2022 MUSE Inspire Conference

May 15-18 Gaylord Texan Resort & Convention Center | Dallas, TX

# 703 - MIPS: Don’t Let It Sink Your Ship

**Understanding MIPS to Achieve Success**

May 15, 2022

Presenters: Alexis O’Grady MPH, and Sherri Pierce RN, BSN

Acmeware

# 2022 MUSE Inspire Conference

May 15-18 Gaylord Texan Resort & Convention Center | Dallas, TX


## Welcome back! Come see our education sessions:

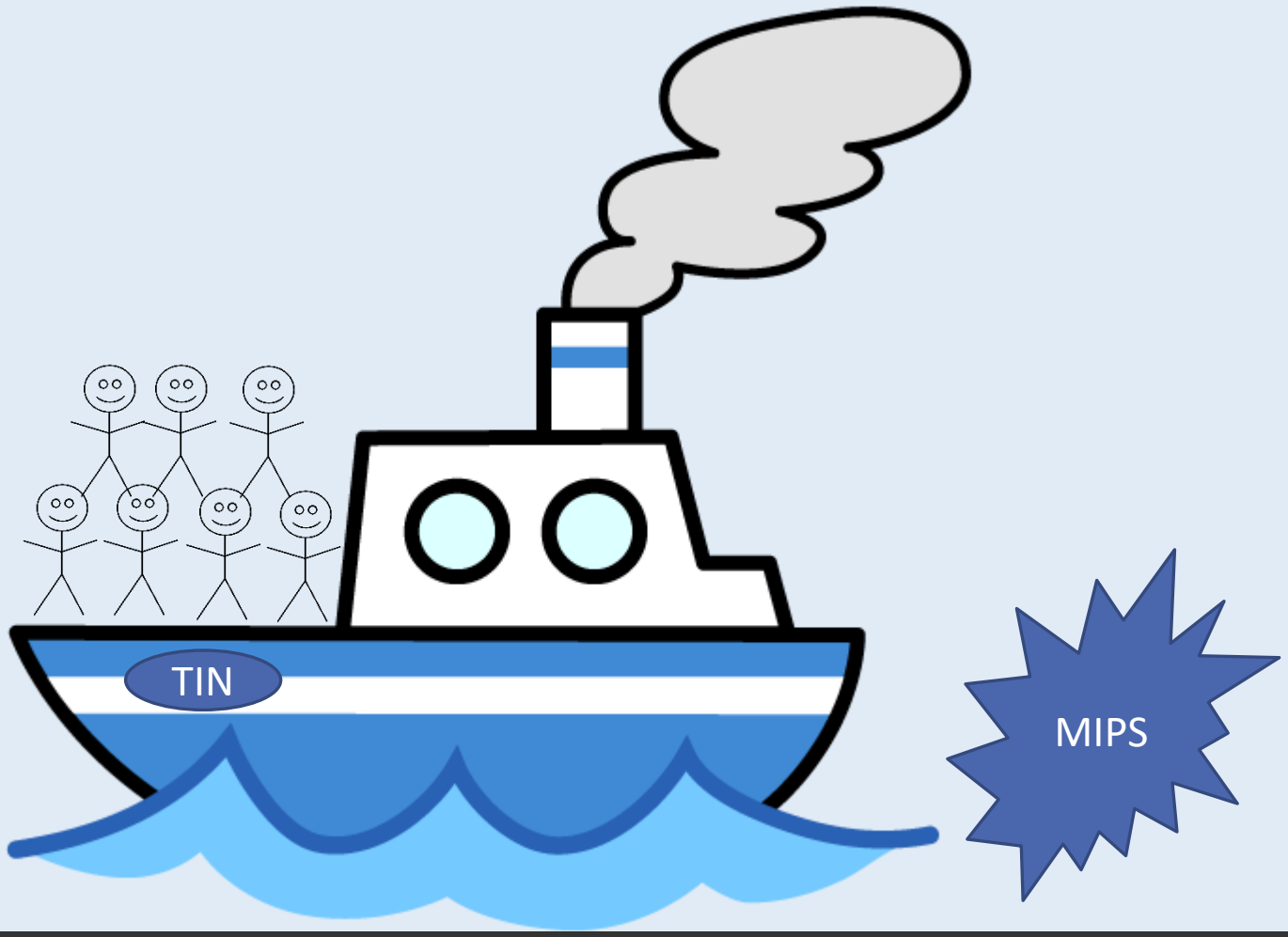
| Day | Date | Time | Room | Session |
|---|---|---|---|---|
| Monday | May 16 | 2:30-3:25 | Grapevine 6 | 1007 - Power BI and DR |
| Tuesday | May 17 | 10:00-10:55 | Austin 4 | 1062 - Improve Quality Performance |
| Wednesday | May 18 | 10:00-10:55 | Austin 4 | 1057 - Microsoft's Power Platform (Northeastern VT) |
| | | 11:00-11:55 | Grapevine 6 | 1097 - OR Utilization Analysis (Northwestern Medical Center) |

# Welcome Aboard!

- Who is in attendance today?
  - Quality Coordinators/Analysts?
  - Information Technology/Analysts?
  - Revenue Cycle/Business Analysts?
  - Nurse Informaticists?
  - Any other roles?

# Our Agenda

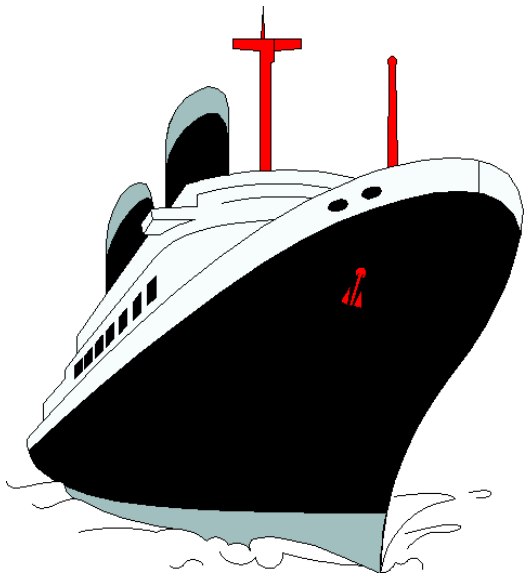
- Objectives
- Traditional MIPS overview
- MIPS scoring
- MIPS real-world examples
- Overview of other MIPS reporting options
- The future of MIPS




Positive
Payment
Adjustment

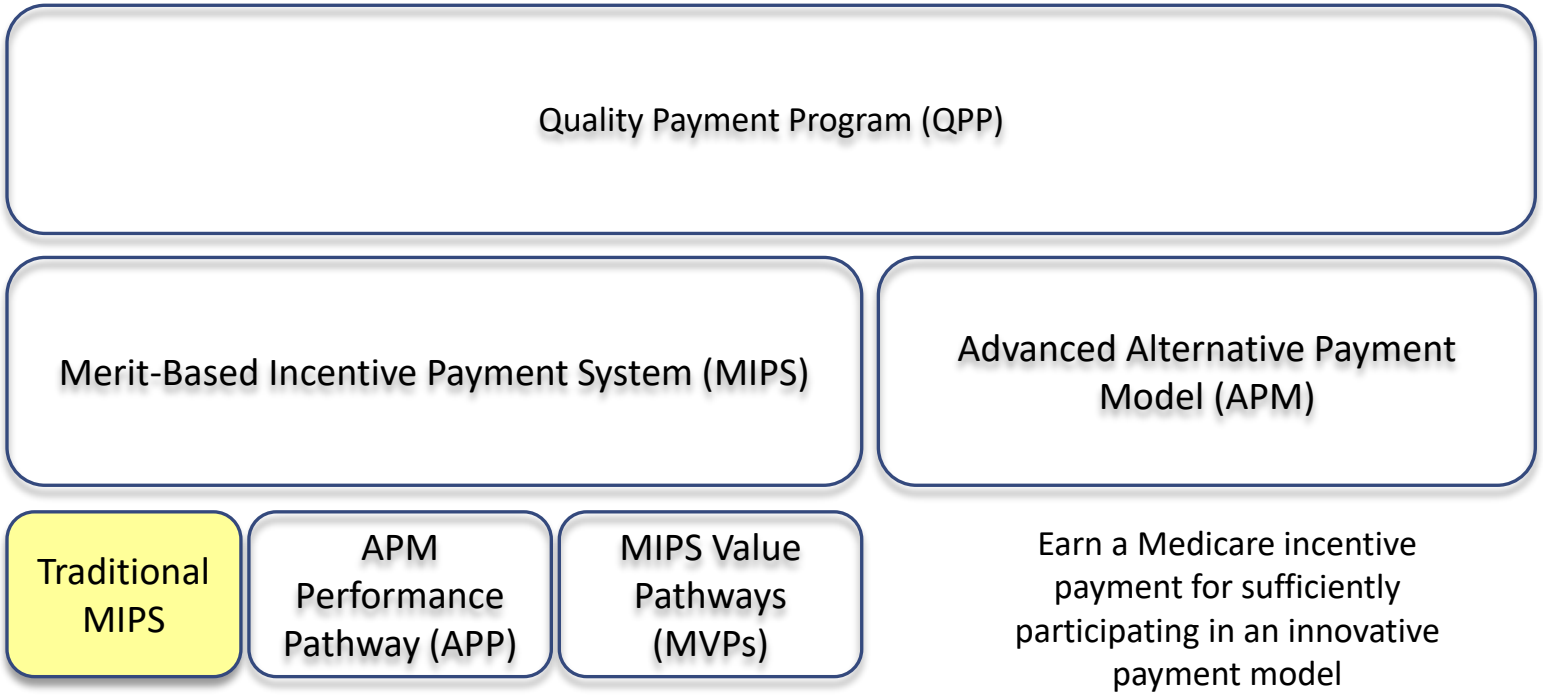
# Objectives

- Understand the structure of the MIPS program
- Identify MIPS changes for 2022 reporting year compared to 2021 reporting
- Explain the scoring for each MIPS category
- Apply gained knowledge to your own clinician reporting



# MIPS Overview

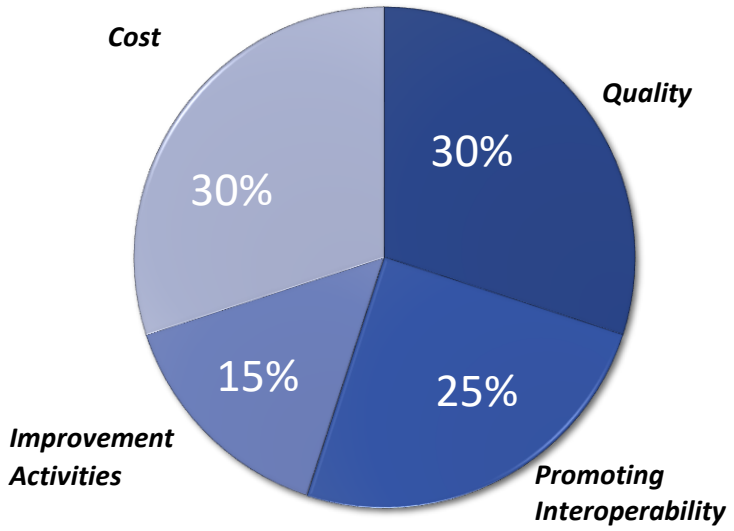
# Quality Payment Program (QPP)



# Performance Threshold and Category Weights

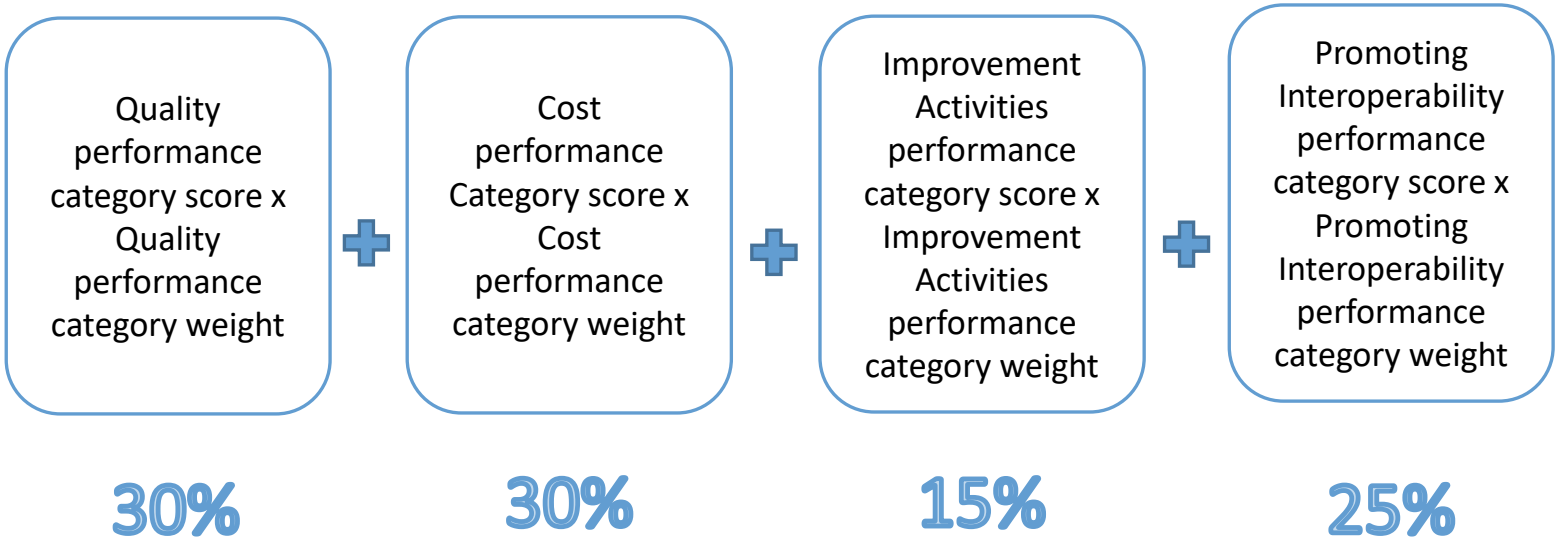
- Performance Threshold: 75 points (increased from 60 points)
- Exceptional Performance at 89 points (increased from 85)
- Quality: 30% (decreased from 40%)
- Cost: 30% (increased from 20%)
- PI: 25%
- IA: 15%
- CMS is statutorily required to weight the cost and quality performance categories equally beginning with PY 2022

**MIPS Performance Category Weights**



# Total Performance Score – 2022 Reporting

## Final MIPS score =




The MIPS Final Score is compared to the MIPS **performance threshold** to determine if you receive a positive, negative, or neutral payment adjustment.

# MIPS Payment Adjustment

| Final Score 2021 | Payment Adjustment 2023 |
|---|---|
| ≥ 85 points | • Positive adjustment<br>• Eligible for exceptional performance bonus – minimum of additional 0.5% |
| 60.01-84.99 points | • Positive adjustment<br>• Not eligible for exceptional performance bonus |
| **60 points** | • **Neutral payment adjustment** |
| 15.01-59.99 points | • Negative payment adjustment between -9% and 0% |
| 0-15 points | • Negative payment adjustment of -9% |

| Final Score 2022 | Payment Adjustment 2024 |
|---|---|
| ≥ 89 points | • Positive adjustment<br>• Eligible for exceptional performance bonus – minimum of additional 0.5% |
| 75.01-88.99 points | • Positive adjustment<br>• Not eligible for exceptional performance bonus |
| **75 points** | • **Neutral payment adjustment** |
| 18.76-74.99 points | • Negative payment adjustment between -9% and 0% |
| 0-18.75 points | • Negative payment adjustment of -9% |

# 2022 MIPS Eligibility

Clinicians are excluded from MIPS if they:

- Are not one of the MIPS eligible clinician types
- Enroll in Medicare after 1/1/2022
- Do not meet the Low-Volume Threshold (LVT)
- Are Qualifying APM Participants (QPs)
- Are partial QPs who elect to not participate in MIPS

**Eligible Clinician Types**

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Physical Therapist
- Occupational Therapist
- Speech-language pathologist
- Audiologist
- Clinical psychologist
- Registered dietitian or nutrition professionals
- Clinical social workers *
- Certified-nurse midwives *

* New MIPS EC types beginning with 2022

**LVT Criteria**

- Billing **>$90,000** a year in Part B allowed charges

**AND**

- Providing care for **>200** Medicare Part B patients a year

**AND**

- Provide **> 200** covered professional services under the Physician Fee Schedule (PFS)

**Opt-In**

OPT-IN: Clinicians or groups can opt-in to MIPS if they exceed at least one of the LVT criteria

No changes to:

- Low-volume threshold (LVT) criteria
- The opt-in policy for MIPS ECs who are excluded from MIPS based on LVT criteria

# Determine MIPS Eligibility

1. **MIPS Participation Look-up Tool**

   - To find out if individual clinicians are MIPS eligible for the 2022 performance year (no login to QPP is required - https://qpp.cms.gov/ )


2. **2022 MIPS Clinician Eligibility at the Group Level**

   - Log in to your account on QPP (https://qpp.cms.gov/ )
   - Browse to TIN associated with the group
   - Click into a details screen to see the eligibility status of every clinician based on NPI to find out if they are MIPS eligible for the 2022 performance year

# Individual vs Group Participation

**Individual**

A single clinician, identified by a single NPI tied to a TIN

Payment adjustment based on their individual performance

**Group**

A single TIN with 2 or more MIPS eligible clinicians, identified by NPI, who have reassigned their Medicare billing rights to the TIN

Payment adjustment based on the group's performance

**Virtual Group**

Can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" to participate in MIPS for a performance period for a year

Payment adjustment based on the Virtual Group's Performance

Virtual group election deadline is December 31st prior to the performance year.

# Participation at Individual vs Group Level: Example

## Individual

Assessed at the TIN/NPI level

### Dr. A

Billed $50,000
Saw 40 Patients
Provided 100 Services

**Exempt from MIPS**

Below LVT for charges, beneficiaries, and services

**CANNOT OPT- IN**

### Dr. B

Billed $100,000
Saw 210 Patients
Provided 400 Services

**Included in MIPS**

Exceeds LVT for charges and beneficiaries and services

### Dr. C

Billed $80,000
Saw 215 Patients
Provided 300 Services

**Exempt from MIPS**

Exceeds LVT for beneficiaries and services but below for charges

**CAN OPT IN**

### Dr. D

Billed $110,000
Saw 150 Patients
Provided 150 Services

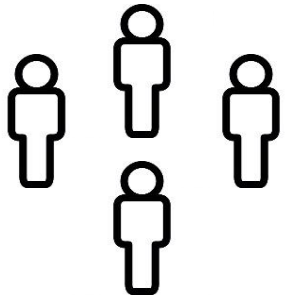
**Exempt from MIPS**

Exceeds LVT for charges but below for beneficiaries and services

**CAN OPT IN**

## Group

Assessed at the TIN level



As a Group
(Dr. A, Dr. B, Dr. C, Dr. D)

Billed $340,000
Saw 615 Patients
Provided 950 Services

**ALL Included in MIPS**

Exceeds LVT for charges AND beneficiaries AND services

# MIPS Scoring

# Quality - Overview

- 30% of MIPS Score
- Report at least 6 measures (including one outcome or high priority measure)
- 3 Administrative Claims Measures
- Reporting period: Full calendar year (January 1, 2022 – December 31, 2022)

# Quality - Overview

- 3 point floor for measures scored against a benchmark
- 3 points for measures scored that don't have a benchmark or don't meet case minimum
- 0 points for measures that don't meet data completeness; except if submitted by small practice which will earn 3 points
- No bonus points available for end-to-end reporting or high priority measures *NEW*
- Improvement scoring measured at the performance category level
- Small practice bonus

# 2022 Quality Measures

- There are a total of 200 quality measures available for the 2022 performance period
  - Available through different collection types – can report multiple collection types

| Collection Type | Info |
|---|---|
| eCQMs | • Can report eCQMs if you use technology that meets the 2015 CEHRT criteria, the 2015 Edition Cures Update criteria, or a combination of both.<br>• If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. |
| MIPS CQMs (registry) | • Often collected and submitted by third party intermediaries<br>• Qualified Registry, QCDR, Health IT vendor or submit on own |
| QCDR measures | • CMS-approved entities that can develop their own quality measures<br>• Need to work with a QCDR to report these measures on your behalf |
| Medicare Part B Claims Measures | • Only available to individual clinicians, groups, virtual groups or APM entities that are small practices (15 or fewer clinicians) |
| CMS Web Interface | • Only groups, virtual groups and APM Entities (with 25 or more clinicians) can report.<br>• Need to register between April 1, 2022 and June 30, 2022<br>• Submit data on a sample of Medicare patients identified by CMS for each measure |
| CAHPS for MIPS Survey Measure | • Only groups, virtual groups and APM Entities (with 2 or more clinicians) can report<br>• Need to register between April 1, 2022 and June 30, 2022<br>• Must be administered by a CMS-approved survey vendor |

# 2022 Quality Measures

**4 New Quality Measures**

Category Weight 30%

Performance Period 1 Year

1. #481 - Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer
2. #482 - Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate
3. #483 - Person-Centered Primary Care Measure Patient-Reported Outcome Performance Measure (PCPCM PRO-PM)
4. Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

# 2022 Quality Measures

**13 Removed Measures**

Category Weight 30%

Performance Period 1 Year

1. **#14 Age-Related Macular Degeneration** (AMD): Dilated Macular Examination for Medicare Part B Claims type only
2. #21 Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
3. #23 Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
4. #44 Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
5. **#50 Urinary Incontinence**: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older for Medicare Part B Claims type only
6. #67 Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
7. #70 Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
8. #154 Falls: Risk Assessment
9. #195 Radiology: Stenosis Measurement in Carotid Imaging Reports
10. #225 Radiology: Reminder System for Screening Mammograms
11. #337 Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier
12. #342 Pain Brought Under Control Within 48 Hours
13. #429 Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy
14. **#434**
15. #444 Medication Management for People with Asthma

# 2022 Quality Measures

**87 Measures Modified**

1, 5, 7, 8, 9, 50, 65, 66,93, 102, 110, 111, 112, 113, 117, 119, 134, 143, 176, 177, 178, 180, 182, 217, 219, 226, 236, 238, 239, 240 , 254, 265, 281, 290, 291, 293, 305, 309, 310, 317, 318, 326, 335, 336, 340, 350, 351, 358, 366, 370, 374, 375, 376, 377, 378, 379, 383, 391, 395, 396, 397, 400, 409, 413, 416, 418, 425, 430, 438, 448, 450, 459, 460, 461, 462, 463, 469, 470, 471, 473, 476, 478

Category Weight 30%

Performance Period 1 Year

# 2022 Quality Measures

Administrative Claims Measures

- automatically evaluated if case minimum requirements are met

| Measure | Case Minimum | Performance Period | Applies to |
|---|---|---|---|
| Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate | 200 | 1-year (January 1 – December 31) | MIPS eligible groups with at least 16 clinicians |
| Risk-standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) | 25 | 3-year (October 1, – September 30,) | All MIPS eligible clinicians and groups |
| Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions **new for 2022** | 18 | 1-year (January 1 – December 31) | MIPS eligible groups with at least 16 clinicians |

# Benchmarks

- Each benchmark is presented in terms of deciles
  - For 2022 reporting, benchmarks are based on 2020 MIPS performance data
  - For measures with no benchmarks, MIPS will attempt to calculate benchmarks based on 2022 performance data
  - Points are awarded within each decile
  - For inverse measures, the scores are reversed in the benchmark deciles.

**Measures with a benchmark**
3-10 points
(if data completeness and case minimum are met)

In 2023, measures with a benchmark will receive 1-10 points if data completeness and case minimum are met.

**Measures without a benchmark**
3 points
(if data completeness is met)

In 2023, measures without a benchmark will receive 0 points (except for small practices).

**New Measures with a benchmark**
Year 1: 7-10 points
Year 2: 5-10 points
(if data completeness and case minimum are met)

**New Measures without a benchmark**
Year 1: 7 points
Year 2: 5 points
(if data completeness is met)

This policy for new measures does not apply to administrative claims measures.

2022 Quality Benchmarks

# Case Minimum

**Case Minimum:** 20 cases

- Measures that don't meet case minimum will earn 0 points
  - Small practices will continue to earn 3 points

This policy doesn't apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum is not met.

If data completeness is met, new measures in Year 1 that do not meet case minimum will receive 7 points; in Year 2 will receive 5 points

# Data Completeness

**Data Completeness:** 70%

- Measures that don't meet data completeness will receive 0 points.
- Small practices will continue to earn 3 points

*When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the eligible population (denominator).*

*Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance ("cherry picking"), would not be considered true, accurate, or complete and may subject you to an audit.*

# Bonus Points

- Beginning with 2022 reporting, there are no bonus points for high priority measures or end-to-end reporting
- Small practice bonus: 6 bonus points added to the quality category if submit at least 1 quality measure

# Achievement Points Calculation

MIPS Group submits Controlling High Blood Pressure via EHR with a performance rate of 68.45%.

| Measure Title | Measure ID | Collection Type | Measure Type | High Priority | Avg Perf Rate | Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 | Topped Out | Seven Point Cap |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Controlling High Blood Pressure | 236 | eCQM | Intermediate Outcome | Y | 62.80 | 51.76 - 56.80 | 56.81 - 60.66 | 60.67 - 64.10 | 64.11 - 67.51 | 67.52 - 71.10 | 71.11 - 75.53 | 75.54 - 81.42 | >= 81.43 | No | No |

| Decile | Number of Points Assigned for the 2018 MIPS Performance Period |
|---|---|
| Below Decile 3 | 3 points |
| Decile 3 | 3-3.9 points |
| Decile 4 | 4-4.9 points |
| Decile 5 | 5-5.9 points |
| Decile 6 | 6-6.9 points |
| Decile 7 | 7-7.9 points |
| Decile 8 | 8-8.9 points |
| Decile 9 | 9-9.9 points |
| Decile 10 | 10 points |

**For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and Decile 10 has the lowest value.*

$X =$ Decile #
$q =$ performance rate
$a =$ bottom of decile range
$b =$ bottom of next decile range

$$\text{Achievement Points} = \text{X} + \frac{(q-a)}{(b-a)}$$

$$\text{Achievement Points} = 7 + \frac{(68.45-67.52)}{(71.11-67.52)}$$

$$\text{Achievement Points} = 7.26$$

# Improvement Scoring

- Improvement for the Quality measures will be measured at the performance category level
- 10 points available for improvement and greater improvement will result in more points
- Improvement score cannot be negative
- Bonus points or improvement percent score adjustments made to the quality score in the prior or current performance period are not considered when determining improvement scoring
- Improvement would be measured only if the clinician's quality achievement score exceeds 30%.

Improvement performance score

$$= \frac{\text{current performance period quality achievement score} - \text{prior performance period quality achievement score}}{\text{prior performance period quality achievement score}} * 10$$

# Promoting Interoperability

- 25% of MIPS Score
- Performance period: minimum 90 continuous days between Jan 1, 2022 and Dec 31, 2022
- Performance-based scoring at the individual measure level
- Requires 2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of both

# PI – What's New in 2022

- Clinical social workers and small practices qualify for automatic reweighting
- New required, but unscored attestation measure: the High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure
- For the Public Health and Clinical Data Exchange objective, clinicians are required to report on 1) Immunization Registry Reporting and 2) Electronic Case Reporting measures
  - A 4th exclusion for ECR measure is available for 2022
  - Clinicians can optionally report on 1) Public Health Registry Reporting, OR 2) Clinical Data Registry Reporting, OR 3) Syndromic Surveillance Reporting measures for 5 bonus points

# PI Reweighting

| PI category will be automatically reweighted to 0% if you are a: | | | | | |
|---|---|---|---|---|---|
| Clinical Social Worker | Physician Assistant | Nurse Practitioner | Clinical Nurse Specialist | Certified Registered Nurse Anesthetist | Registered Dietitian or Nutrition Professional |
| Physical Therapist | Occupational Therapist | Clinical Psychologist | Qualified Speech-Language Pathologist | Qualified Audiologist | **Special Status:**<br>• Small Practice<br>• Ambulatory Surgical Center (ASC)-based<br>• Hospital-based<br>• Non-patient facing |

- If you qualify for reweighting, you may still submit data. If you submit, the reweighting will be canceled – the PI category will be scored and weighted at 25%.
- Groups or virtual groups qualify for automatic reweighting if:
  - 100% of the MIPS EC are ASC-based as individuals OR
  - More than 75% of the MIPS EC are hospital-based as individuals OR
  - More than 75% of the MIPS EC are non-patient facing as individuals OR
  - Has 15 or fewer clinicians billing under the practice's TIN
- A group or virtual group qualifies for automatic reweighting when 100% of the MIPS eligible clinicians in the group or virtual group qualify for reweighting as individuals for any combination of reasons.

# PI Hardship Exception

- You may submit a MIPS PI performance category hardship exception application if any of the following reasons apply to you during the 2022 performance year:
  - You're using decertified EHR technology.
  - You have insufficient Internet connectivity.
  - You experienced an extreme and uncontrollable circumstance.
  - You lack control over the availability of CEHRT.
- Deadline for submission is December 31, 2022
- If accepted, PI will be reweighted to 0%

# PI Measures and Objectives

| Objectives | Measures | | Required | Available Points | Reporting Requirements |
|---|---|---|---|---|---|
| Protect Patient Health Information | Security Risk Analysis | | Required | NA | Yes/No |
| | Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) – High Priority Guide | | Required | NA | Yes/No (reporting No is accepted for 2022) |
| e-Prescribing | e-Prescribing | | Required | 1-10 points | Num/Den |
| | Bonus: Query of Prescription Drug Monitoring Program (PDMP) | | Optional | 10 bonus points | Yes/No |
| Health Information Exchange | Option 1 | Support Electronic Referral Loops by Sending Health Information | Required (unless option 2 is reported) | 1-20 points | Num/Den |
| | | Support Electronic Referral Loops by Receiving and Reconciling Health Information | | 1-20 points | Num/Den |
| | Option 2 | HIE Bi-Directional Exchange | Required (unless option 1 is reported) | 40 points | Yes/No |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | | Required | 1-40 points | Num/Den |
| Public Health and Clinical Data Exchange | Report the 2 Required Measures<br>• Immunization Registry Reporting<br>• Electronic Case Reporting | | Required | 10 points for the entire objective | Yes/No |
| | Bonus:<br>• Public Health Registry Reporting<br>• Clinical Data Registry Reporting<br>• Syndromic Surveillance Reporting | | Optional | 5 bonus points (whether reporting 1, 2 or all 3 optional measures) | Yes/No |

# PI Measure Scoring

- Performance-based scoring at the individual measure level
  - Each measure will be scored based on the individual/group's performance for that measure
  - Each measure score would be added together to calculate the total PI score, capped at 100 points (115 points available)

Numerator/Denominator = Performance Rate
Performance Rate * Total Possible Measure points = Measure Score

When calculating scores, CMS will round to the nearest whole number. (example 8.53 → 9; 8.33 → 8)

A performance rate or measure score of less than 0.5 will be awarded a score of 1 (if the numerator is at least 1)

To earn any score, must attest yes to Security Risk Analysis and yes/no to the SAFER Guides measure

For measures with a numerator/denominator, must submit a numerator of at least 1

Failure to report on a required attestation or measure (or claim an exclusion for a required measure if available and applicable) will result in a score of 0

# Reallocation of PI Points

When you claim an exclusion for a measure, the measure's points are redistributed to a different measure

| Objectives | Measures | | Exclusion Available | When the Exclusion is claimed |
|---|---|---|---|---|
| e-Prescribing | e-Prescribing | | Yes | …the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective:<br>• 5 points to the Support Electronic Referral Loops by Sending Health Information measure<br>• 5 points to the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure<br>OR<br>…the 10 points are redistributed to the HIE Bi-Directional Exchange measure |
| | Bonus: Query of Prescription Drug Monitoring Program (PDMP) | | N/A | N/A |
| Health Information Exchange | Option 1 | Support Electronic Referral Loops by Sending Health Information | Yes | …the 20 points are redistributed to the Provide Patients Electronic Access to their Health Information measure |
| | | Support Electronic Referral Loops by Receiving and Reconciling Health Information | Yes | …the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure |
| | Option 2 | HIE Bi-Directional Exchange | N/A | N/A |

# Reallocation of PI Points (cont)

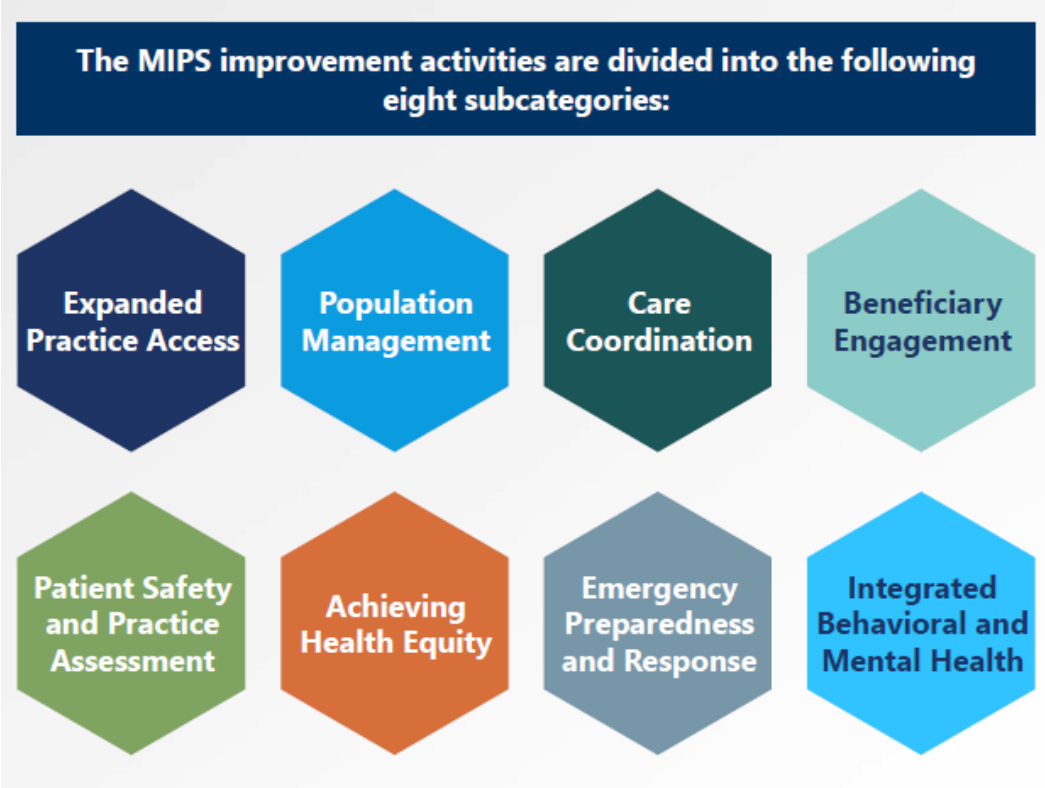
When you claim an exclusion for a measure, the measure's points are redistributed to a different measure

| Objectives | Measures | Exclusion Available | When the Exclusion is claimed |
|---|---|---|---|
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | No | N/A |
| Public Health and Clinical Data Exchange | Report the 2 Required Measures<br>• Immunization Registry Reporting<br>• Electronic Case Reporting | Yes | …the 10 points are still available in this objective if you **claim an exclusion**for one of the required measures and submit a 'yes' attestation for the other required measure in the objective.<br>… the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you **claim two exclusions**. |
| | Bonus:<br>• Public Health Registry Reporting<br>• Clinical Data Registry Reporting<br>• Syndromic Surveillance Reporting | N/A | N/A |

# Let’s take a quick break!

# Improvement Activities

- 15% of MIPS Score
- Over 100 activities to choose from
- Requires you to implement 2 to 4 IA to receive the maximum 40 points
- Performance period: 90 continuous days for most IA
- Attestation – but must keep documentation for 6 years following submission




Source: QPP

# IA Reporting Requirements

| Individuals or Groups with more than 15 clinicians that aren't in a rural area or HPSA | Groups with 15 or fewer clinicians, non-patient facing clinicians, and/or clinicians located in a rural area or HPSA |
|---|---|
| Each activity is weighted medium or high | Each activity is weighted medium or high |
| Max score of 40 points available | Max score of 40 points available |
| **Medium-weighted activities are worth 10 points**<br>**High-weighted activities are worth 20 points** | **Medium-weighted activities are worth 20 points**<br>**High-weighted activities are worth 40 points** |
| Some possible combinations to achieve 40 points:<br>• 2 high-weighted activities<br>• 1 high-weighted and 2 medium-weighted activities<br>• 4 medium-weighted activities | Some possible combinations to achieve 40 points:<br>• 1 high-weighted activity<br>• 2 medium-weighted activities |

- Groups can attest to an IA if 50% of the clinicians in the group perform the same activity during any continuous 90-day period within the same performance year
- If you're a MIPS eligible clinician practicing in a certified patient-centered medical home (PCMH) or comparable specialty practice, you'll earn full credit for the IA category. For a group to receive full credit, at least 50% of practice sites within the TIN need to be certified/recognized as a PCMH or comparable specialty practice.
    - You must attest to this status as a PCMH – it is not automatically rewarded.

# IA Scoring

IA Score =

[ Total # points scored for each activity / Total maximum # of points ] x 100

- You can't earn more than 40 points in this performance category, regardless of the number of activities you submit. If you do attest to more than 40-points worth of activities, you are responsible for compiling and maintaining documentation for all activities to which you attest even though these additional activities won't increase your score.

# 2022 IA

**7 New Improvement Activities**

1. Create and Implement an Anti-Racism Plan (IA_AHE_8)
2. Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols (IA_AHE_9)
3. Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice (IA_BMH_11)
4. Promoting Clinician Well-Being (IA_BMH_12)
5. Implementation of a Personal Protective Equipment (PPE) Plan (IA_ERP_4)
6. Implementation of a Laboratory Preparedness Plan (IA_ERP_5)
7. Application of CDC's Training for Healthcare Providers on Lyme Disease (IA_PSPA_33)

# 2022 IA

**15 Modified Improvement Activities**

1. Enhance Engagement of Medicaid and Other Underserved Populations (IA_AHE_1)
2. MIPS Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research (CBPR) (IA_AHE_5)
3. Use of Certified EHR to Capture Patient Reported Outcomes (IA_BE_1)
4. Regularly Assess Patient Experience of Care and Follow Up on Findings (IA_BE_6)
5. Promote Self-Management in Usual Care (IA_BE_16)
6. Drug Cost Transparency (IA_BE_25)
7. Practice Improvements that Engage Community Resources to Support Patient Health Goals (IA_CC_14)
8. PSH Care Coordination (IA_CC_15)
9. Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (IA_EPA_1)
10. Use of Telehealth Services that Expand Practice Access (IA_EPA_2)
11. Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities (IA_PM_6)
12. Regular Review Practices in Place on Targeted Patient Population Needs (IA_PM_11)
13. Consultation of the Prescription Drug Monitoring Program (IA_PSPA_6)
14. Measurement and Improvement at the Practice and Panel Level (IA_PSPA_18)
15. COVID-19 Clinical Data Reporting with or without Clinical Trial (IA_ERP_3)

# 2022 IA

**6 Removed Improvement Activities**

1. Regularly Assess the Patient Experience of Care through Surveys, Advisory Councils and/or Other Mechanisms (IA_BE_13)
2. Participation in CAHPS or Other Supplemental Questionnaire (IA_PSPA_11)
3. Use of Tools to Assist Patient Self-Management (IA_BE_17)
4. Provide Peer-Led Support for Self-Management (IA_BE_18)
5. Implementation of Condition-Specific Chronic Disease Self-Management Support Programs (IA_BE_20)
6. Improved Practices that Disseminate Appropriate Self-Management Materials
7. (IA_BE_21)

# Cost

- 30% of MIPS score
- A total of 25 cost measures
  - 23 episode-based measures
    - Includes 5 new measures added for 2022
  - Total Per Capita Cost (TPCC) measure
  - Medicare Spending Per Beneficiary (MSPB) Clinician measure
- Administrative claims-based measures – no reporting required

# Cost Measures

| MSPB Clinician | TPCC | Episode-Based Measures |
|---|---|---|
| The MSPB Clinician measure assesses Medicare Parts A and B costs incurred by a single patient during an episode window, which is the period of time beginning 3 days before an index admission through 30 days after hospital discharge. | The TPCC measure is intended to assess the impact of primary care management on health care costs. | Episode-based measures are intended to assess and compare clinicians on the costs of care clinically related to their initial treatment of a patient, care provided during a specific time frame, and/or costs related to the treatment and management of a chronic condition.<br>• 15 Procedural episode-based measures<br>• 6 Acute inpatient medical condition episode-based measures<br>• 2 Chronic condition episode-based measures |
| Case minimum: 35 MSPB Clinician episodes (surgical and/or medical) | Case minimum: 20 patients | Case minimums:<br>• Procedural episode-based measures: 10 episodes<br>• Acute inpatient medical condition episode-based measures: 20 episodes<br>• Chronic condition episode-based measures: 20 episodes |

# Episode-Based Measures

| Procedural | Acute Inpatient Medical Condition | Chronic Condition |
|---|---|---|
| 1. Elective Outpatient PCI<br>2. Knee Arthroplasty<br>3. Revascularization for Lower Extremity Chronic Critical Limb Ischemia<br>4. Routine Cataract Removal with Intraocular Lens (IOL) Implantation<br>5. Screening/Surveillance Colonoscopy<br>6. Acute Kidney Injury Requiring New Inpatient Dialysis<br>7. Elective Primary Hip Arthroplasty<br>8. Femoral or Inguinal Hernia Repair<br>9. Hemodialysis Access Creation<br>10. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels<br>11. Lumpectomy Partial Mastectomy, Simple Mastectomy<br>12. Non-Emergent CABG<br>13. Renal or Ureteral Stone Surgical Treatment<br>14. Melanoma Resection*<br>15. Colon and Rectal Resection* | 1. Intracranial Hemorrhage or Cerebral Infarction<br>2. Simple PN with hospitalization<br>3. STEMI with PCI<br>4. Inpatient COPD Exacerbation<br>5. Lower GI Hemorrhage (applies to groups only)<br>6. Sepsis* | 1. Diabetes*<br>2. Asthma/COPD* |

*new for 2022

# Cost Scoring

- A cost measure is scored if the MIPS EC or group meets or exceeds the case minimum for that cost measure
- To calculate cost score, CMS will
  - Compare your performance to other MIPS eligible clinicians' and groups' during the performance period (no historical benchmarks)
  - Assign 1-10 points to each measure
  - Average the scored measures (if only 1 measure can be scored, that score will be the performance category score)
  - If none of the measures can be scored, then CMS will reweight the Cost performance category to 0%.

$$\textbf{Cost Performance Category Score} = \frac{\text{cost achievement points}}{\text{available cost achievement points}}$$

# Facility-based Measurement

- MIPS eligible clinicians and groups can receive scores in the MIPS quality and cost performance categories based on the FY 2023 score for the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility

| Individual MIPS EC | Groups |
|---|---|
| Qualify if billed at least 75% of the covered prof services in a hospital setting (POS21, 22, or 23) between Oct 1, 2020 and Sept 30, 2021;<br>Billed at least one service in an inpatient hospital or emergency room between October 1, 2020 and September 30, 2021; and<br>Are assigned to a facility that receives a FY 2023 Hospital VBP Program score. (Note that we won't know if a facility has a FY 2023 score until late 2022.) | Qualify if more than 75% of the clinicians in the practice qualify as individuals; and<br>The group is assigned to a facility that receives a FY 2023 Hospital VBP Program score. (Note that we won't know if a facility has a FY 2023 score until late 2022.) |
| Automatically receive quality and cost performance category scores as an individual based on their facility's FY 2023 Hospital VBP Program score, even if:<br>• They don't submit data for the Promoting Interoperability or improvement activities performance categories; or<br>• Their practice chooses to participate in MIPS as a group. (In this instance, the clinician will get the higher of the two final scores – their individual final score from facility-based measurement OR the group's final score.) | Must submit data for the improvement activities and/or Promoting Interoperability performance categories to be able to receive quality and cost scores based on their attributed facility's FY 2022 Hospital VBP Program score.<br>• The submission signals the intent to participate as a group. |

# Complex Patient Bonus

- Revised beginning with 2022 reporting
  - Bonus is limited to clinicians who have a median or higher value for at least 1 of the 2 risk indicators (Hierarchical Condition Category score and proportion of patients dually eligible for Medicare and Medicaid benefits)
  - Formula is updated to standardize the distribution of 2 risk indicators so that clinicians who have a higher share of socially and/or medically complex patients
  - Bonus increased to 10 points
- Need to submit data for at least 1 performance category to qualify for the bonus
- Bonus added to MIPS score

# MIPS Extreme and Uncontrollable Circumstances Policy

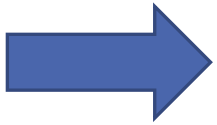
- You can apply to request any or all MIPS performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency that is outside your control. This must prevent you from collecting data for an extended period of time or could impact your performance on cost measures.
- For the 2022 performance year, CMS will continue to use the Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians and groups to submit an application requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency.
  - Application deadline: December 31, 2022 at 8 p.m. ET

# MIPS Real-World Examples

# Example 1: Check Clinician Eligibility

TIN A
Clinician 1
Clinician 2
Clinician 3
Clinician 4
Clinician 5

- Small practice
- All are MIPS Eligible clinicians
- Clinician 1 and 2 exceed the LVT individually
- Clinician 3 can opt-in
- The TIN exceeds the LVT



TIN A decides to report as a group under traditional MIPS

# Select Quality Measures and Collect Data

1. Decide Collection Type
2. Select measures

eCQMs
(6 measures, including 1 outcome)

Outcome measure
Measure 2
Measure 3
Measure 4
Measure 5
Measure 6

**TIPS:**

1. Choose measures that are relevant to your providers
2. Choose measures that your providers perform well in
3. Choose measures that you meet data completeness, case minimum and have a benchmark
4. Monitor / validate measures during the performance period

# Measures and scoring

**Table 2. Performance Year 2022 Historical Benchmark Results**

| Measure Title | Collection Type | Measure Type | Average Performance Rate | Measure has a Benchmark | Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 | Topped Out | Seven Point Cap |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | eCQM | Intermediate Outcome | 44.92 | Y | 80.00 - 70.01 | 70.00 - 60.01 | 60.00 - 50.01 | 50.00 - 40.01 | 40.00 - 30.01 | 30.00 - 20.01 | 20.00 - 10.01 | <= 10.00 | No | No |
| Appropriate Treatment for Upper Respiratory Infection (URI) | eCQM | Process | 88.21 | Y | 82.14 - 86.05 | 86.06 - 88.66 | 88.67 - 91.31 | 91.32 - 93.54 | 93.55 - 95.79 | 95.80 - 98.01 | 98.02 - 99.99 | 100.00 | No | No |
| Pneumococcal Vaccination Status for Older Adults | eCQM | Process | 52.82 | Y | 22.14 - 36.49 | 36.50 - 48.08 | 48.09 - 57.67 | 57.68 - 65.43 | 65.44 - 72.87 | 72.88 - 80.23 | 80.24 - 88.35 | >= 88.36 | No | No |
| Breast Cancer Screening | eCQM | Process | 51.60 | Y | 28.57 - 39.38 | 39.39 - 48.51 | 48.52 - 55.55 | 55.56 - 61.47 | 61.48 - 67.43 | 67.44 - 73.50 | 73.51 - 81.08 | >= 81.09 | No | No |
| Controlling High Blood Pressure | eCQM | Intermediate Outcome | 62.80 | Y | 51.76 - 56.80 | 56.81 - 60.66 | 60.67 - 64.10 | 64.11 - 67.51 | 67.52 - 71.10 | 71.11 - 75.53 | 75.54 - 81.42 | >= 81.43 | No | No |
| Falls: Screening for Future Fall Risk | eCQM | Process | 54.28 | Y | 13.88 - 27.94 | 27.95 - 43.19 | 43.20 - 58.36 | 58.37 - 71.66 | 71.67 - 83.13 | 83.14 - 92.58 | 92.59 - 98.05 | >= 98.06 | No | No |

| Measure | Performance | Decile | Achievement Points |
|---|---|---|---|
| Diabetes: Hemoglobin A1c | 46.5% | 6 | 6.35 |
| Appropriate Treatment for Upper Respiratory Infection (URI) | 98.7% | 9 | 9.35 |
| Pneumococcal Vaccination Status for Older Adults | 84.3% | 9 | 9.5 |
| Breast Cancer Screening | 69.9% | 8 | 8.41 |
| Controlling High Blood Pressure | 62.4% | 5 | 5.5 |
| Falls: Screening for Future Fall Risk | 56.3% | 5 | 5.86 |
| | | **TOTAL** | 44.97 |

# Quality Category Score

44.97 points/60 points = 0.7495

0.7495 * 30 = **22.49/30 points**

**But wait... you are a small practice**

44.97 points + *6 points*/60 points = 0.8495

0.8495 * 30 = **25.49/30 points**

- does not take into account the administrative claims measures that CMS will evaluate and calculate if case minimums are met
- you may also receive additional points for improvement scoring
- *Assumes you will report on PI (PI will not be reweighted)*

# Collect Data for PI

Decide to collect and report data for PI and override the automatic reweighting

| Objectives | Measures | | Performance | Available Points | Points Earned |
|---|---|---|---|---|---|
| e-Prescribing | e-Prescribing | | 90% | 1-10 points | 9 |
| | Bonus: Query of Prescription Drug Monitoring Program (PDMP) | | Yes | 10 bonus points | 10 |
| Health Information Exchange | Option 1 | Support Electronic Referral Loops by Sending Health Information | 65% | 1-20 points | 13 |
| | | Support Electronic Referral Loops by Receiving and Reconciling Health Information | 48% | 1-20 points | 10 |
| | Option 2 | HIE Bi-Directional Exchange | | 1-40 points | |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | | 76% | 40 points | 30 |
| Public Health and Clinical Data Exchange | Report the 2 Required Measures<br>• Immunization Registry Reporting<br>• Electronic Case Reporting | | Yes | 10 points for the entire objective | 10 |
| | Bonus:<br>• Public Health Registry Reporting<br>• Clinical Data Registry Reporting<br>• Syndromic Surveillance Reporting | | Yes | 5 bonus points (whether reporting 1, 2 or all 3 optional measures) | 5 |
| | | | | **TOTAL** | 87 |

# PI Category Score

87 points/100 points = 0.87

0.87 * 25 = **21.75/25 points**

# Improvement Activities Scoring

- As a small practice you only need to report 1 high-weighted activity or 2 medium-weighted activities

Decide that you will attest to:

- Drug Cost Transparency (High weighted activity)

## Drug Cost Transparency

Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.

| Subcategory Name | Activity Weighting |
| --- | --- |
| Beneficiary Engagement | High |

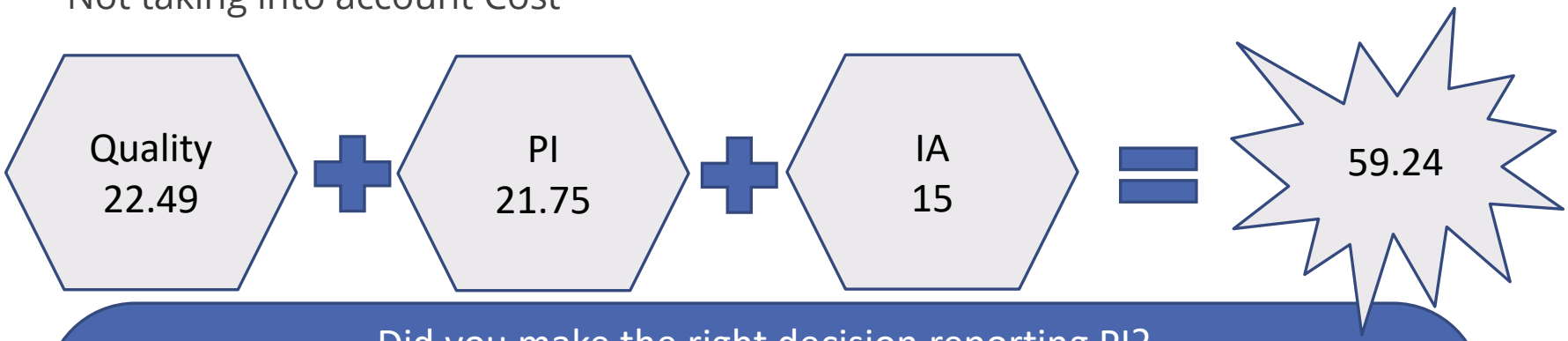
IA Score

40 points/ 40 points = 1

1 * 15 = **15/15 points**

# Calculate MIPS Score

Not taking into account Cost




Did you make the right decision reporting PI?
Let's break it down…

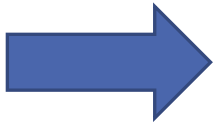
When PI is automatically reweighted for small practices, Quality will be weighted at 40%, IA at 30%, Cost at 30% (no change for cost).

So, Quality = 0.8495 * 40% = 34
IA = 1 * 30 = 30
MIPS Score = 64 points (without cost)
!! You would have a higher MIPS Score not reporting PI !!

# Example 2: Check Clinician Eligibility

TIN B
32 clinicians

- All are MIPS Eligible clinicians
- 27/ 32 clinicians exceed the LVT individually
- >75% of clinicians are hospital-based
- The TIN exceeds the LVT



TIN B decides to report as a group under traditional MIPS

# Select Quality Measures and Collect Data

1. Decide Collection Type
2. Select measures

eCQMs
(6 measures, including 1 outcome)

Outcome measure
Measure 2
Measure 3
Measure 4
Measure 5
Measure 6

Quality Score

Achievement points earned = 37.6
37.6/60 = 0.627
0.627 * 30 = **18.8/30 points**

# Collect Data for PI

Decide to collect and report data for PI and override the automatic reweighting

| Objectives | Measures | | Performance | Available Points | Points Earned |
|---|---|---|---|---|---|
| e-Prescribing | e-Prescribing | | 78% | 1-10 points | 8 |
| | Bonus: Query of Prescription Drug Monitoring Program (PDMP) | | No | 10 bonus points | |
| Health Information Exchange | Option 1 | Support Electronic Referral Loops by Sending Health Information | | 1-20 points | |
| | | Support Electronic Referral Loops by Receiving and Reconciling Health Information | | 1-20 points | |
| | Option 2 | HIE Bi-Directional Exchange | Yes | 40 points | 40 |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | | 87% | 1-40 points | 35 |
| Public Health and Clinical Data Exchange | Report the 2 Required Measures<br>• Immunization Registry Reporting<br>• Electronic Case Reporting | | Yes | 10 points for the entire objective | 10 |
| | Bonus:<br>• Public Health Registry Reporting<br>• Clinical Data Registry Reporting<br>• Syndromic Surveillance Reporting | | Yes | 5 bonus points (whether reporting 1, 2 or all 3 optional measures) | 5 |
| | | | | **TOTAL** | 98 |

# PI Category Score

98 points/100 points = 0.98

0.98 * 25 = **24.5/25 points**

# Improvement Activities Scoring

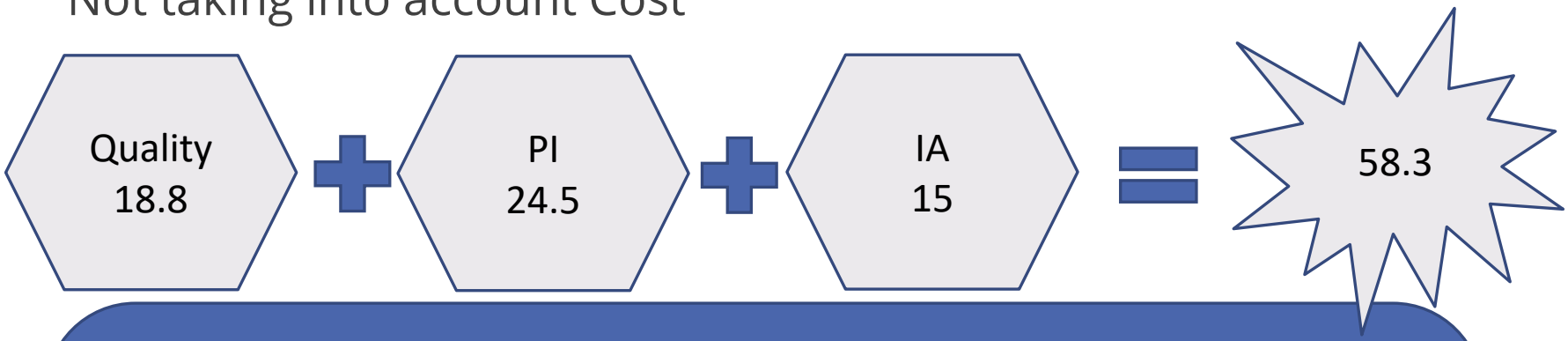
Decide that you will attest to:

- Care transition documentation practice improvements (medium)
- Completion of CDC Training on Antibiotic Stewardship (high)
- Comprehensive Eye Exams (medium)

IA Score
40 points/ 40 points = 1
1 * 15 = **15/15 points**

# Calculate MIPS Score

Not taking into account Cost




Did you make the right decision reporting PI?
Let's break it down…

When PI is automatically reweighted for hospital-based groups, Quality will be weighted at 55%, IA at 15%, Cost at 30% (no change for IA & Cost).

So, Quality = 0.627 * 55 = 34.5
MIPS Score = 49.5 points (without cost)
!! You have a higher MIPS Score reporting PI !!

# Overview of other MIPS Reporting Options

APP and MVP

# APM Performance Pathway (APP)

- APP is a single, pre-determined measure set that MIPS APM participants may report on beginning with 2021 reporting
- Quality (50%): scored on a fixed set of measures
- PI (30%): same reporting as traditional MIPS submitted at individual or group level, not through APM entity
- IA (20%): a score of 100% will automatically be applied to MIPS APM participants
- Cost (0%): no requirements

Quality measures:

- CAHPS for MIPS
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups
- Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure

# MIPS Value Pathways (MVPs)

- A subset of measures and activities that can be used to meet MIPS reporting requirements beginning with 2023 reporting
- Quality – Select 4 measures (one must be an outcome measure)
- Improvement Activities – Select 1 high-weighted measure or 2 medium-weighted measures
- Cost – Uses administrative claims data for the MVP cost measures
- Foundational Layer (New)
  - Population Health Measures
- Promoting Interoperability (PI) – Report the same MIPS Measures

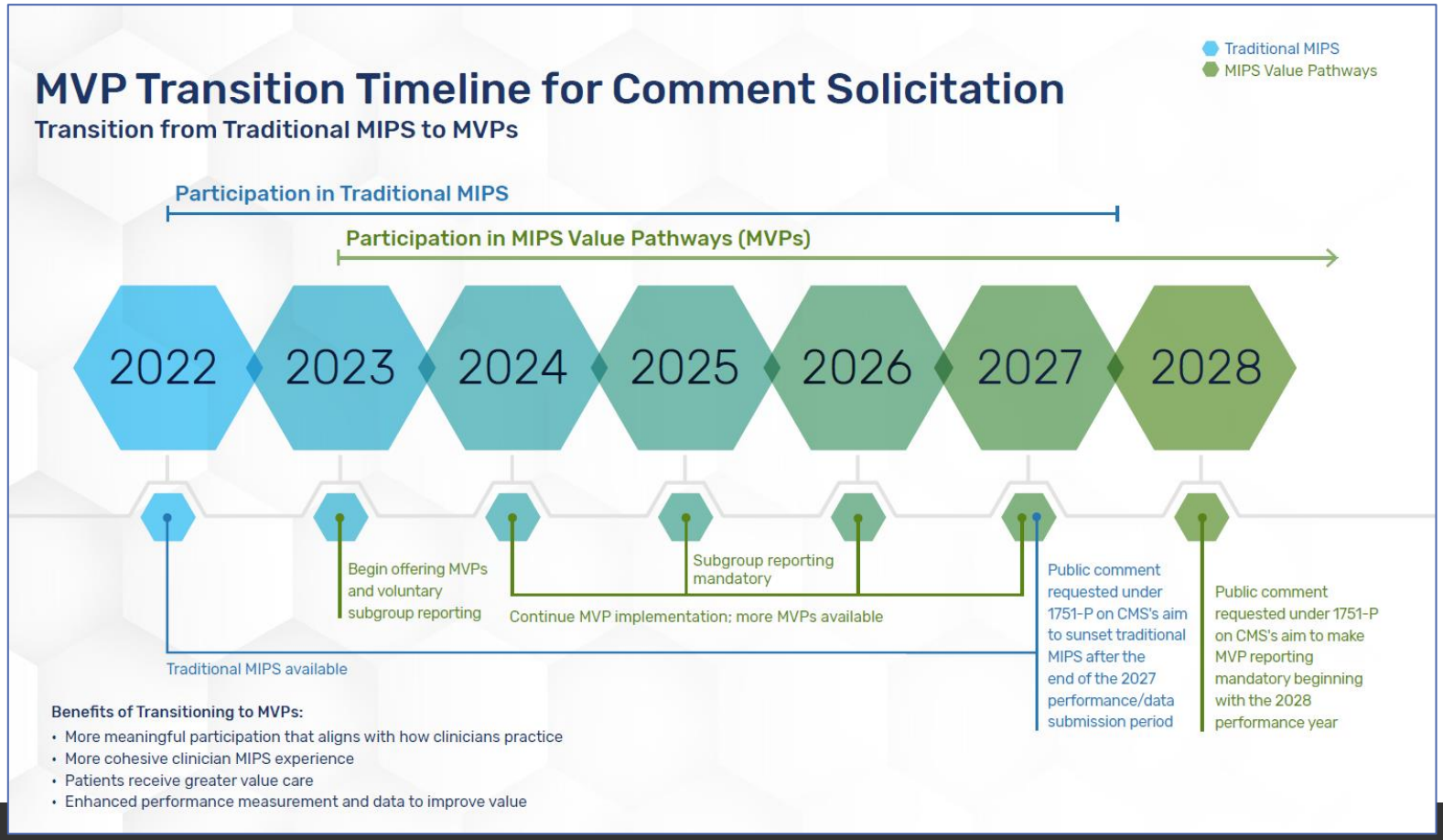
**7 MVPs for 2023 performance year:**

- Anesthesia
- Chronic Disease Management
- Emergency Medicine
- Heart Disease
- Lower Extremity Joint Repair
- Rheumatology
- Stroke Care & Prevention

# Future of MIPS

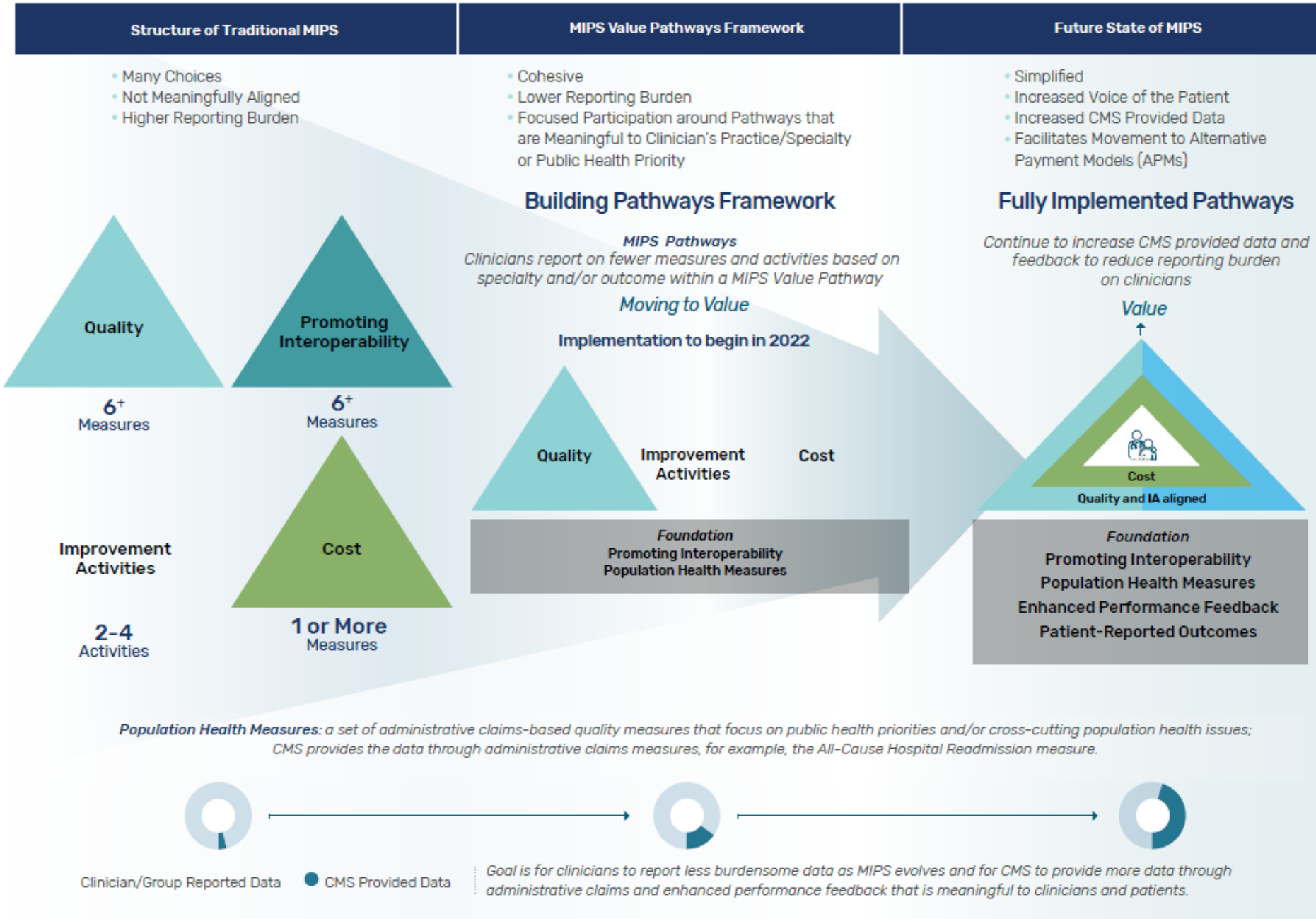
# Future of MIPS

*"The goal is to move away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority."*




Source: QPP

# MIPS Value Pathways

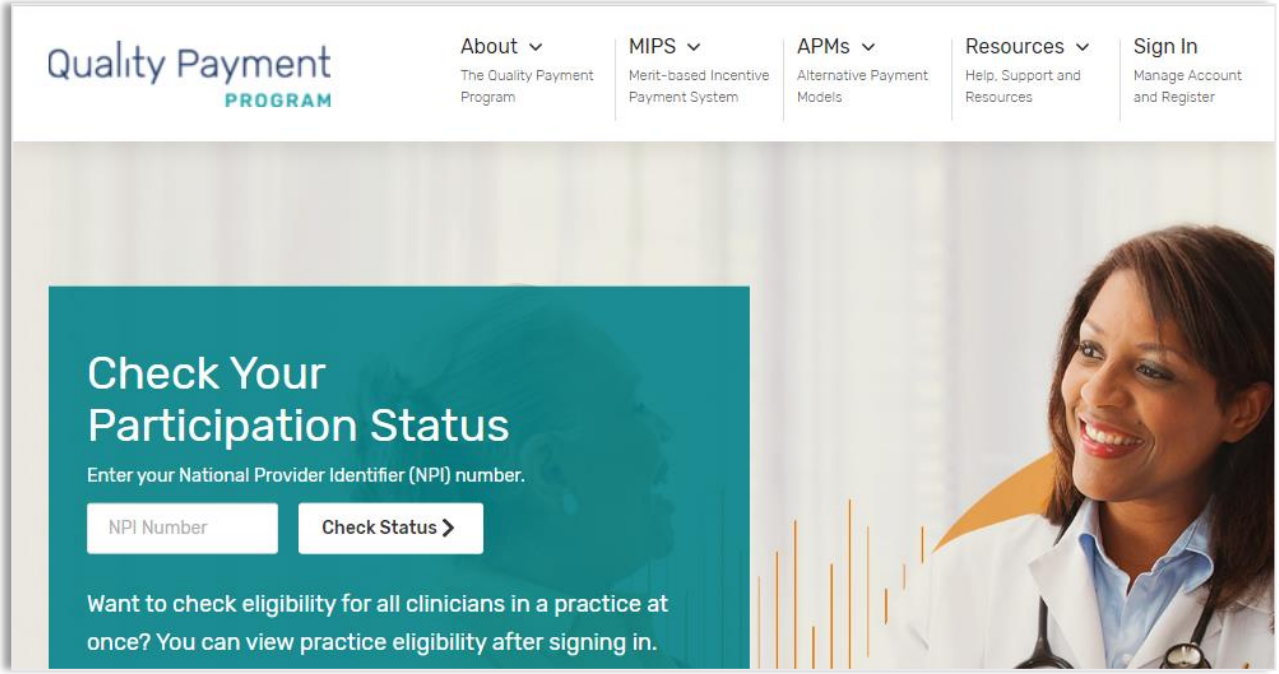



Source: QPP

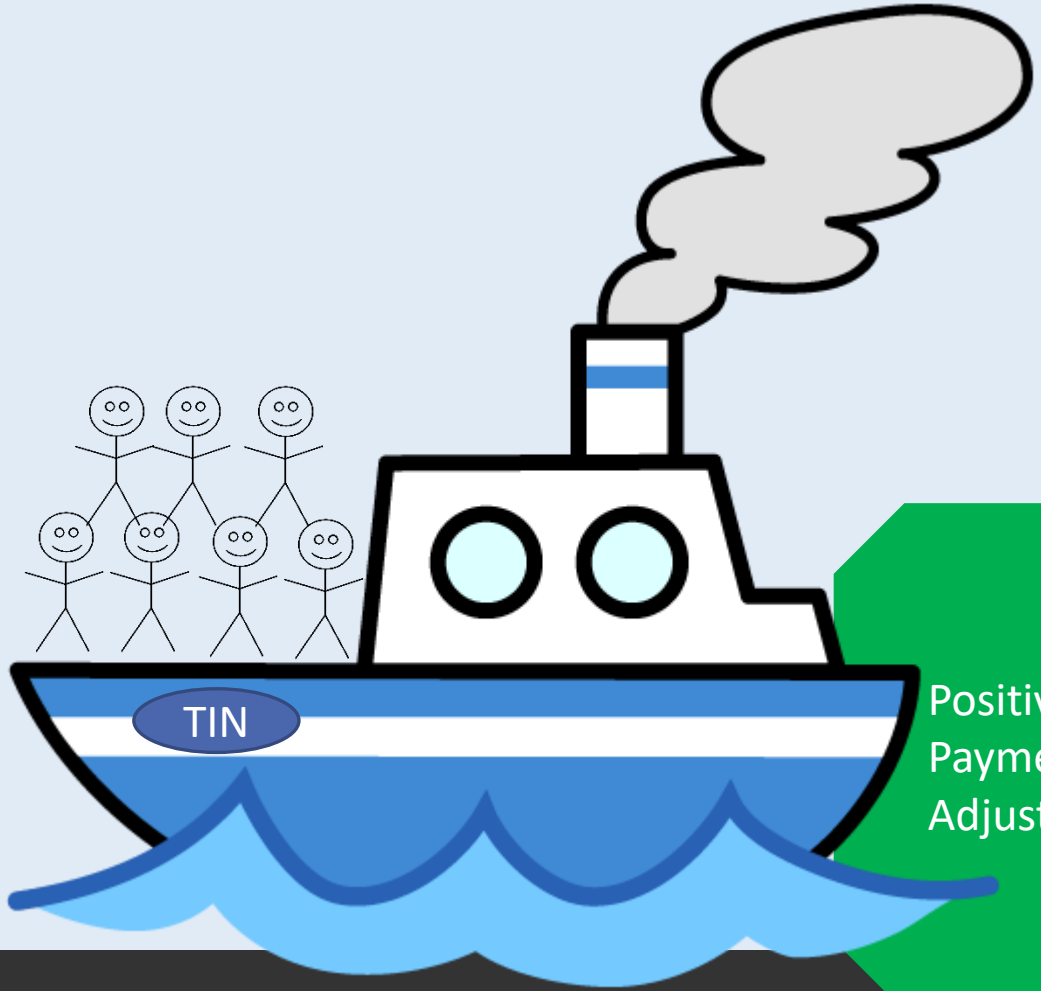
# MIPS Resources

## CMS QPP Site

- [qpp.cms.gov](qpp.cms.gov)



# We made it to land!



# Open discussion

- What questions do you have?

Acmeware Est.1998


Keep in touch!

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