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Quality Reporting Engagement Group-2022 MIPS Proposed Rule

September 1, 2021

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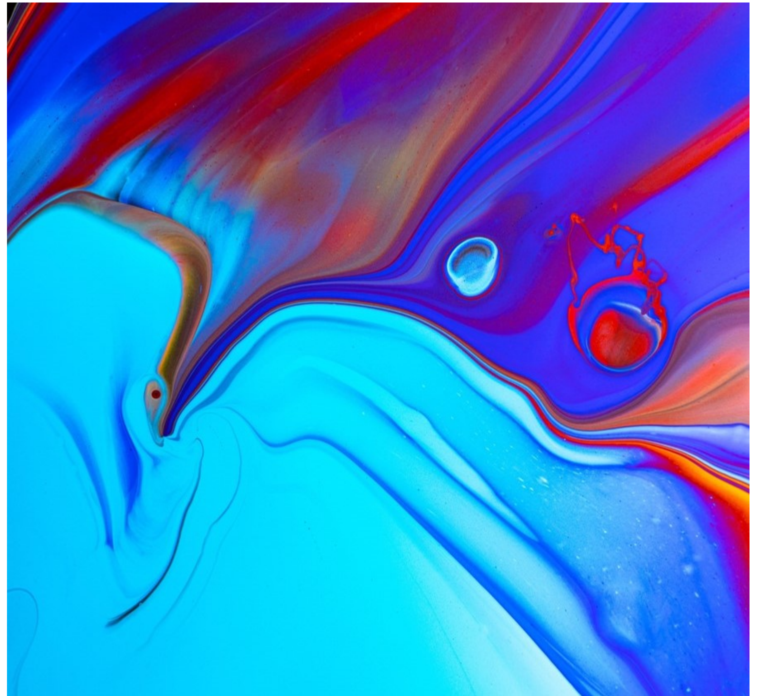
Agenda

1. Introductions-
   Jackie Rogers
2. Complex Patient Bonus & Quality Category-
   Valerie Hicks
3. Cost Category-
   Kate Elam
4. PI/IA Categories-
   Wendy Renfrow
5. MIPS MVP's-
   Jacinda Tuley
6. APM's-
   Valerie Hicks
7. Closing Remarks



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Introduction to todays Team

Jackie Rogers

Director, MACRA Consulting
QREG

Wendy Renfrow

QREG Account Manager
PI/IA Categories

Valerie Hicks

QREG Account Manager
Quality/Cost Categories

Kate Elam

QREG Account Manager
Quality/Cost Categories

Jacinda Tuley

QREG Account Manager
PI/IA Categories

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Complex Patient Bonus

Valerie Hicks

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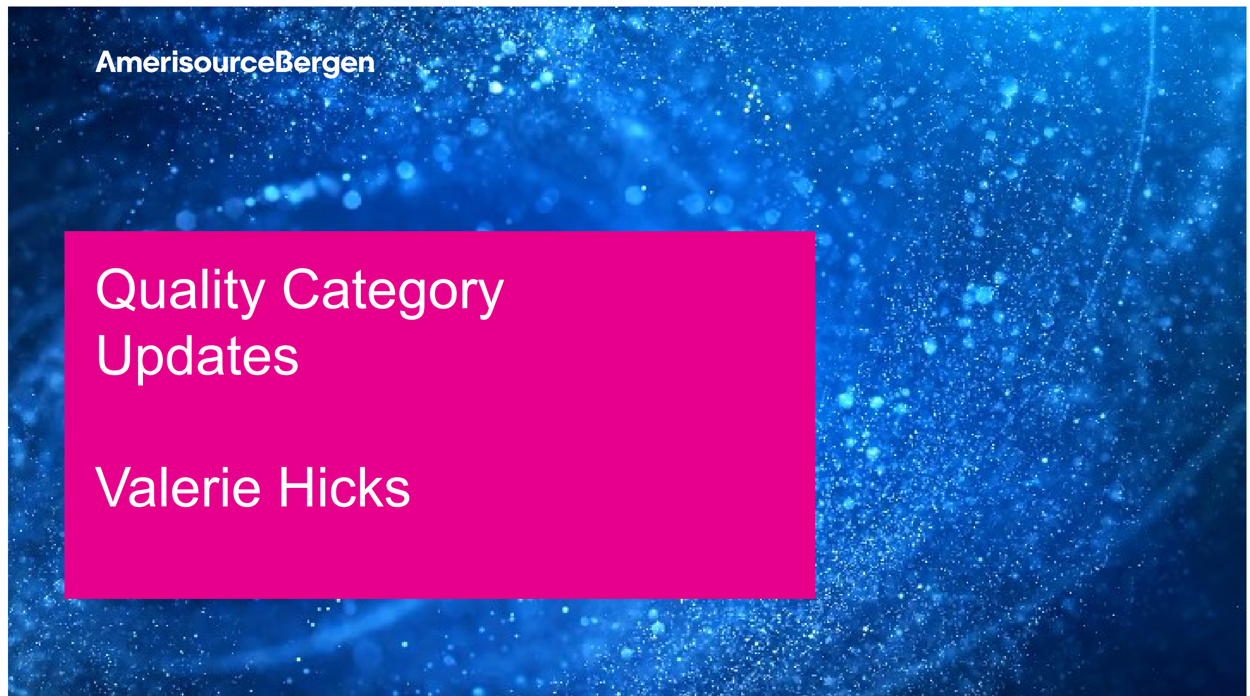
Complex Patient Bonus

- For 2020, due to the complexities of the COVID PHE, CMS doubled the Complex Patient Bonus from up to 5 to up to 10 points.
- Due to continued concerns, CMS is proposing to continue to give up to 10 points.
- Starting in 2022, it is proposed to modify the bonus to limit it to clinicians who see more complex patients or dual-eligible patients and to increase it permanently to 10 points.



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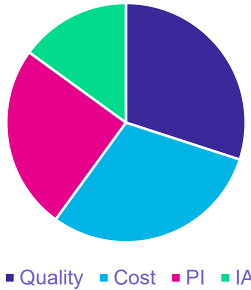
Quality Category

Changes to the Category Weights –

CMS is required by mandate to make Quality and Cost each worth 30% of the total Composite Score starting in 2022.



Traditional MIPS

Quality – 30%

Cost – 30%

Promoting Interoperability – 25%

Improvement Activities – 15%

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Quality Measures Proposed for REMOVAL

- This list is NOT comprehensive, but includes several measure CMS has proposed to REMOVE for the 2022 performance year.
- If you currently use any of these measures for your MIPS Quality submission and do not want the measure to be removed, please consider commenting on the rule.
- Please review Table Group C to review the complete list.

MEASURE NAME
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
Falls: Risk Assessment
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Oncology: Medical and Radiation - Plan of Care for Pain

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Other Proposed Updates

Quality Measure Benchmarks

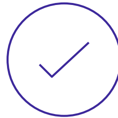
- Due to COVID, CMS is anticipating not having good data from 2020 to determine benchmarks. Once the 2020 data review is complete, they propose to either:
  - **Use Performance Year data to determine benchmarks**

  OR

  - **Use a previous year (like 2019)**

Data Completeness Thresholds

- 2022 – remains at 70%
- 2023 – proposed for 80%



Part B Claims – Small Practice

- Part B Claims will only be scored as Group for small practices when another category is submitted as a group.

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Proposed Scoring Changes

Policy Topic	Current Policy	Proposed Policy
New Measures	No specific separate policy – 3-point floor. Earn 3 – 10 points	5-point floor for the first 2 performance years. Earn 5-10 points
Existing Measures with Benchmark	3-point floor. Earn 3 – 10 points	Remove the 3-point floor. Earn 1-10 points
Existing Measures with NO Benchmarks	3-point floor. Earn 3 - 10 points	Remove the 3-point floor. Earn 0-10 points. (Small practices would still earn minimum 3 points.)
Existing Measures that do not meet Case Minimums	3 points	0 Points (Small practices still earn 3 points.)
High-Priority Bonus points	Earn 1 point for each additional High-Priority measure or 2 points for Outcome measures reported beyond the 1st required measure	Continue to require 1 Outcome or High-Priority measure. NO BONUS for additional reported measures
End-to-End Bonus points	Earn 1 point for each measures that meets the end-to-end reporting criteria	No Bonus Points

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Cost Category

Kate Elam

Newly Proposed Episode-based measures

5 new episode-based measures have been proposed for 2022.

- Procedural measures are triggered by the CPT/HSPCS codes that correlate to the measure & are attributed to the physician/supplier that bills that code.
- Acute inpatient medical condition measures are triggered by the occurrence of acute inpatient E&M codes on Part B Physician/Supplier claims during an acute inpatient facility stay with a specified Medicare Severity Diagnosis-Related Group.
- Chronic condition measures are new for 2022.

MEASURE NAME	EPISODE TYPE	CASE MINIMUM
Melanoma Resection	Procedural	10 episodes
Colon and Rectal Resection	Procedural	20 episodes
Sepsis	Acute Inpatient Medical Condition	20 episodes
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	20 episodes
Diabetes	Chronic condition	20 episodes

Episode-based measure specifications for comment/review: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

Chronic Condition Cost Measures

NEW for 2022

- Chronic condition episode-based measures are triggered by the occurrence of **two claims** billed within 180 days of each other by the same clinician group.
  - The first claim (aka "**trigger claim**") is an initial "primary care" E&M code with a relevant chronic condition diagnosis.
  - The second claim (aka "**confirming claim**") can be either another "primary care" E&M code with a relevant chronic condition diagnosis, or a condition-related CPT/HCPCS code with a relevant chronic condition diagnosis.
- Chronic condition **attribution** can extend for multiple years
  - Attribution begins at the start of the trigger claim and occurs for 1 year.
  - If a **reaffirming claim** is billed, the attribution is extended by 1 year, and continues to be extended until the final reaffirming claim is billed.
  - A reaffirming claim is essentially a repeat confirming claim.
- Multiple episodes can occur within a single attribution event.
  - An episode can vary in length between one year (365 days) and two years minus one day (729 days).
  - Additional episodes may occur in later performance years as part of the original attribution but will NOT include any time/cost previously measured in preceding measurement periods.

Cost Measure Development

CURRENTLY

Cost measures are introduced through a process in which the measure development contractor convening hundreds of clinician experts to provide information to prioritize, conceptualize, and specify clinically refined cost measures and conducting national field testing on an 18-month timeline.

PROPOSED

In addition to the current process, CMS is proposing a process of external cost measure development and a call for cost measures beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period.

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Promoting Interoperability

Wendy Renfrow

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Promoting Interoperability Category

-Continue to require a minimum of a continuous 90 days for reporting

-This category score will continue to be worth 25% of the total MIPS score

-Continue to automatically reweight certain clinician types:

Nurse Practitioners
Physician Assistants
Certified Registered Nurse Anesthesiologists
Clinical Nurse Specialists
Qualified Audiologists
Clinical Psychologist
Registered Dieticians or Nutrition Professionals
Physical Therapist, Occupational Therapists, Qualified Speech-Language Pathologist

***Clinical Social Worker (new clinician type for 2022)**

(No reweighting for certified nurse-midwives – also new EC for 2022)

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Promoting Interoperability Category

-Continue to make the Query of PDMP measure as optional and worth 10 bonus points

(scored at 10 bonus points in 2021)

-Provide Patients Electronic Access objective would ensure patient health information remains available indefinitely

This would ensure that patient data would remain available to the patient or patient–authorized representative using any application of their choice that is configured to meet the technical specification of the Application Programming Interface (API) in the MIPS CEHRT

The proposed requirement would apply beginning with the performance period in 2022 and would include all patient health information from encounters on or after January 1, 2016

-Changes for Public Health and Clinical Data Exchange

Immunizations Registry Reporting and Electronic Case Reporting will be required in 2022, exclusions that were previously established will remain

Five bonus points are available for reporting "yes", that you are participating in one of the other options which include Public Health Registry Reporting measure or the Clinical Data Registry Reporting measure or the Syndromic Surveillance Reporting measure. Reporting on more than one of these optional measures would not yield additional bonus points

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Promoting Interoperability Category

-Proposing to add a new SAFER Guides measure to the Protect Patient Health Information objective

Required - but not scored, report a "yes" or "no" response

Must be completed within the calendar year

SAFER Guides

The SAFER Guides consist of nine guides organized into three broad groups. These guides enable healthcare organizations to address EHR safety in a variety of areas. Most organizations will want to start with the Foundational Guides, and proceed from there to address their areas of greatest interest or concern.

The guides identify recommended practices to optimize the safety and safe use of EHRs. The content of the guides can be explored here, at the links below, or interactive PDF versions of the guides can be downloaded and completed locally for self-assessment of an organization's degree of conformance to the Recommended Practices. The downloaded guides can be filled out, saved, and transmitted between team members.

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Promoting Interoperability Category

-Information Blocking Statements

Proposing to make some changes to the Information Blocking Statements beginning in CY 2022

Making modifications and will possibly remove 2 of the statements

Required - but not scored, report a "yes" or "no" response

-Small practices

Proposing to no longer require an application for clinicians and small practices seeking to qualify for the small practice hardship exception and reweighting

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Promoting Interoperability Category

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.

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Improvement Activities

Wendy Renfrow

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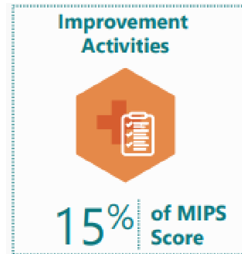
Improvement Activities Category



-You must perform your IA for a minimum of 90 days, unless otherwise noted in the IA description

-This category score will continue to be worth 15% of the total MIPS score

-If you are eligible to participate in MIPS and do not report to participating in any activities, you will receive 0 points in this performance category

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Improvement Activities Category

-Most clinicians must implement and attest to 2 to 4 improvement activities to receive the maximum score of 40 points in this performance category

-Each improvement activity is worth 10 to 40 points depending on its weight (medium or high) and applicable special status designations

2021 Improvement Activities List

Activity Name	Activity Description	Activity ID	Subcategory Name	Activity Weighting
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	IA_EPA_1	Expanded Practice Access	High
Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	IA_EPA_2	Expanded Practice Access	Medium
Collection and use of patient experience and	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help	IA_EPA_3	Expanded Practice	Medium

***Please note, this is referencing the 2021 IA inventory, an updated list for 2022 will be published once finalized

For most MIPS eligible clinicians, groups, virtual groups, and APM Entities:

Each medium-weighted activity is worth **10 points**

Each high-weighted activity is worth **20 points**

For MIPS eligible clinicians, groups, virtual groups, and APM Entities with certain special status designations (small practice, non-patient facing, rural, or Health Professional Shortage Area (HPSA)):

Each medium-weighted activity is worth **20 points**

Each high-weighted activity is worth **40 points**

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Improvement Activities Category

-Proposing to revise group reporting requirements for the 50 percent threshold to address subgroups

Beginning with the 2022 performance year, each improvement activity for which groups and virtual groups submit a yes response must be performed by at least 50 percent of the NPIs that are billing under the group's TIN or virtual group's TINs or that are part of the subgroup, as applicable; and the NPIs must perform the same activity during any continuous 90-day period within the same performance year

-Proposing to revise timeframe for improvement activities nominated during a public health emergency

-Would like to revise the required criteria for improvement activity nominations received through the Annual Call for Activities

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Improvement Activities Category

-Removal of Activities

Proposing a policy to suspend improvement activities

In the case of an improvement activity for which there is a reason to believe that the continued collection raises possible patient safety concerns or is obsolete, they would promptly suspend the improvement activity and immediately notify clinicians and the public through the usual communication channels, such as listservs and Web postings. They would then propose to remove or modify the improvement activity as appropriate in the next rulemaking cycle

-Criteria for Nominating a New Improvement Activity

We are proposing 2 new criteria for nominating new improvement activities:

Improvement activities:

- Shouldn't duplicate other improvement activities in the Inventory
- Should drive improvements that go beyond standard clinical practices

Improvement Activities Category

Proposing that new improvement activities must at minimum meet all of the following 8 criteria, consisting of: the 2 proposed criteria above and these 6 existing criteria:

1. Relevance to an existing improvement activities subcategory (or a proposed new subcategory)
2. Importance of an activity toward achieving improved beneficiary health outcomes
3. Feasible to implement, recognizing importance in minimizing burden, including, to the extent possible, for small practices, practices in rural areas, or in areas designated as geographic Health Professional Shortage Areas by the Health Resources and Services Administration
4. Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes
5. Can be linked to existing and related MIPS quality, Promoting Interoperability, and cost measures, as applicable and feasible
6. CMS is able to validate the activity

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Improvement Activities Category

Proposing 6 optional factors that may used to consider nominated activities (made up of previously finalized criteria):

1. Alignment with patient-centered medical homes
2. Support for the patient's family or personal caregiver
3. Responds to a public health emergency as determined by the Secretary
4. Addresses improvements in practice to reduce health care disparities
5. Focus on meaningful actions from the person and family's point of view
6. Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care)

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Improvement Activities Category

Activity Inventory

- Proposing the addition of 7 new improvement activities, 3 of which are related to promoting health equity
- Proposing to modify 15 current improvement activities, 11 of which address health equity
- Also proposing to remove 6 previously adopted improvement activities

Table A: Proposed New Improvement Activities for the MIPS CY 2022 Performance Period/2024 MIPS Payment Year and Future Years

Table B: Proposed Changes to Previously Adopted Improvement Activities for the 2022 MIPS Performance Period/2024 MIPS Payment Year and Future Years

TABLE C: Improvement Activities Proposed for Removal for the 2022 MIPS Performance Period/2024 MIPS Payment Year and Future Years

In this rule, we are proposing to remove six previously finalized improvement activity from the MIPS Program for the 2022 MIPS performance period/2024 MIPS payment year and future years. These improvement activities are discussed in detail below. Improvement activity removal factors are discussed in the MIPS CY 2020 final rule

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MIPS Value Pathways (MVPs)

Jacinda Tuley

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MIPS Value Pathways (MVPs) Proposals

The MVP framework will connect all 4 performance categories with the goal of improving performance measurements.

Relevant activities and measures that tie to a specialty, medical condition, or episode of care are what the Quality Payment Program (QPP) intends to use to provide more effective comparison for how clinicians practice.

QPP wants to deliver more meaningful feedback to help improve clinician scores and provide more value to patients.

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Proposed MVPs

7 Proposed MVPs for the 2023 performance year:

1. Rheumatology
2. Stroke Care and Prevention
3. Heart Disease
4. Chronic Disease Management
5. Emergency Medicine
6. Lower Extremity Joint Repair
7. Anesthesia

❖ There are currently no clinical MVPs for Urology or Oncology.

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Proposed Participant Registration Dates

For MVP reporting, registration must be completed between April 1 and November 30 of the performance year, or a later date as specified by CMS. At registration, the specific MVP needs to be selected.

The registration period closes November 30 of the performance year and changes to the MVP selected are not allowed once closed.

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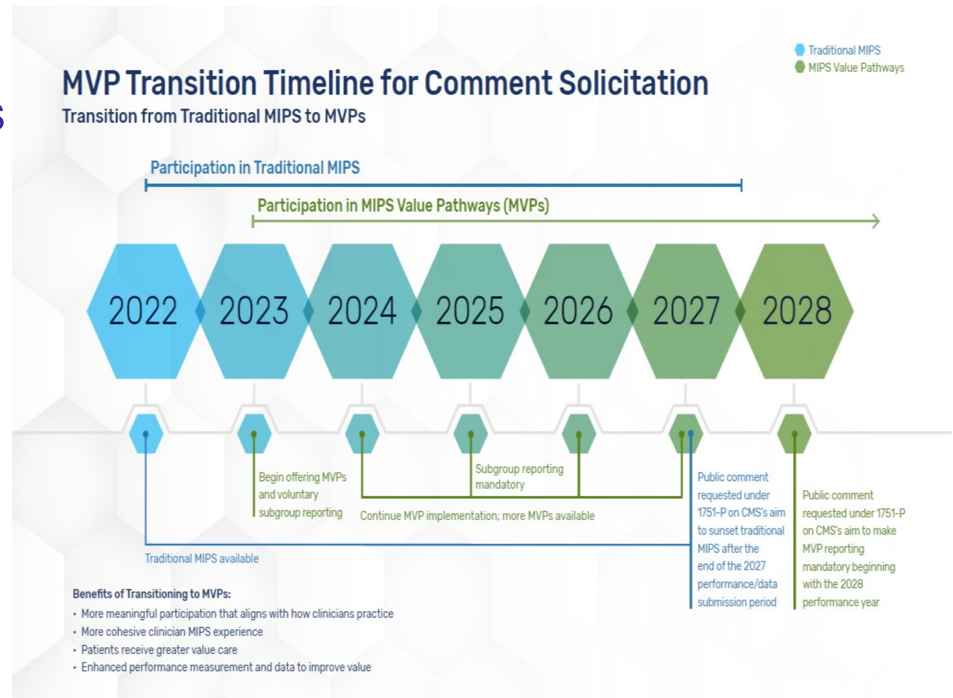
QPP's 2022 PFS Proposed Rule MVP Transition Timeline



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CMS is requesting comments

CMS is requesting public comment on the timeline for ending traditional MIPS after the 2027 performance year and submission period.

Eventually MVPs will become mandatory and no longer be voluntary – but the timeframe will be determined in future rulemaking.

Comments for the MIPS Proposed Rule can be submitted at:
https://www.regulations.gov/

❖ Established MIPS participation options are collectively being referred to as traditional MIPS (85 FR 84844).

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APM / APP Updates

Valerie Hicks

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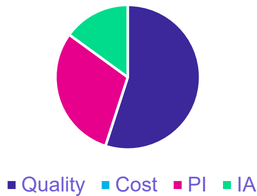
APM / APP Category Weights

No Proposed changes to the category weights for APMs or APPs

Traditional MIPS – APM Participants

- Quality – 55%
- Cost – 0%
- Promoting Interoperability – 30%
- Improvement Activities – 15%



Quality Cost PI IA

APM Performance Pathways - APP

Quality – 50%

Cost – 0%

Promoting Interoperability – 30%

Improvement Activities – 20%

Quality Cost PI IA

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Proposed APM / APP Changes

APM – Proposed Changes
Extending the CMS Web-Interface as a reporting option for 2022 and 2023
Adding a step to the Advanced APM QP Payment processing hierarchy to make determining the appropriate TIN for payees easier to identify.

APM Performance Pathways (APP) – Proposed Changes
Extending the CMS Web-Interface as a reporting option for 2022 and 2023
Similar to MVPs – CMS will begin to allow subgroups to report and be scored under the APP

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Final Comments- Performance Thresholds & Payment Adjustments

Threshold to avoid penalty increased to **75**

Threshold to earn Exceptional Performer increased to **89**

Note 2022 Performance Year/ 2024 Payment Year will be the LAST year for the Exceptional Performer Payment Adjustment

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Final Comments- Future of MIPS

- MIPS is approaching its 6th year of the program
- Proposal is to begin transitioning to MVP's in the 2023 performance year and sunset traditional MIPS after the 2027 performance year.
- Any proposal to sunset traditional MIPS would be made in a future rule making, however CMS is seeking comment on this plan.

https://www.regulations.gov/commenton/CMS-2021-0119-0053

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Contact

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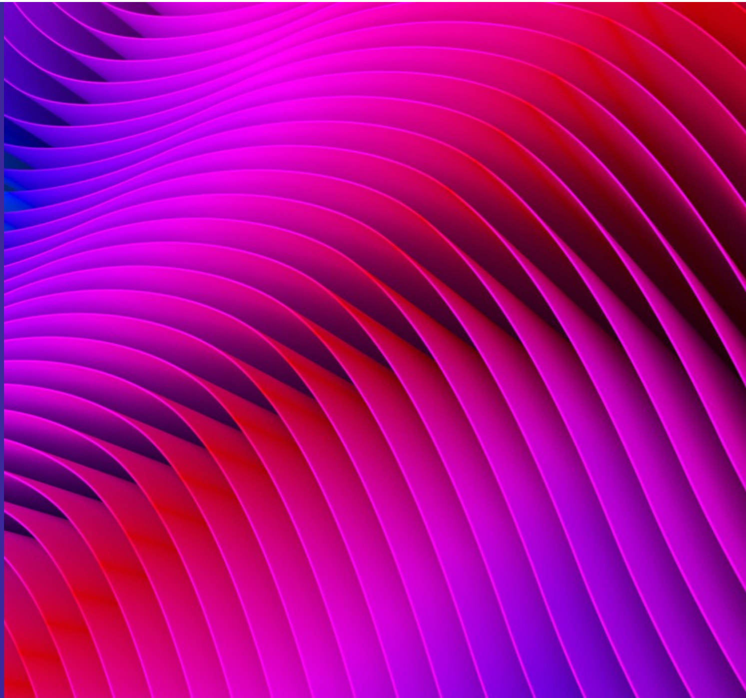

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Acronyms

ACI	Advancing Care Information
ACO	Accountable Care Organization
APM	Advanced Payment Model
APP	APM Performance Pathway
CEHRT	Certified Electronic Health Record Technology
CHPL	Certified Health IT Product List
CMS	Centers for Medicare and Medicaid Services
CNS	Clinical Nurse Specialist
CPS	Composite Performance Score
CRNA	Certified Registered Nurse Anesthetist
EC	Eligible Clinician
EHR	Electronic Health Record
EP	Eligible Professional
IA	Improvement Activities
MACRA	Medicare Access & CHIP Reauthorization Act
MIPS	Merit-Based Incentive Payment System
MU	Meaningful Use
MVP	MIPS Value Pathway
NP	Nurse Practitioner
NPI	National Provider ID
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PI	Promoting Interoperability
QCDR	Qualified Clinical Data Registry
QP	Qualifying APM Pathway
QRDA	Quality Reporting Document Architecture
TIN	Tax ID Number

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