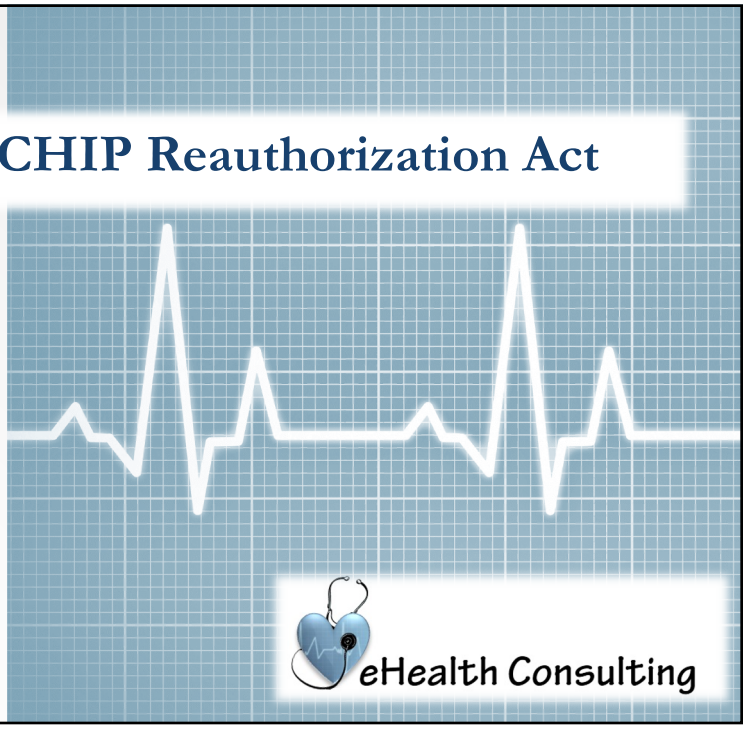
Medicare Access and CHIP Reauthorization Act

MIPS and APMs

- A **Medicare** Program

YEAR 6, 2022



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2021 Clarifications

- Data Completeness for a Part B Claims measure is 70% of Medicare Part B patients seen during the performance period that meet the denominator criteria, retroactive to 2020 PY
- Continue doubling the Complex Patient Bonus – up to 10 points
- Medicare Part B Claims Measures suppressed due to code rejections
  - 001: Hemoglobin A1c
  - 117: Diabetes: Eye Exam

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Extreme and Unusual Circumstances (EUC)

- Extreme and Unusual Circumstance Hardship
  - Application submission by 12/31/YYYY
  - Ransomware, Natural Disaster, PHE
  - APMs are eligible

Estimated Payments based on 2022

TABLE 146: MIPS Estimated CY 2022 Performance Period/MIPS 2024 Payment Year Impact on Total Estimated Paid Amount by Participation Status and Practice Size**

Practice Size*	Number of MIPS eligible clinicians	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount***
Among those who submit data**					
1) 1-15	108,274	63.6%	22.4%	36.4%	1.5%
2) 16-24	36,925	56.8%	15.7%	43.2%	0.5%
3) 25-99	174,982	60.7%	15.7%	39.3%	0.9%
4) 100+	463,232	70.6%	12.1%	29.4%	1.1%
Overall	**783,413**	**66.8%**	**14.5%**	**33.2%**	**1.2%**
Among those not submitting data					
1) 1-15	22,475	0.0%	0.0%	100.0%	-8.4%
2) 16-24	1,094	0.0%	0.0%	100.0%	-8.5%
3) 25-99	2,028	0.0%	0.0%	100.0%	-8.5%
4) 100+	583	0.0%	0.0%	100.0%	-8.6%
Overall	**26,180**	**0.0%**	**0.0%**	**100.0%**	**-8.5%**

NOTE: Results of this model may change significantly if more clinicians apply for the application-based extreme and uncontrollable circumstances policy exception in CY 2021 because of the PHE for COVID-19.
*Practice size is the total number of TIN/NPIs in a TIN.
** 2019 data used to estimate CY 2022 performance period/2024 MIPS payment year payment adjustments. Payments estimated using 2019 dollars trended to 2024.
***The percentage represents the total adjustments after taking all the positive adjustments and subtracting the negative adjustments for all MIPS eligible clinicians in the same respective practice size.
****Includes facility-based clinicians cost and quality data are submitted through hospital programs.

MIPS Eligible Clinicians

MIPS Year 6

Physicians billing Medicare

Doctor of Osteopathy
Doctor of Podiatric Medicine
Doctor of Optometry
Doctor of Oral Surgery
Doctor of Dental Medicine
Doctor of Chiropractic

*Exempt from PI

MIPS Year 6

Practitioners billing Medicare

Physician Assistant
Nurse Practitioner
Clinical Nurse Specialist
Certified Registered Nurse Anesthetist
*Clinical Psychologist
Certified Nurse Midwife
*Clinical Social Worker
*Physical Therapist
*Occupational Therapist
*Qualified Speech Therapist
*Audiologist
*Registered Dietician
*Nutrition Professional

Adding In future years

Future Participants

Registered Nurse

Do you have to participate?

> $90,000 allowed charges > 200 MCR patients > 200 covered services

Determination Period

Source: CMS 2020 Quick Start Guide

October 1, 2020 - September 30, 2021 (2 years prior)
October 1, 2021 - September 30, 2022 of the reporting year

Choose not to participate?

-9 %

Payment Adjustment

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Definition Updates

- Collection Types
  - Electronic Clinical Quality Measures (eCQM)
  - MIPS Clinical Quality Measures (MIPS CQMs)
  - Qualified Clinical Data Registry (QCDR)
  - Medicare Part B Claims
  - *CMS Web Interface – 2022 last year for large practices, 2024 for APP and MSSP
  - CAHPS for MIPS survey
  - Administrative Claims

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Definition Updates

- Submission Type
  - Direct
  - Login and Upload
  - Login and Attest
  - Medicare Part B Claims **Counted individually unless another category is submitted as a group
  - *CMS Web Interface – 2022 last year for large practices, 2024 for APP and MSSP
- Submitter Type
  - Individual
  - Group
  - Subgroup
  - Virtual Group
  - APM Entity
  - 3rd party intermediary

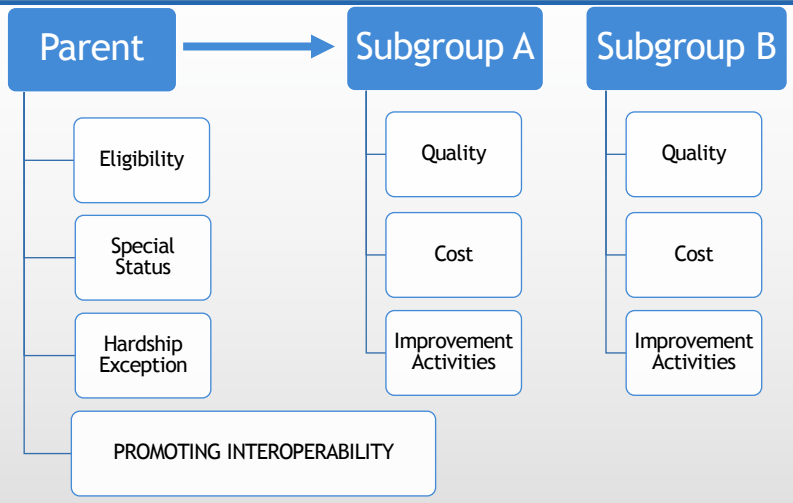
Definition updates

- Single specialty group - a TIN limited to one specialty
- Multi-specialty group – a TIN with 2 or more specialties

Submitter Type – Subgroup

- Introduced for Reporting year 2023 for MVPs and APPs
- Subgroups in an MVP will *register* and be assigned an identifier. Subgroups in an APP do NOT have to register.
- 75% of the subgroup must be the same specialty
- Reweighting can occur if the affiliated group qualifies for reweighting or if an EUC is approved

Parent to Subgroup Relationship



2022 Scoring Updates

- Final Score = 75 points
- Exceptional performance >= 89 points
- $500 Million for Exceptional Performers
  - 2022 performance year is the last year

MIPS Performance Categories/Reporting Periods

- Quality (30%)
  - FULL CALENDAR YEAR or 9 months if substantive changes determined and published by CMS
- Cost (30%)
  - FULL CALENDAR YEAR
  - Feedback reports based on 2021, published July 2022
- Improvement Activities (IA) (15%) – 100% credit if a Medical Home or CPC+ practice
  - 90 CONSECUTIVE DAYS up to the full calendar year
- Promoting Interoperability (PI) (25%) – Meaningful Use
  - 90 CONSECUTIVE DAYS up to the full calendar year

Performance Category Weight in Final Score

	MIPS 2022	APP 2022	MIPS APM 2022
Quality	30%	50%	55%
Cost	30%	0%	0%
Improvement Activities	15%	20%*	15%
Promoting Interoperability	25%	30%	30%

*APMs submitting using the APP receive 100% of IA points automatically

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Quality Measure Performance Category

- Report on six quality measures
  - One outcome measure or another high priority measure
  - One specialty-specific or subspecialty-specific if applicable
  - CAHPS for MIPS survey counts as 1 high priority CQM
  - Both patient and non-patient facing EPs must meet the requirement
- Published each year in the Federal Register by 11/1
- measure stewards are still working to increase specialty specific measures as we transition to MIPS Value Pathways

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CAHPS for MIPS Survey

- Patients that received an ICH (In-center Hemodialysis) CAHPS survey in the previous spring will be excluded from the MIPS survey – this surveys are sent out twice a year
- An Asian language survey is added
- There are still 10 SSMs – 9 benchmarked and 1 not benchmarked, includes the Access to Specialists measure

Large Practice Change – the 7th measure…

- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS**
- **If the 200-case minimum is not met, the practice is scored on 6 measures**

A.1. Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups

Category	Description
NQF # / eCQM NQF #:	N/A / N/A
Quality #:	479
Description:	This measure is a re-specified version of the measure, "Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition" (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.
Measure Steward:	Centers for Medicare & Medicaid Services
Numerator:	The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned.
Denominator:	Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short-term acute care hospital; and, Not transferred to another acute care facility.
Exclusions:	1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for "rehabilitation care; fitting of prostheses and adjustment devices" (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group.
Measure Type:	Outcome
Measure Domain:	Communication and Care Coordination (section 1848(s)(1)(B)(iii) of the Act)
High Priority Measure:	Yes (Outcome)
Collection Type:	Administrative Claims
Measure Implementation:	MIPS eligible groups with at least 16 clinicians / 200 case minimum / 1 year performance period (January 1st – December 31st)

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2022 Quality Measures - 200

TABLE 90: Summary of Quality Measures Finalized for the CY 2022 Performance Period/2024 MIPS Payment Year

Collection Type	# Measures Finalized as New	# Measures Finalized for Removal*	# Measures Finalized with a Substantive Change*	# Measures Finalized for CY 2022*
Medicare Part B Claims Specifications	0	-13	16	34
MIPS CQMs Specifications	+2	-13	70	174
eCQM Specifications	+1	0	41	48
Survey – CSV	0	0	0	1
CMS Web Interface Measure Specifications	0	0	10	10
Administrative Claims	+1	0	0	3
Total	+4	-13*	+87*	200*

*A measure may be specified under multiple collection types but will only be counted once in the total.

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Quality – Submission Types – APM Entity

- Traditional APM scoring was removed in 2021
- New APP or Alternate Payment Model Performance Pathway
  - Decrease burden of reporting
  - Provide flexibility in choosing measures
  - Less measures to report
  - Begin the transition to value pathways
- Two Quality reporting options through 2024
  - CMS Web Interface
  - eCQMs or MIPS CQM Registry
- 2025
  - Submit 3 eCQMs and achieve a quality score >= 40% across all the MIPS category scores

CMS Web Interface 2022 APPs and MSSP 2024

**Measures 134, 370, and 438 are not scored

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Prevention and Treatment of Opioid and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

+ We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) do not have benchmarks and are therefore not scored for PY 2022; they are, however, required to be reported in order to complete the Web Interface dataset.
* ACOs will have the option to report via Web Interface for the 2022, 2023, & 2024 MIPS performance periods only.

APM Entity eCQM or MIPS CQM

Measure #	Measure Title	Measure Type	SSP Quality Performance Standard	
			MIPS Comparable Measure	Outcome Measure
Quality ID#: 321	CAHPS for MIPS	Patient-Reported Outcome	Yes	No
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Outcome	Yes	Yes
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS	Outcome	Yes	Yes
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Intermediate Outcome	Yes	Yes
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	Yes	No
Quality ID#:236	Controlling High Blood Pressure	Intermediate Outcome	Yes	Yes

Data Completeness

- Data completeness is the percentage of data submitted based on the patient population that meets the denominator criteria for a given measure
- Thresholds for data completeness for 2022 **AND** 2023 performance year
  - CMS Web Interface = 100%
  - Administrative Claims Data = 100%
  - All other measurement methods = 70%

Switching EHRs?

- Quality performance period remains the full calendar year
- Aggregate data from the 2 CEHRTs
- If this cannot be done, data completeness is a risk and could significantly impact scoring

Quality Measure Scoring

Class	Benchmark	Case Minimum	Data Completeness	Scoring
1	✓	✓	✓	3 - 10 points based on benchmark
2	✓	X	✓	3 points
3	✓	✓	X	Small practice = 3 points Large practice = 0 points
4a	X	X	✓	No Benchmark Year 1 = 7 points No Benchmark Year 2 = 5 points
4b	✓	✓	✓	Benchmark Year 1 = 7 - 10 points Benchmark Year 2 = 5 - 10 points

Quality Performance Benchmarks

- Benchmarks can be calculated from the 2020 performance period
- There is no need to use a different benchmark methodology for the 2022 performance year

Quality Performance Category – 60 to 100 pts

- Small practices → 60 possible points
- Large practices → 70 possible points (6 measures + HWR)
  - The Unplanned Hospital Wide Readmission for large practices with over 200 pts in the sample → the extra 10 points
- Group practices via CMS web Interface → 100 possible pts (10 measures)
  - Must register through the CMS web interface by June 30, 2022
  - Report on 258 Medicare beneficiaries for each measure
- Bonus points are no longer available for additional outcome/high-priority measures or end-to-end reporting

New Quality Measures

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Quality Scoring for New Measures

- New Quality Measures have a 7-point floor for the first performance year if data completeness and case minimums are met
  - If there is a benchmark – 7 to 10 points depending on performance
  - No benchmark = 7 points
  - Data completeness or case minimum not met
    - 0 for large practices
    - 3 for small practices
- New Quality Measures have a 5-point floor in the second performance year – same rules as above

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TABLE Group A: New Quality Measures Proposed for the CY 2022 MIPS Performance Period/2024 MIPS Payment Year and Future Years

A.1. Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	TBD
Description:	Percentage of patients initially diagnosed with non-muscle invasive bladder cancer and who received intravesical Bacillus-Calmette-Guerin (BCG) within 6 months of bladder cancer staging.
Measure Steward:	Oregon Urology
Numerator:	Intravesical Bacillus-Calmette Guerin (BCG) instillation for initial dose or series. BCG is initiated within 6 months of the bladder cancer staging and during the measurement period.
Denominator:	All patients initially diagnosed with T1, Tis or high grade Ta non-muscle invasive bladder cancer and a qualified encounter in the measurement period.
Exclusions:	Denominator Exceptions: Unavailability of BCG Denominator Exclusions: Immunosuppressed patients, includes HIV and immunocompromised state. Immunosuppressive drug therapy. Active Tuberculosis. Mixed histology urothelial cell carcinoma including micropapillary, plasmacytoid, sarcomatoid, adenocarcinoma and squamous disease. Patients who undergo cystectomy, chemotherapy or radiation within 6 months of Bladder Cancer Staging.
Measure Type:	Process
Measure Domain:	Effective Clinical Care (section 1848(s)(1)(B)(i) of the Act)
High Priority Measure:	No
Collection Type:	eCQM Specifications
Measure-Specific Case Minimum/Performance Period:	N/A for this measure
	We are proposing this measure because it addresses a gap in care for patients diagnosed with bladder cancer. Treatment at this stage (non-muscle invasive) can help prevent invasion into the muscle layer which leads to potential bladder removal and additional chemotherapy and/or radiation treatment. It was reviewed by the 2016 National Quality Forum (NQF) Measure Application Partnership (MAP) with a recommendation to refine to address concerns what populations would be included or excluded from the measure. The measure was updated according to MAP feedback by redefining the eligible patient population and exclusions.

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A.2. Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	TBD
Description:	Percentage of adult hemodialysis patient-months using a catheter continuously for three months or longer for vascular access attributable to an individual practitioner or group practice.
Measure Steward:	Centers for Medicare & Medicaid Services
Numerator:	The numerator is the number of adult patient-months in the denominator who were on maintenance hemodialysis using a catheter continuously for three months or longer as of the last hemodialysis session of the reporting month.
Denominator:	All patients at least 18 years old as of the first day of the reporting month who are determined to be maintenance hemodialysis patients (in-center and home HD) for the complete reporting month under the care of the same practitioner or group partner.
Exclusions:	Exclusions that are implicit in the denominator definition include: • Pediatric patients (<18 years old). • Patients on Peritoneal Dialysis for any portion of the reporting month. • Patient-months where there are more than one MCP provider listed for the month. In addition, patients with a catheter that have limited life expectancy, as defined by the following criteria are excluded: • Patients under hospice care in the current reporting month. • Patients with metastatic cancer in the past 12 months. • Patients with end stage liver disease in the past 12 months. • Patients with coma or anoxic brain injury in the past 12 months
Measure Type:	Intermediate Outcome
Measure Domain:	Effective Clinical Care (section 1848(s)(1)(B)(i) of the Act)
High Priority Measure:	Yes
Collection Type:	MIPS CQMs Specifications
Measure-Specific Case Minimum/Performance Period:	N/A for this measure

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A.3. Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	TBD
Description:	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM PROM (a comprehensive and parsimonious set of 11 patient-reported items) to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature.
Measure Steward:	The American Board of Family Medicine
Numerator:	The target population is all active patients in a practice during the performance reporting period. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of their birth month within the measurement period. The PCPCM PROM is the same for all patients, regardless of age. Because the PCPCM PROM applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month. The target population is defined the same, regardless of unit of analysis (clinician, practice, or system). The numerator is the sum of all PCPCM PROM scores for active patients. 1. My practice makes it easy for me to get care. 2. My practice is able to provide most of my care. 3. In caring for me, my doctor considers all the factors that affect my health. 4. My practice coordinates the care I get from multiple places. 5. My doctor or practice knows me as a person. 6. My doctor and I have been through a lot together. 7. My doctor or practice stands up for me. 8. The care I get takes into account knowledge of my family. 9. The care I get in this practice is informed by knowledge of my community. 10. Over time, my practice helps me to stay healthy. 11. Over time, my practice helps me to meet my goals.
Denominator:	The denominator is the total number of complete PCPCM PROM instruments received in the reporting period. A completed PROM instrument is defined as a PROM instrument for which the patient has responded to at least 8 of 11 items. The target population is all active patients in a practice during the performance reporting period. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of their birth month during the measurement period. The PCPCM PROM is the same for all patients, regardless of age. Because the PCPCM PROM applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month. The target population is defined the same, regardless of unit of analysis (clinician, practice, or system).
Exclusions:	None
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Measure Domain:	Person and Caregiver-centered Experience and Outcomes (section 1848(s)(1)(B)(iv) of the Act)
High Priority Measure:	Yes
Collection Type:	MIPS CQMs Specifications

2022 Case Minimums can vary based on Measure – default is 20 cases

A.3. Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	TBD
Measure-Specific Case Minimum/Performance Period::	For each MIPS eligible clinician, group, subgroup*, virtual group, and APM Entity, a minimum of 30 PCPCM PROM instruments per clinician are needed for submission of this measure. All valid survey results (as defined in the specification) should be included in the aggregate score. For MIPS eligible groups, subgroups*, virtual groups, and APM Entities with 5 or more clinicians, a minimum of 150 PCPCM PROM instruments per TIN for each site/location associated with the clinicians part of the group, subgroups, virtual groups, and APM Entities are needed for submission of this measure. For TINs with a composition of multiple specialty practices at one site/location, a minimum of 150 PCPCM PROM instruments per specialty practice within a TIN are needed for submission of this measure. If the MIPS eligible group, subgroup*, virtual group, and APM Entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PROM instruments requirements as stated. *Subgroups are only available through MVP reporting. All measure-specific criteria must be met by the subgroup.

150 minimum if more than 5 ECs reporting in a group

A.5. Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions[267]

Category	Description
NQF # / eCQM NQF #:	N/A
Quality #:	TBD
Description:	Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs).
Measure Steward:	Centers for Medicare & Medicaid Services
	"The outcome for this measure is the number of acute, unplanned hospital admissions per 100 person-years at risk for admission during the measurement period. Time Period The outcome includes inpatient admissions to an acute care hospital during the measurement year. Excluded Admissions This measure does not include the following types of admissions in the outcome because they do not reflect the quality of care provided by ambulatory care clinicians who are managing the care of MCC patients: 1. Planned hospital admissions. 2. Admissions that occur directly from a skilled nursing facility (SNF) or acute rehabilitation facility. 3. Admissions that occur within a 10-day "buffer period" of time after discharge from a hospital, SNF, or acute rehabilitation facility. 4. Admissions that occur after the patient has entered hospice. 5. Admissions related to complications from procedures or surgeries. 6. Admissions related to accidents or injuries. 7. Admissions that occur prior to the first visit with the assigned clinician or clinician group. To identify planned admissions, the measure adopted an algorithm CORE previously developed for CMS's hospital readmission measures, CMS's Planned Readmission Algorithm Version 4.0. [1,2] In brief, the algorithm uses the procedure codes and principal discharge diagnosis code on each hospital claim to identify planned admissions. A few specific, limited types of care are always considered planned (for example, major organ transplant, rehabilitation, and maintenance chemotherapy). Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure (for example, total hip replacement or cholecystectomy). Admissions for an acute illness are never considered planned.

18 CASE MINIMUM

Quality Measures – Substantive Changes

- Makes measure more stringent
- Modifies the collection/submission type
- Impacts clinical outcome or action
- Increases burden on clinicians
- Modifies the objective of the measure
- Changes the scope (population or measurement period)

- Addressed either by a shortened reporting period (9 months) or suppressing the measure from scoring

2022 Quality Measures for Removal

- Age-Related Macular Degeneration (AMD): Dilated Macular Examination 0087 – Claims, MIPS CQMs
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care 0019 – eCQM, MIPS CQMs
- Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin NQF 268 – Claims, MIPS CQMs
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) 023 – Claims, MIPS CQMs

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2022 Quality Measures for Removal

- Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery 044 – MIPS CQMs
- Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older 050 – Claims, MIPS CQMS
- Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow 067 – MIPS CQMs
- Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry 070 – MIPS CQMs
- Melanoma: Continuity of Care – Recall System 137 – MIPS CQMs

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2022 Quality Measures for Removal

- Oncology: Medical and Radiation - Plan of Care for Pain 144 - MIPS CQMs
- Falls: Risk Assessment 154 - Claims, MIPS CQMs
- Radiology: Stenosis Measurement in Carotid Imaging Reports 195 - Claims, MIPS CQMs
- Radiology: Reminder System for Screening Mammograms 225 - Claims, MIPS CQMs
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented 317 - Claims, eCQM, MIPS CQMs

2022 Quality Measures for Removal

- Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier 337 - MIPS CQMs
- Pain Brought Under Control Within 48 Hours 342 - MIPS CQMs
- Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy 429 - Claims, MIPS CQMs
- Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair 434 - MIPS CQMs
- Medication Management for People with Asthma 444 - MIPS CQMs

Performance Feedback Reports

- Access your Performance Feedback Report at QPP.CMS.GOV
  - 2020 performance on **quality** and **cost** measures relative to national benchmarks
  - Indicate whether physicians will receive an upward, neutral or downward adjustment
  - Preview of data that will be published on Physician Compare
- July 2022 – the 2021 performance metrics will be available for review

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Cost Performance Category

- 30 % of the final score for MIPS, 0% for APMs
- Benchmark is based on the performance year (2022 in this case)
- Achievement points per measure (up to 10) are applied based on comparison to the benchmark
- All cost performance measures are based on claims and are calculated as an equally weighted average of all measures scored
- 5 additional measures for 2022

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Cost Category Measures

Existing Measures	Minimums
Total Per Capita Cost	20 Cases
Medicare Spending Beneficiary	35 Cases
Elective Outpatient Percutaneous Coronary Intervention (PCI)	10 Cases
Knee Arthroplasty	10 Cases
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	10 Cases
Routine Cataract Removal with Intraocular Lens (IOL) implantation	10 Cases
Screening/Surveillance Colonoscopy	10 Cases
Intracranial Hemorrhage or Cerebral Infarction	20 Cases
Simple Pneumonia with Hospitalization	20 Cases
ST Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	20 Cases

Cost Category Measures

Measure	Minimums
Acute Kidney Injury Requiring New Inpatient Dialysis	20 Cases
Elective Primary Hip Arthroplasty	20 Cases
Femoral or Inguinal Hernia Repair	20 Cases
Hemodialysis Access Creation	20 Cases
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	20 Cases
Lower Gastrointestinal Hemorrhage (Group Only)	20 Cases
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	20 Cases
Lumpectomy Partial Mastectomy, Simple Mastectomy	20 Cases
Non-Emergent Coronary Artery Bypass Graft (CABG)	20 Cases
Renal or Ureteral Stone Surgical Treatment	20 Cases

New Cost Category Measures

Measure	Minimums
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	20 Cases
Diabetes	20 Cases
Colon and Rectal Resection	20 Cases
Melanoma Resection	10 Cases
Sepsis	20 Cases

Call for Cost Measures for the 2024 performance period

Consideration of substantive changes – has the objective changed, patient population, new cost category and the impact of those changes on measurement
Results in measure being excluded from calculation of score

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Cost Measure Attribution

- Each Cost measure specification includes the exact definition of attribution
- For the new chronic disease measure, a triggering event occurs when a clinician bills an E&M charge for two visits in close proximity. This opens a 1 year attribution period for the clinician.
- If other clinicians bill services for the same patient, the patient would be attributed to the clinician with 30% of the services
- Whether or not the clinician writes prescriptions for the chronic condition is also considered when determining the correct attribution

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Improvement Activity Scoring

- 15% for MIPS
- 20% for MIPS APMs
- Full credit awarded to
  - PCMH credentialed practices
  - APP participants
  - CPC+ or other medical home model
- At least 50% of providers must participate

Improvement Activity Changes for Health Equity

- 7 new
- 15 modified
- 6 removed

New Improvement Activities

- Create and Implement an Anti-Racism Plan IA_AHE_XX
- Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols IA_AHE_XX
- Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice IA_BMH_XX
- Promoting Clinician Well-Being IA_BMH_XX
- Implementation of a Personal Protective Equipment (PPE) Plan IA_ERP_XX
- Implementation of a Laboratory Preparedness Plan IA_ERP_XX
- Application of CDC's Training for Healthcare Providers on Lyme Disease IA_PSPA_XX

Criteria for New Improvement Activities

- No duplication of existing
- Drive care to exceed the current standard of practice
- Fall under an existing improvement activity subcategory
- High probability of improving beneficiary health outcomes
- Able to implement with minimal burden
- Lines up with existing MIPS Quality, Cost, and PI measures to support development of MVPs
- CMS can validate the activity

Improvement Activity Selection – Optional

- PCMH alignment
- Support the family or caregivers
- Respond to PHE
- Reduces health care disparities
- Focus on meaningful actions from the patient and family perspective
- Applicable to multiple specialties and groups

Removed Improvement Activities

- Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms
- Participation in CAHPS or another supplemental questionnaire
- Use of tools to assist patient self-management
- Provide peer-led support for self-management
- Implementation of condition-specific chronic disease self-management support programs
- Improved practices that disseminate appropriate self-management materials

Promoting Interoperability

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Certified EHR Technology

- New certification criteria have been finalized by the Office of the National Coordinator (ONC) based on the 21st Century Cures Act
- 2021 and 2022 are transition years
- 2023 – all practices will be expected to use EHR technology certified to the 2015 CEHRT Cures Update
- Focus is on expanding interoperability and patient access

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Automatic Reweighting

- Small practices will be automatically reweighted from PI if they do **NOT** submit data
- If an APM is made up of one TIN and has less than 15 providers, it would also be automatically reweighted
- Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists
- Physical Therapists, Occupational Therapists, Speech Language Pathologists, Audiologists, Clinical Psychologists, Registered Dieticians or Nutrition Professionals
- Clinical Social Workers*

PI Measures

Security Risk Assessment Required

Includes SAFER

TABLE 46: Scoring Methodology for the Performance Period in CY 2022

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Bonus: Query of PDMP	10 points (*bonus*)*
Health Information Exchange -OR-	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
Health Information Exchange (alternative)	Health Information Exchange Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information*	40 points
Public Health and Clinical Data Exchange	Report the following 2 measures:* • Immunization Registry Reporting • Electronic Case Reporting	10 Points
	• Public Health Registry Reporting OR • Clinical Data Registry Reporting OR • Syndromic Surveillance Reporting	5 points (*bonus*)*

Notes: The Security Risk Analysis measure and the SAFER Guides measure are required, but will not be scored.
* Signifies a proposal made in this CY 2022 PFS proposed rule.

115 Possible Points Capped at 100

SAFER – High Priority

SAFER Guides by Group

Foundational Guides	○ High Priority Practices* ○ Organizational Responsibilities*
Infrastructure Guides	○ Contingency Planning* ○ System Configuration* ○ System Interfaces*
Clinical Process Guides	○ Patient Identification* ○ Computerized Provider Order Entry with Decision Support* ○ Test Results Reporting and Follow-Up* ○ Clinician Communication*

- Yes/No Attestation
- Answer required, but does not impact score

- Optimal Team for Review:
  - Clinicians
  - Allied health staff
  - IT team
  - External partners
- Team completes assessment, listing names and NPIs

https://www.healthit.gov/sites/default/files/safer/pdfs/safer_highprioritypractices_sg001_form_0.pdf

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*Recommended Practices for **Domain 1 — Safe Health IT***

			Implementation Status: Fully in all areas	Partially in some areas	Not implemented	
1.1	Data and application configurations are backed up and hardware systems are redundant.	Worksheet 1.1	○	◉	○	reset
1.2	EHR downtime and reactivation policies and procedures are complete, available, and reviewed regularly.	Worksheet 1.2	○	○	◉	reset
1.3	Allergies, problem list entries, and diagnostic test results, including interpretations of those results, such as "normal" and "high," are entered/stored using standard, coded data elements in the EHR.	Worksheet 1.3	○	◉	○	reset
1.4	Evidence-based order sets and charting templates are available for common clinical conditions, procedures, and services.	Worksheet 1.4	○	◉	○	reset
1.5	Interactive clinical decision support (CDS) features and functions (e.g., interruptive warnings, passive suggestions, info buttons) are available and functioning.	Worksheet 1.5	○	◉	○	reset
1.6	Hardware and software modifications and system-system interfaces are tested (pre- and post-go-live) to ensure that data are not lost or incorrectly entered, displayed, or transmitted within or between EHR system components.	Worksheet 1.6	○	◉	○	reset

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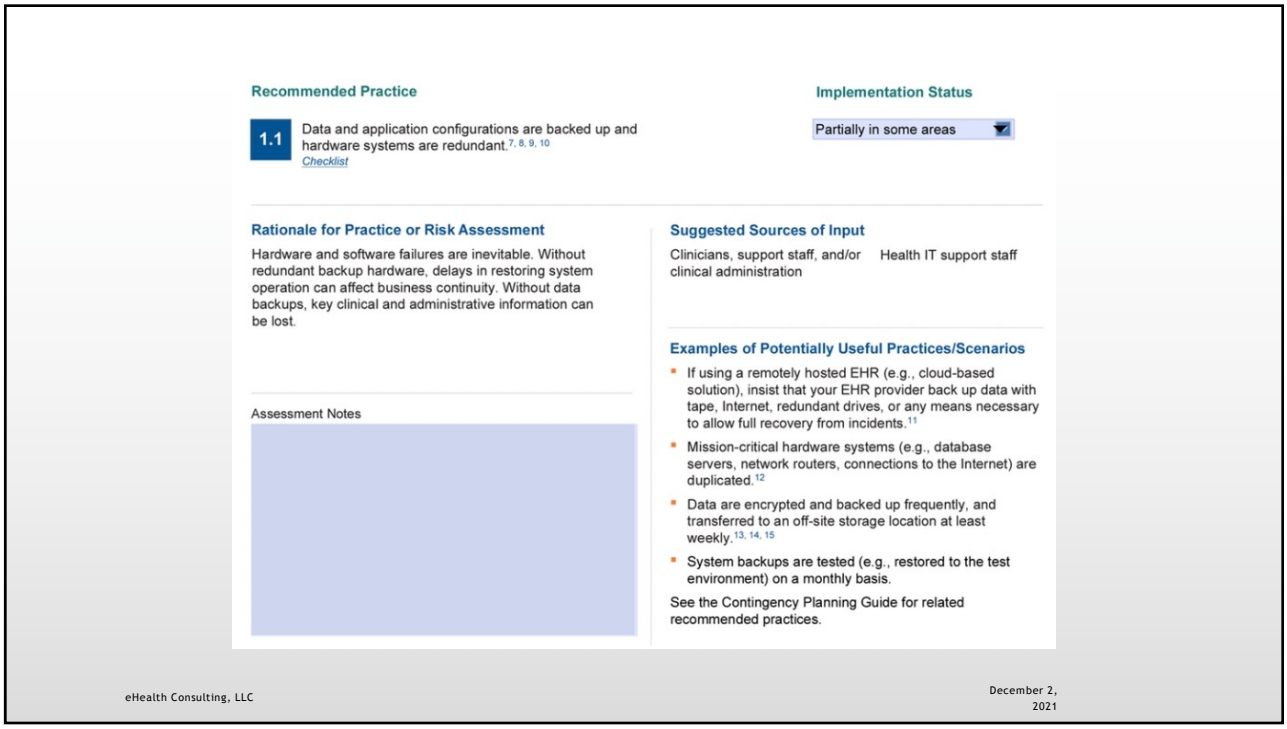
Recommended Practice
Implementation Status
1.1
Data and application configurations are backed up and hardware systems are redundant.[7, 8, 9, 10]
Checklist
Partially in some areas
Rationale for Practice or Risk Assessment
Hardware and software failures are inevitable. Without redundant backup hardware, delays in restoring system operation can affect business continuity. Without data backups, key clinical and administrative information can be lost.
Suggested Sources of Input
Clinicians, support staff, and/or clinical administration
Health IT support staff
Examples of Potentially Useful Practices/Scenarios
If using a remotely hosted EHR (e.g., cloud-based solution), insist that your EHR provider back up data with tape, Internet, redundant drives, or any means necessary to allow full recovery from incidents.[11]
Mission-critical hardware systems (e.g., database servers, network routers, connections to the Internet) are duplicated.[12]
Data are encrypted and backed up frequently, and transferred to an off-site storage location at least weekly.[13, 14, 15]
System backups are tested (e.g., restored to the test environment) on a monthly basis.
See the Contingency Planning Guide for related recommended practices.
Assessment Notes
eHealth Consulting, LLC
December 2, 2021

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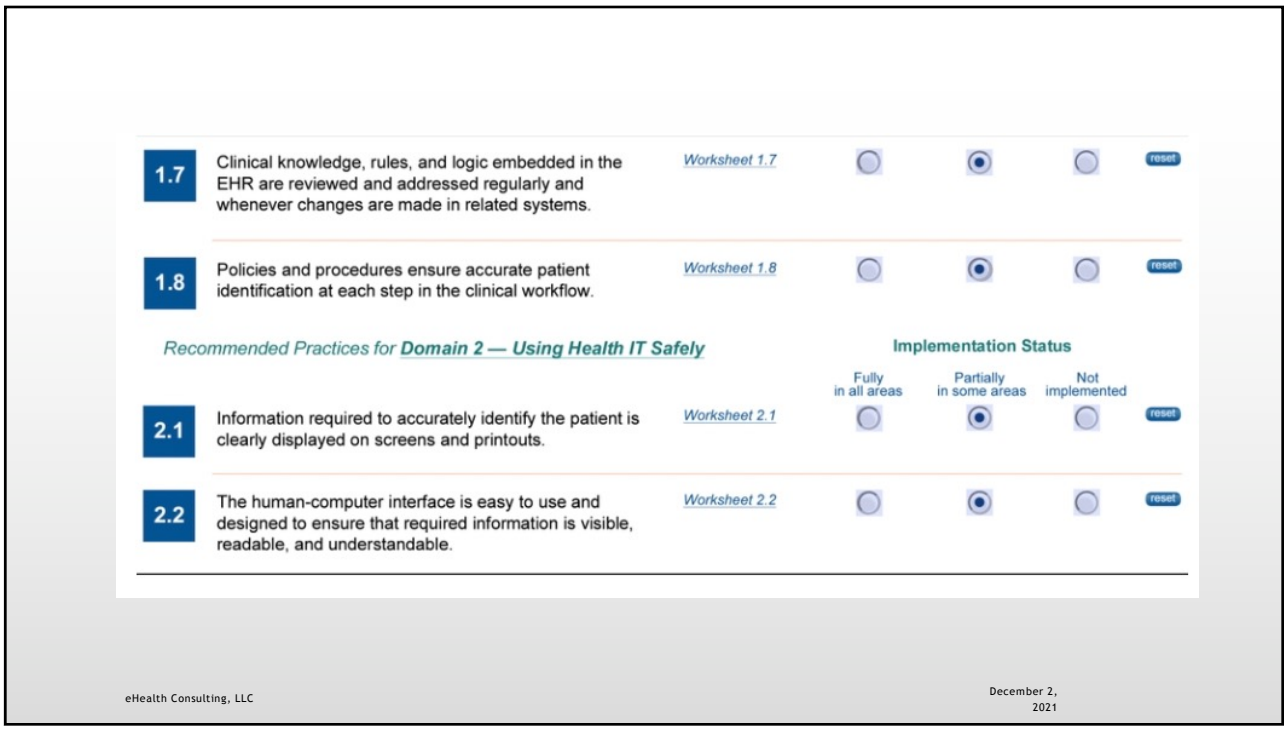
1.7
Clinical knowledge, rules, and logic embedded in the EHR are reviewed and addressed regularly and whenever changes are made in related systems.
Worksheet 1.7
reset
1.8
Policies and procedures ensure accurate patient identification at each step in the clinical workflow.
Worksheet 1.8
reset
Recommended Practices for Domain 2 — Using Health IT Safely
Implementation Status
Fully in all areas
Partially in some areas
Not implemented
2.1
Information required to accurately identify the patient is clearly displayed on screens and printouts.
Worksheet 2.1
reset
2.2
The human-computer interface is easy to use and designed to ensure that required information is visible, readable, and understandable.
Worksheet 2.2
reset
eHealth Consulting, LLC
December 2, 2021

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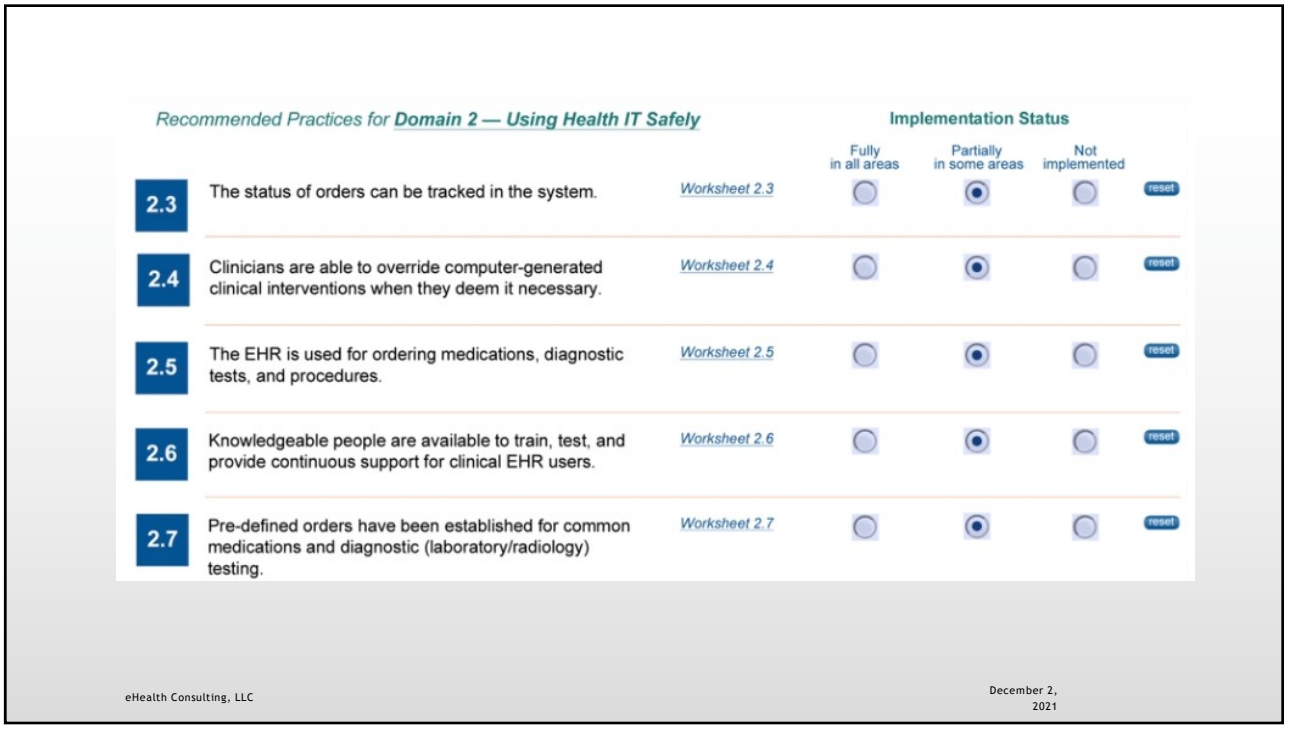
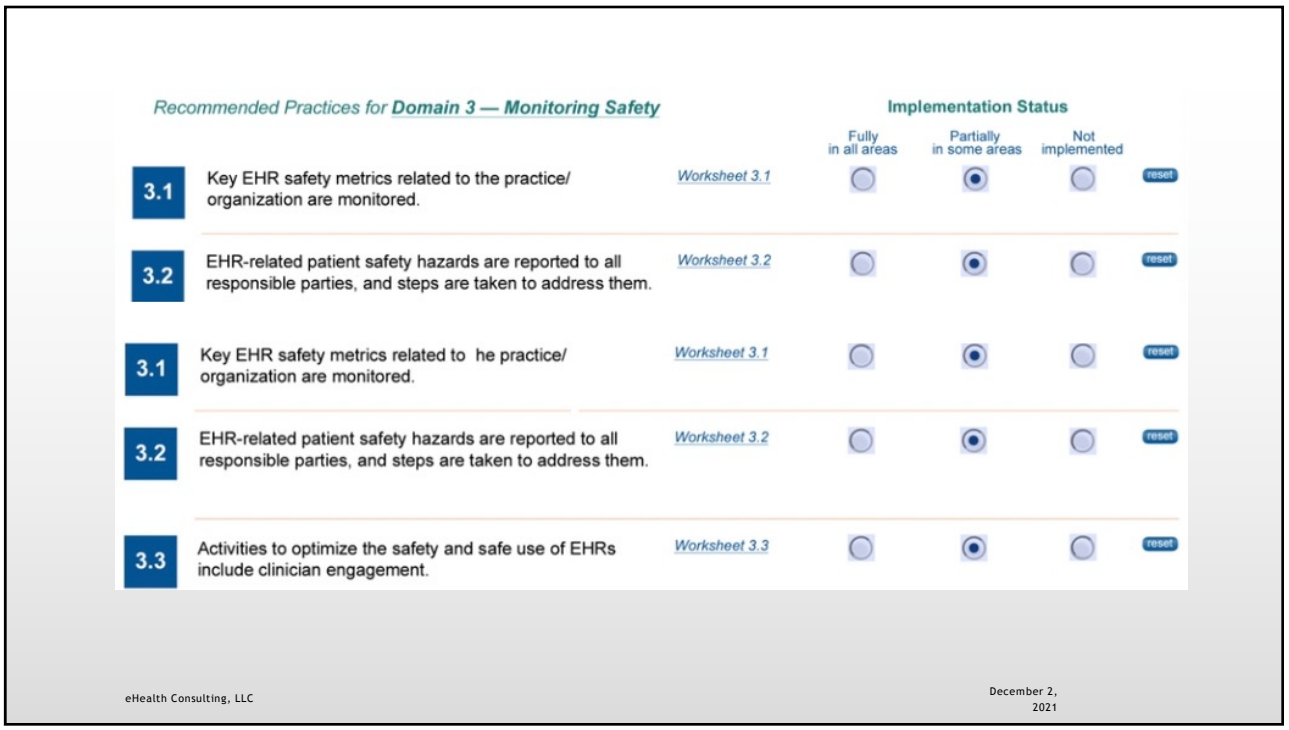

Recommended Practices for Domain 2 — Using Health IT Safely
Implementation Status
Fully in all areas
Partially in some areas
Not implemented
2.3 The status of orders can be tracked in the system. Worksheet 2.3 reset
2.4 Clinicians are able to override computer-generated clinical interventions when they deem it necessary. Worksheet 2.4 reset
2.5 The EHR is used for ordering medications, diagnostic tests, and procedures. Worksheet 2.5 reset
2.6 Knowledgeable people are available to train, test, and provide continuous support for clinical EHR users. Worksheet 2.6 reset
2.7 Pre-defined orders have been established for common medications and diagnostic (laboratory/radiology) testing. Worksheet 2.7 reset
eHealth Consulting, LLC
December 2, 2021

66


Recommended Practices for Domain 3 — Monitoring Safety
Implementation Status
Fully in all areas
Partially in some areas
Not implemented
3.1 Key EHR safety metrics related to the practice/ organization are monitored. Worksheet 3.1 reset
3.2 EHR-related patient safety hazards are reported to all responsible parties, and steps are taken to address them. Worksheet 3.2 reset
3.1 Key EHR safety metrics related to he practice/ organization are monitored. Worksheet 3.1 reset
3.2 EHR-related patient safety hazards are reported to all responsible parties, and steps are taken to address them. Worksheet 3.2 reset
3.3 Activities to optimize the safety and safe use of EHRs include clinician engagement. Worksheet 3.3 reset
eHealth Consulting, LLC
December 2, 2021

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Query of Prescription Drug Monitoring Program

- The PDMP measure remains optional for the 2022 performance year
- 10 bonus points are awarded to participants that have implemented Electronic Prescribing of Controlled Substances (EPCS) and have checked the PDMP prior to issuing at least one prescription
- CMS still plans to make this measure part of the PI set and could do so as early as 2023 depending on technology support and EHR integration

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PDMP

- All 50 states have a tracking system
- RxCheck – CMS is in early prototype testing
- Based on FHIR standards

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Patient Access

- **Not finalized**
  - PHI exchanged with a patient portal account after 1/1/2016 should be available indefinitely, even if you switch EHRs

Patient Access

- ONC 21st Century Cures Act
  - Information Blocking Rule
  - Implementation of the USCDI (US Core Data for Interoperability)
  - Expanded documents: D/C summary, progress notes, consult notes, imaging narratives, lab report narratives, pathology report narratives, and procedure notes
  - Implemented as part of the new CEHRT requirement

Public Health Measures - Required

- Immunization Registry
  - Exclusions still meet the requirement
- Electronic Case Reporting - eCR
  - Currently 120 diseases and conditions identified
  - 4th Exclusion
- Remaining 3 measures optional – 5 bonus points overall
  - Exclusions removed

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Electronic Case Reporting – Exclusion

- Electronic case reporting (eCR) requires bi-directional exchange between the practice and the public health agency
- Bi-directional exchange is supported in all 50 States but needs to be integrated into EHRs
- Current 3 exclusions still exist
- 4th exclusion
  - Uses CEHRT that isn't certified to the electronic case reporting criteria prior to the start of the performance period selected in reporting year 2022

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2022 Reweighting due to Exclusions

Excluded from:	Points transfer to:	
ePrescribe (10 pts)	SERL: Sending	SERL: Receiving
SERL: Sending (20 pts)	Provider to patient exchange	
SERL: Receiving (20 pts)	SERL: Sending	
SERL: Sending and Receiving (40 pts)	Provider to patient exchange	
Public Health Measures	Provider to patient exchange	

SERL: Supporting Electronic Referral Loop

Non-Patient Facing Providers/Groups

Determination of non-patient facing status

- Greater than 75% of covered professional services are in a hospital setting (POS 21, 22 or 23) OR;
- If an EC bills 100 or fewer patient-facing codes, they would be considered non-patient facing
- Non-patient facing providers do not submit Quality or Cost
  - measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program is used for Quality
- Non-patient facing providers do submit IA
- Non-patient facing providers are excluded from PI

Reminder of Attestation Statements

- Statement 1: A health care provider must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

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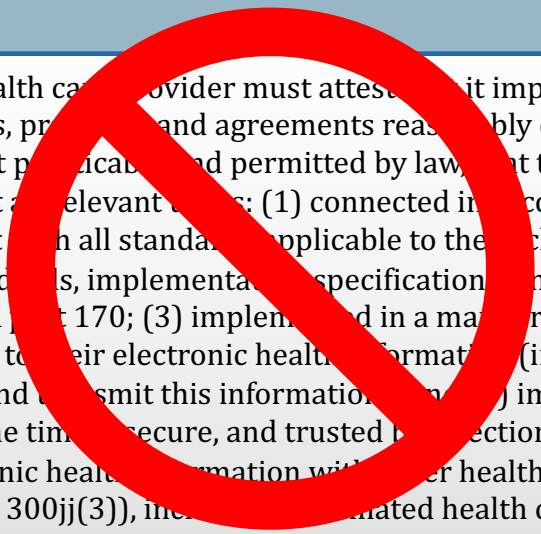
Attestation Statements



Statement 2: A health ca ovider must attes it implemented technologies, standards, policies, pr and agreements rea bly calculated to ensure, to the greatest extent p ica d permitted by law, t the certified EHR technology was, at a elevant s: (1) connected in cordance with applicable law; (2) compliant h all standa pplicable to the change of information, including the stand ls, implementa specification nd certification criteria adopted at 45 CFR t 170; (3) implen d in a ma r that allowed for timely access by patients t eir electronic healt ormati (including the ability to view, download, and smit this informatio) implemented in a manner that allowed for the tim ecure, and trusted ectional exchange of structured electronic healt rmation wit r health care providers (as defined by 42 USC 300jj(3)), inc iated health care providers, and with disparate certified EHR technology and vendors.

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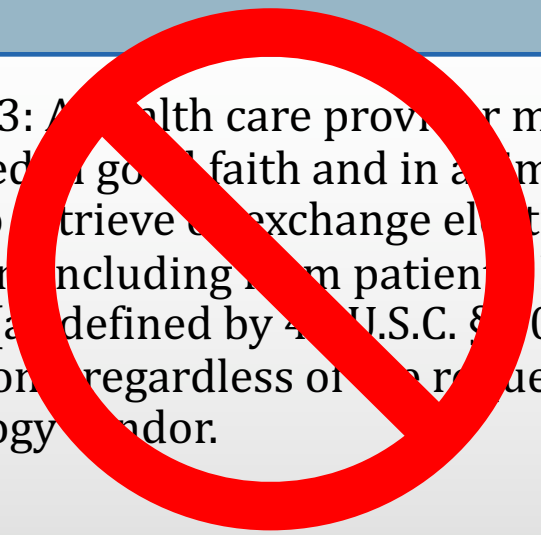
Attestation Statements

- Statement 3: A[illegible]lth care provi[illegible]r must attest that it responded i[illegible] go[illegible] faith and in a[illegible]mely manner to requests to [illegible]trieve [illegible]exchange el[illegible]tronic health information [illegible]ncluding [illegible]m patient[illegible] health care providers (a[illegible] defined by 4[illegible] U.S.C. §[illegible]00jj(3)), and other person[illegible] regardless of [illegible] r[illegible]uestor's affiliation or technology [illegible]ndor.



Calculating the final score - MIPS

- Quality – 30%
- Cost – 30%
- Improvement Activities – 15%
- Promoting Interoperability – 25%

- Complex patient bonus – up to 10 points
  - Calculated from a medical (HCC) and social (Dual Eligible +) indicator
  - EC or group must qualify under one of the indicators to receive the bonus
  - Second determination period
  - Reported in the Performance Feedback Report

Final Score – Reweighting Large Practices

TABLE 63: Performance Category Redistribution Policies Finalized for the CY 2022 Performance Period/2024 MIPS Payment Year and for Future MIPS Performance Periods/MIPS Payment Years

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	55%	30%	15%	0%
-No Quality	0%	30%	15%	55%
-No Improvement Activities	45%	30%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	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%

Final Score – Reweighting Small Practices

TABLE 64: Performance Category Redistribution Policies for Small Practices for the CY 2022 Performance Period/2024 MIPS Payment Year and Future MIPS Performance Periods/MIPS Payment Years

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.

Payment Adjustments for 2024

2024 MIPS Payment Year	
Final Score Points	**MIPS Adjustment**
0.0-18.75	Negative 9%
18.76-74.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
75.0	0% adjustment
75.01-88.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality
89.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for final scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality. PLUS An additional MIPS payment adjustment for exceptional performance. The additional MIPS payment adjustment starts at 0.5% and increases on a linear sliding scale. The linear sliding scale ranges from 0.5 to 10% for scores from 89.00 to 100.00. This sliding scale is multiplied by a scaling factor not greater than 1.0 in order to proportionately distribute the available funds for exceptional performance

Calculating the final score - APMs

- Quality – 50%
- Cost – 0%
- Improvement Activities – 20%
  - Full credit awarded for APP participation
- Promoting Interoperability – 30%
  - Check QP status prior to submitting

Approved Advanced APMs for 2022

- Bundled Payments for Care Improvement Advanced Model;
- Comprehensive Care for Joint Replacement Payment Model;
- Global and Professional Direct Contracting Model;
- Kidney care Choices Model (Kidney Care First: Professional Option and Global Option);
- Maryland Total Cost of Care Model (Care Redesign Program);
- Medicare Shared Savings Program (Basic Track Level E, and the ENHANCED Track;
- Oncology Care Model (2-sided Risk)
- Primary Care First (PCF) Model
- Radiation Oncology Model
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative)

APM Performance Pathway

- New scoring methodology for APMs
- MSSP APMs are required to participate in 2025
- Subgroup reporting supported in 2023

TABLE 47: Measures included in the Final APM Performance Pathway Measure Set+

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions

Multiple NPI/TIN combinations?

TABLE 72: Hierarchy for Final Score When More than One Final Score Is Associated with a TIN/NPI

Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI has a virtual group final score, an APM Entity final score, an APP final score, a group final score, and/or an individual final score.	Virtual group final score.
TIN/NPI has an APM Entity final score, an APP final score, a group final score, and/or an individual final score, but is not in a virtual group.	The highest of the available final scores.

Facility based Clinicians/Groups

- Quality and Cost scores come from the facility unless they use an alternate submission method that results in a higher score
- APMs are not eligible for Facility based scoring unless the APM is under one tax ID number

MIPS
Possible sunset date

2027

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MIPS Value Pathways (MVP) – for implementation in 2023

CONSOLIDATION OF QUALITY, COST, AND IMPROVEMENT ACTIVITIES TO STREAMLINE THE INCENTIVE PROGRAM AND REDUCE THE BURDEN ON PHYSICIANS

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MVP Participant

An individual MIPS eligible clinician, Single specialty group, Subgroup, or APM entity that submits and is assessed on an MVP

MIPS Value Pathways (MVP)

- 2023 - 2025 - Can be reported by individual, single specialty group, multi-specialty group, subgroup, or APM entity
- 2026 –multi-specialty groups must create applicable subgroups for MVP submission
- Registration required

MIPS Value Pathways (MVP) – 7 in 2023

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

MVP Registration Dates

Appendix B: MVP Participant Registration Timeline

The table below provides an overview of the registration process and timeline for MVP and subgroup registration, beginning with the 2023 MIPS performance year.

April 1st of the applicable performance year	MVP Participants may begin to register for MVP reporting.
June 30th of the applicable performance year (or a later date as specified by CMS)	Groups, subgroups, and APM Entities who intend to report the CAHPS for MIPS Survey Measure through a MVP, must: • Submit their MVP selection and population health measure selection. • As applicable, select an outcomes-based administrative claims measure that's associated with a MVP. • As applicable, each subgroup must submit a list of each TIN/NPI associated with the subgroup. • As applicable, each subgroup must submit a plain language name for the subgroup. • Separately register through the MIPS registration system by June 30th to participate in the CAHPS for MIPS Survey.
November 30th of the applicable performance year	The registration period closes. New registrations or changes to registration won't be accepted after November 30th. MVP Participants can't make any changes to their registration of: • MVP selection. • Population health measure selection. • As applicable, the selection of an outcomes-based administrative claims measure associated with the MVP. • As applicable, the list of each TIN/NPI associated with the subgroup. • As applicable, subgroup participation (including the subgroup's plan language name).

MVP Reporting Requirements

Appendix A: MVP Reporting Requirements

The table below provides an overview of the MVP reporting requirements.

QUALITY PERFORMANCE CATEGORY*	IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY*	COST PERFORMANCE CATEGORY
An MVP Participant selects 4 quality measures, one must be an outcome measure (or a high priority measure if an outcome is not available or applicable). Note: As applicable, an administrative claims measure, that is outcome-based, may be selected at the time of MVP registration to meet the outcome measure requirement.	MVP Participant selects: • Two medium weighted improvement activities **OR** one high weighted improvement activity **OR** IA_PCMH (participation in a PCMH), if the activity is available in the MVP	An MVP Participant is scored on the cost measures included in the MVP that they select and report.

FOUNDATIONAL LAYER (MVP AGNOSTIC)

Population Health Measures*
An MVP Participant selects one population health measure, at the time of MVP registration, to be scored on. The results are added to the quality performance category score.

Promoting Interoperability Performance Category
An MVP Participant is required to meet the Promoting Interoperability performance category requirements at § 414.1375(b).

*Indicates MVP Participant may select measures and/or improvement activities.

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Improving Care for Lower Extremity Joint Repair

Quality	
(!) Q024: Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older (Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications)	**(*)(!) Q351:** Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation (MIPS CQMs Specifications)
(*) Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications)	**(*)(!) Q376:** Functional Status Assessment for Total Hip Replacement (eCQM Specifications)
(*)(!) Q350: Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy (MIPS CQMs Specifications)	**(*)(!!) Q470:** Functional Status After Primary Total Knee Replacement (MIPS CQMs Specifications)
	(!!) Q480: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (Administrative Claims)

! = High Priority !! = Outcome * = with Revisions

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Requirements for Quality Measures in an MVP

- At least one outcome measure per clinical specialty included in reporting of the MVP
- Administrative Claims outcome measures can count, but this could be problematic if you don't meet the case minimum
- Multiple clinical specialties represented in the MVP group – there must be a high priority measure applicable to each of the specialties represented
- Any QCDR measure included must be fully tested in a clinical setting and submitted for approval by 9/1 of the prior year

Improvement Activities – one high OR two mediums

Improvement Activities
(~) IA_AHE_3: Promote use of Patient-Reported Outcome Tools (High)
(*) IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings (High)
IA_BE_12 Use evidence-based decision aids to support shared decision-making (Medium)
IA_CC_7: Regular training in care coordination (Medium)
(~) IA_CC_9: Implementation of practices/processes for developing regular individual care plans (Medium)
IA_CC_13: Practice improvements for bilateral exchange of patient information (Medium)
(*) IA_CC_15: PSH Care Coordination (High)
(*) IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program (High)
(~) IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements (Medium)
(*) IA_PSPA_18: Measurement and improvement at the practice and panel level (Medium)
IA_PSPA_27: Invasive Procedure or Surgery Anticoagulation Medication Management (Medium)

Cost Measures

Elective Primary Hip Arthroplasty	20 Cases
Knee Arthroplasty	10 Cases

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Population Health Measures – Choose one

(!!) **Q479:** Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Groups
(Administrative Claims)

(^)(!!) **Q484:** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
(Administrative Claims)

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Promoting Interoperability

Security Risk Analysis	Immunization Registry Reporting
(^) Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)	Syndromic Surveillance Reporting
Prevention of Information Blocking	Electronic Case Reporting
e-Prescribing	Public Health Registry Reporting
Query of the Prescription Drug Monitoring Program (PDMP) (Optional)	Clinical Data Registry Reporting
Provide Patients Electronic Access to Their Health Information	
Support Electronic Referral Loops By Sending Health Information	
Support Electronic Referral Loops By Receiving and Reconciling Health Information	
Health Information Exchange (HIE) Bi-Directional Exchange	

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Special Considerations for 2023

- The following cannot form sub-groups in 2023
  - Voluntary reporters
  - Opt-in eligible clinicians
  - Virtual groups

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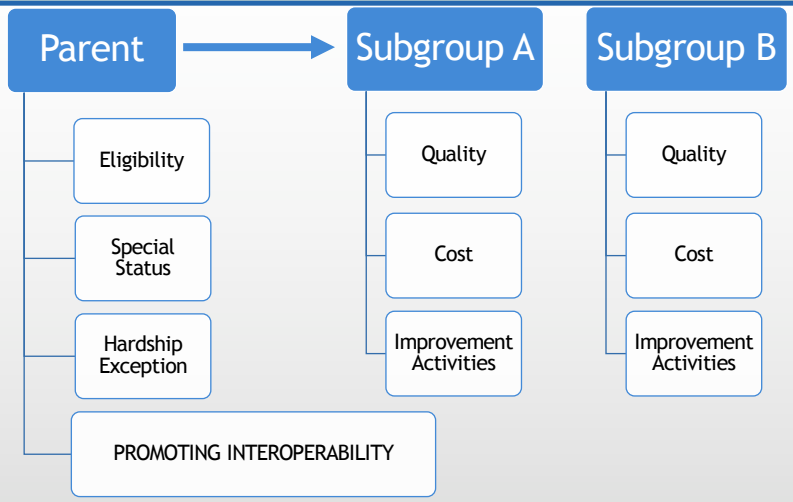
MVP Scoring with Subgroups



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MVP Scoring

- Quality/Cost/PI follow the same concepts, except
  - New quality measures without benchmarks
    - 7 to 10 points in year 1
    - 5 to 10 points in year 2
  - No Bonus points
- Cost
  - Only measures within the MVP are evaluated
- Improvement Activities
  - 40 points for a high-weighted, 20 points for a medium-weighted
  - Full credit for PCMH certification
  - 50% of subgroup must participate

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Population Health Measures and PI

- Population Health
  - 1 selected by the group
  - Only scored if there is a benchmark and data completeness is met
  - If the parent group meets data completeness, then the sub-group will inherit their score on the pop health measure
- Promoting Interoperability – aggregated at Parent Group level
  - Sub-group providers are included in calculation of PI measures for their affiliated parent group
  - Sub-group inherits the score of the parent group
  - if no data is submitted, the sub-group would receive a score of zero in the Promoting Interoperability category.

MVP – Promoting Interoperability

TABLE 46: Scoring Methodology for the Performance Period in CY 2022

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Bonus: Query of PDMP	10 points (*bonus*)*
Health Information Exchange -OR-	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
Health Information Exchange (alternative)	Health Information Exchange Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information*	40 points
Public Health and Clinical Data Exchange	Report the following 2 measures:* • Immunization Registry Reporting • Electronic Case Reporting	10 Points
	• Public Health Registry Reporting OR • Clinical Data Registry Reporting OR • Syndromic Surveillance Reporting	5 points (*bonus*)*

Notes: The Security Risk Analysis measure and the SAFER Guides measure are required, but will not be scored.
* Signifies a proposal made in this CY 2022 PFS proposed rule.

MVP Scoring

- CMS awards the highest score to the TIN/NPI combination after considering all submission types
  - Traditional MIPS
  - APP
  - Individual, Group, Subgroup
  - MVP

Parent Group Final Scoring

- MVP participants in sub-groups will still be included when analyzing data for the parent group
- This is similar to when you have a multi-specialty practice where the primary care providers are participating in an ACO and the specialists are participating in MIPS. All of the clinicians would be included in the MIPS reporting.

Future focus of MVP Development

1. Primary care*
2. Emergency Medicine*
3. Diagnostic Radiology
4. Anesthesiology*
5. Cardiology*
6. OB/GYN
7. Orthopedic Surgery*
8. Psychiatry
9. General Surgery
10. Ophthalmology

MVP Guiding Principles

- Include connected and complimentary measures and activities from all 4 MIPS performance categories
- Providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care. This can be expanded by allowing subgroup reporting to accommodate multi-specialty groups.
- Follow the Meaningful Measures approach to measure selection, and support the transition to digital quality measures
- Capture the patient's experience of care

Questions…

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