CureMD

MIPS 2023

Final Rule

Contents

Performance Threshold & Payment Adjustments

- Minimum performance threshold is **75** points.
- Maximum payment adjustments remain the same at **+- 9%.**

Quality Category

- Quality category weightage is **30%.**
- Data completeness remains at **70%.**
- There are no bonus points awarded for reporting an extra High Priority or Outcome Quality measure.
- For Program Year 2023, CMS has finalized a comprehensive set of 198 quality measures. Among these measures, 76 have undergone substantive changes, reflecting CMS's commitment to continuous improvement.
- Additionally, CMS has introduced 9 new quality measures to address emerging areas of focus, while retiring 11 measures that are no longer deemed relevant or necessary. These changes demonstrate CMS's ongoing efforts to promote high-quality care and improve health outcomes for patients.

New Quality Measures	Collection Type
#485 Psoriasis – Improvement in Patient-Reported Itch Severity	MIPS Clinical Quality Measure (CQM)
#486 Dermatitis – Improvement in Patient-Reported Itch Severity	MIPS CQM
#487 Screening for Social Drivers of Health	MIPS CQM
#488 Kidney Health Evaluation	Electronic CQM (eCQM) and MIPS CQM
#489 Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	MIPS CQM
#490 Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	MIPS CQM
#491 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma	MIPS CQM
#492 Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	Administrative Claims*
#493 Adult Immunization Status	MIPS CQM

Retired Quality Measures	Collection Type
#76 Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	Medicare Part B Claims, MIPS CQM
#119 Diabetes: Medical Attention for Nephropathy	eCQM, MIPS CQMs
#258 Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	MIPS CQM
#265 Biopsy Follow-Up	MIPS CQM
#323 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	MIPS CQM
#375 Functional Status Assessment for Total Knee Replacement	eCQM
#425 Photodocumentation of Cecal Intubation	MIPS CQM
#455 Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)	MIPS CQM
#460 Back Pain After Lumbar Fusion	MIPS CQM
#469 Functional Status After Lumbar Fusion	MIPS CQM
#473 Leg Pain After Lumbar Fusion	MIPS CQM

Quality Measures Removed from Traditional MIPS*	Collection Type
#110: Preventive Care and Screening: Influenza Immunization	Medicare Part B Claims, eCQM, MIPS CQM
#111: Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims, eCQM, MIPS CQM

Promoting Interoperability Category

- Promoting Interoperability Category weightage is **25%.**
- Promoting Interoperability Category is reported for a minimum of **90 days.**
- Changes to this category aim to improve the interoperability of health data and promote better care coordination. With these updates, CMS expects to increase the accuracy and completeness of patient data while also reducing administrative burdens for MIPS eligible clinicians.
- CMS has announced a number of changes to the Promoting Interoperability (PI) category to further improve healthcare data exchange. These updates include:
- Updating the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure to require additional information and to make it more effective.

- Expanding the PDMP measure to include Schedule III and IV drugs, in addition to Schedule II opioids.

- Adding a new option for the Health Information Exchange (HIE) Objective, the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure, as an optional way to meet the objective.

- Reducing the number of active engagement options from three to two levels for the Public Health and Clinical Data Exchange Objective, while also requiring reporting of active engagement for the measures under the objective.

- Continuing to reweight the PI category for certain types of non-physician practitioner MIPS eligible clinicians.

- These changes aim to improve the interoperability of health data and promote better care coordination. With these updates, CMS expects to increase the accuracy and completeness of patient data while also reducing administrative burdens for MIPS eligible clinicians.

PI Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Query of PDMP	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points
	OR	
	Health Information Exchange Bi-Directional Exchange*	30 points
	OR	
	Participation in TEFCA	30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points
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)

Improvement Activities Category

- Improvement Activities Category weightage is **15%.**
- Improvement Activities Category is reported for a minimum of **90 days.**
- CMS will suspend an Improvement Activity if reporting the activity is considered obsolete or it may be of concern towards a patient's safety. In such cases, CMS will notify clinicians through their communication channels and propose to either modify the activity or completely remove it.
- The MIPS Improvement Activities (IA) category is undergoing updates to its inventory, with no major changes in its overall structure. Specifically, the Centers for Medicare & Medicaid Services (CMS) is introducing four new activities, modifying five existing ones, and removing five improvement activities from the IA inventory.

New Improvement Activities	Retired Improvement Activities
IA_AHE_10 Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data (Medium)	IA_BE_7 Participation in a QCDR, that promotes use of patient engagement tools
IA_AHE_11 Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients (High)	IA_BE_8 Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive
IA_EPA_6 Create and Implement a Language Access Plan (High)	IA_PM_7 Use of QCDR for feedback reports that incorporate population health
IA_ERP_6 COVID-19 Vaccine Achievement for Practice Staff (Medium)	IA_PSPA_6 Consultation of the Prescription Drug Monitoring program
	IA_PSPA_20 Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
	IA_PSPA_30 PCI Bleeding Campaign

Cost Category

- Cost Category weightage is **30%.**

- For the 2023 performance period, there are a total of 25 cost measures that CMS utilizes to evaluate performance. These measures are calculated using Medicare claims data, which eliminates the need for clinicians to manually submit any data for this particular performance category. This streamlined process allows clinicians to focus their efforts on other areas of performance evaluation.

- There are 25 total cost measures for the 2023 performance period. CMS uses Medicare claims data to calculate cost measure performance which means clinicians do not have to submit any data for this performance category.

Measure Name	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	This population-based measure assesses the overall cost of care delivered to a Medicare patient with afocus on primary care received.	20 Medicare patients	Medicare Parts A and B claims data
Medicare Spending Per Beneficiary (MSPB) Clinician	This population-based measure assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient	35 episodes	Medicare Parts A and B claims data
15 procedural episode-based measures	Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.	10 episodes for all procedural episode-based measures except the Colon and Rectal Resection measure which has a case minimum of 20 episodes.	Medicare Parts A and B claims data
6 acute inpatient medical condition episode-based measures	Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode based measures	Medicare Parts A and B claims data
2 chronic condition episode based measures	Assess the cost of care clinically related to the care and management of patients' specific chronic conditions provided during a total attribution window divided into episodes.	20 episodes for chronic condition episode-based measures	Medicare Parts A, B and D claims data

Measure Name	Measure Type	Episode Window	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Acute inpatient (IP) hospitals, hospital outpatient department (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	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	ASCs, ambulatory/ office-based care, and HOPDs
Screening/ Surveillance Colonoscopy	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 14 days	ASCs, ambulatory/ office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Acute IP hospitals
Elective Primary Hip Arthroplasty	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Acute IP hospitals, HOPDs,ambulatory/ office-based care centers, and ASCs

Femoral or Inguinal Hernia Repair	Procedural	Pre-Trigger Period = 60 days Post-Trigger Period = 90 days	Acute IP hospitals, HOPDs, ambulatory/ office-based care centers, and ASCs
Hemodialysis Access Creation	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	Ambulatory/office-based care centers, OP hospitals, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	ASCs, HOPDs, and acute IP hospitals
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Procedural	Pre-Trigger Period = 60 days Post-Trigger Period = 90 days	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	Acute IP hospitals
Renal or Ureteral Stone Surgical Treatment	Procedural	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Melanoma Resection	Procedural	Pre-Trigger Period = 30 days Post-Trigger Period = 90 days	ASCs, ambulatory/ office-based care, and HOPDs.
Colon and Rectal Resection	Procedural	Pre-Trigger Window : 15 days Post-Trigger Window : 90 days	ASCs, HOPDs, and acute IP hospitals.

Measure Name	Measure Type	Episode Window	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 90 days	Acute IP hospitals
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Acute IP hospitals
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary I ntervention (PCI)	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 30 days	Acute IP hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Trigger Period = 60 days	Acute IP hospitals
Lower Gastrointestinal Hemorrhage	Acute inpatient medical condition	Pre-Trigger Period = 0 days Post-Tigger period = 35 days	Acute IP hospitals
Sepsis	Acute inpatient medical condition	Pre-Trigger Window : 0 days Post-Trigger Window : 45 days	Acute IP hospitals

Measure Name	Measure Type	Episode Window	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Diabetes	Chronic condition	An episode is a segment of time during which clinicians or clinician groups are assessed for the care that they provide to a patient with diabetes.The episode window length for the Diabetes measure is between 1 year (365 days) and 2 years minus 1 day (729 days) and can vary in length across patients.	The measure focuses on care provided by clinicians practicing in non-IP hospital settings for patients with diabetes. The most frequent settings in which a Diabetes episode is triggered include: Office, Skilled Nursing Facility (SNF), and OP Hospital.
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	An episode is a segment of time during which clinicians or clinician groups are assessed for the care that they provide to a patient with asthma or COPD. The episode window length for the Asthma/ COPD measure is between 1 year (365 days) and 2 years minus 1 day (729 days) and can vary in length across patients.	The measure focuses on care provided by clinicians practicing in non-IP hospital settings for patients with asthma or COPD. The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP Hospital.

Complex Patient Bonus

- The complex patient bonus is 10 points. These 10 points are added to a clinician's final score.

- The bonus is available to clinicians who have a median or higher value for at least one of the two risk indicators (Hierarchical Condition Category (HCC) and proportion of patients eligible for both Medicare and Medicaid benefits).

MIPS Value Pathways (MVPs)

- MVPs will connect measures and activities from all the MIPS performance categories.
- MVPs will be made of measures and activities that are relevant to a medical condition, episode of care, and specialty.
- The MVP framework aims to provide feedback and data to clinicians and patients by comparing performance of clinicians that reported the same MVP.

In accordance with the 2022 MIPS final rule, CMS has announced the availability of MVPs for reporting, commencing from the 2023 performance year.

The details are as follows:

- For the years 2023, 2024, and 2025, individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM Entities can report MVPs.

- For the 2026 performance year and subsequent years, individual clinicians, single specialty groups, and subgroups, and APM Entities can report MVPs, whereas multispecialty groups will be required to create subgroups to report MVPs.

- In line with CMS's continued emphasis on the development of MVPs and subgroup reporting, a total of 12 MVPs have been finalized for the 2023 performance year

MVPs	
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP	Improving Care for Lower Extremity Joint Repair MVP
Advancing Cancer Care MVP	Optimal Care for Kidney Health MVP
Advancing Care Heart Disease MVP	Optimizing Chronic Disease Management MVP
Advancing Rheumatology Patient Care MVP	Patient Safety and Support of Positive Experiences with Anesthesia MVP
Optimal Care for Patients with Episodic Neurological Conditions MVP	Promoting Wellness MVP
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP	Supportive Care for Neurodegenerative Conditions MVP

CureMD

MIPS Registry

- CureMD has been approved MIPS registry since beginning of program.
- With a 100% success rate, we have successfully submitted MIPS data before the deadline. 78.4% of providers that have worked with us have been awarded exceptional performance bonus.
- CureMD MIPS consultant have a collective experience of 100 years. We've worked with providers across 40 specialties.

Learn more about MIPS
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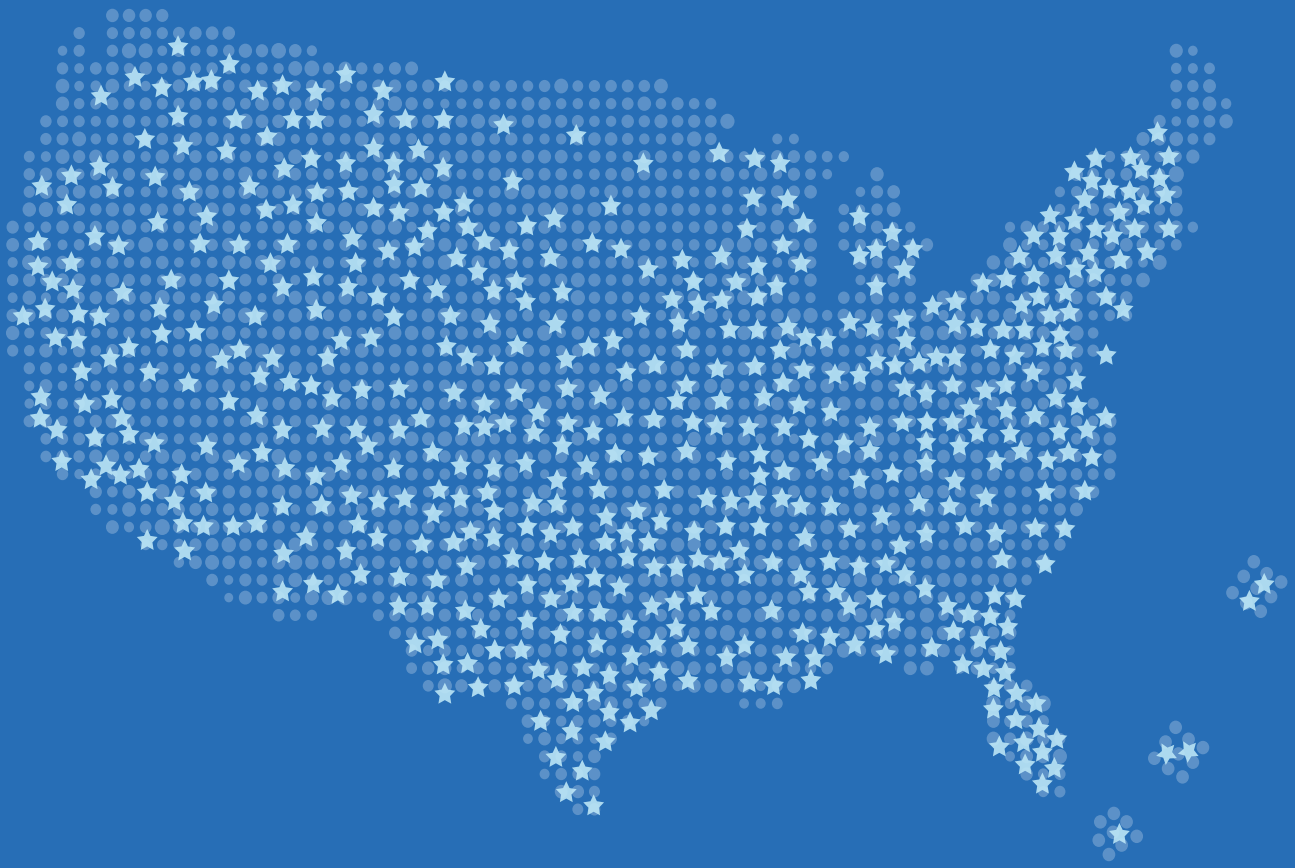

Customer footprint as of Jan 2023

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