost
CMS collects data from Parts A, B, and D claims.
Data is collected for a full calendar year.
Cost measures are assigned a point value from 1-10 if case volume is met.
Performance is compared to the performance year benchmark.
Must receive a score on 1 cost measure to receive a Category score.