

Welcome to the **MIPS 2022 What's New?**

The presentation will begin shortly.

Please note that all attendees are in listen only mode.

Inquiries may be submitted using the **Questions** window.

A recording of this webinar will be sent out to all attendees.

Presented by:




MIPS 2022


What's New?






Inquiries may be submitted using the **Questions** window.

Questions 

Show Answered Questions

X	Question	Asker	Rec'd		Answer

 Send Privately  Send to All 

eMedApps - About Us

eMedApps is a Healthcare Information Technology Services company providing practices, clinics and hospitals with a full range of services, as well as a suite of products designed to increase efficiency and facilitate communication.

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- Working as partner with NextGen since 2001
- Worked as subcontractor for NextGen
- Serving healthcare clients across USA
- Services and Products for NextGen clients



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About Our Presenter

About Our Presenter

- Christina is a Project Manager and Senior Systems Analyst
- She has been with eMedApps for and she is a Certified MIPs Professional
- In her spare time, Christina enjoys going to concerts and enjoying the newly renovated Downtown Detroit.



2022 Payment Adjustments

2022 MIPS Payment Year

- Your 2020 final score determines the 2022 payment adjustment received.
- The type of payment adjustments include positive, neutral and negative.

Type of Payment Adjustment	Impact to Payments in 2022
Positive	Each covered professional service you furnish in 2022 is reimbursed more than 100% – increase to paid amount
Neutral	Each covered professional service you furnish in 2022 is reimbursed 100% – no increase or decrease to paid amount
Negative	Each covered professional service you furnish in 2022 is reimbursed less than 100% – decrease to paid amount



Determining your Payment Adjustment

Based on your final score in 2020, a comparison is made with performance thresholds which determines the adjustment received.

The exceptional performance threshold for the 2022 MIPS payment year is 85 points or higher. If your final score reflects 85 points or above, the additional payment adjustment will be received.



The performance threshold for the 2022 MIPS payment year is 45 points. If you received a final score of 45 points or above, you have avoided a negative payment adjustment.

How 2020 MIPS Scores Relate to 2022 Payment Adjustments

Final Score Points	MIPS Payment Adjustment
0.00 – 11.25 points	Negative (-) MIPS payment adjustment of -9%
11.26 – 44.99 points	Negative (-) MIPS payment adjustment, between 0% and -9%, on a linear sliding scale
45.00 points (Performance threshold=45.00 points)	Neutral MIPS payment adjustment (0%)
45.01 – 84.99 points	<ul style="list-style-type: none"> • Positive (+) MIPS payment adjustment, greater than 0%, on a linear sliding scale and multiplied by a scaling factor to preserve budget neutrality • Not eligible for an additional adjustment for exceptional performance
85.00 – 100.00 points (Additional performance threshold=85.00 points)	<ul style="list-style-type: none"> • Positive (+) MIPS payment adjustment, greater than 0%, on a linear sliding scale and multiplied by a scaling factor to preserve budget neutrality AND • Additional positive (+) adjustment for exceptional performance on a linear sliding scale and multiplied by a scaling factor to proportionately distribute funds

Why is my adjustment so small?

CMS notes that the “modest” adjustments given were due to:

- Small number of negative payment adjustments due to the flexibilities from Covid-19 response
- High participation rates
- Large % of final scores above the low 45-point threshold

Due to the successful participation of many more Providers, the distribution of the positive payment adjustment was affected

Additionally, those that did not submit data received the neutral payment adjustment instead of the maximum negative adjustment which also impacted your overall adjustment

Scaling Factor & Budget Neutrality????

MIPS is a budget neutral program which means that negative adjustments need to be balanced by positive adjustments.

Positive payment adjustment factors can be increased or decreased by an amount called a scaling factor which is a number between 0 & 3.

The exact amount depends on final scores distributed across all providers.



Remittance Advice Document Breakdown

The following will be displayed on the RA:

Positive MIPS Payment Adjustments	CARC⁷ 144: "Incentive adjustment, e.g., preferred product/service"	RARC⁸ N807: "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	Group Code⁹: CO. This group code is used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment.
Negative MIPS Payment Adjustments	CARC 237: "Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"	RARC N807: "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	Group Code: CO

Traditional MIPS

2022 Traditional MIPS Overview

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). The program reimburses MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Performance across four categories that lead to improved quality and value are evaluated.



2022 Category Weights

The MIPS performance categories have different “weights,” and the scores from each of the categories are added together to give you a MIPS final score .

Traditional MIPS Performance Category Weights in 2022: Individual, Group, and Virtual Group Participation

Quality



30% of MIPS Score

Cost



30% of MIPS Score

Improvement Activities



15% of MIPS Score

Promoting Interoperability



25% of MIPS Score

Clinician Types

Physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry)

Osteopathic practitioners

Chiropractors

Physician assistants

Nurse practitioners

Clinical nurse specialists

Certified registered nurse anesthetists

Physical therapists

Occupational therapists

Clinical psychologists

Qualified speech-language pathologists

Qualified audiologists

Registered dietitians or nutrition professionals

Clinical social workers

Certified nurse midwives

Performance



Provider performance across the MIPS categories, each with a specific weight, will result in a final score of 0 to 100 points.



The final score will determine whether you receive a negative, neutral, or positive payment adjustment.



The payment adjustment is based on performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

2022 Performance Threshold

The performance threshold is set at 75 points.

The additional performance threshold is set at 89 points.

This the last year of the additional performance threshold and the additional MIPS adjustment factors for exceptional performance.

CMS 2022 Final Score Breakdown:

Final Score: Performance Thresholds and Payment Adjustments

Performance Thresholds for 2022*

- The performance threshold is set at **75 points**
 - This is the minimum final score needed to avoid a negative payment adjustment in 2024.
- The additional performance threshold for exceptional performance is set at **89 points**
- We'll compare your final score to the performance threshold (and exceptional performance threshold) to determine your payment adjustment

*As required by statute, beginning with performance year 2022, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period.



The 2022 performance year/2024 payment year is the FINAL YEAR for the additional adjustment for exceptional performance.

Final Score 2022	Payment Adjustments 2024
> = 89 points	<ul style="list-style-type: none">• Positive adjustment greater than 0%• Eligible for additional payment for exceptional performance
75.01-88.99 points	<ul style="list-style-type: none">• Positive adjustment greater than 0%• Not eligible for additional payment for exceptional performance
75 points	<ul style="list-style-type: none">• Neutral payment adjustment (0%)
18.76 – 74.99 points	<ul style="list-style-type: none">• Negative payment adjustment between -9% and 0%
0 – 18.75 points	<ul style="list-style-type: none">• Negative payment adjustment of -9%

Quality

Quality 30% of the Final Score

- The quality performance category has a 12-month performance period January 1 –December 31, 2022
- Submit data for at least 6 measures including at least one outcome measure & high priority measure.
- There are 200 available quality measures to select from
- 13 quality measures have been removed

New Quality Measures:

ID# 481 Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer

ID# 482 Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate

ID# 483 Person-Centered Primary Care Measure
Patient-Reported Outcome Performance Measure



Quality Measures Removed

- *ID#14 Age related macular degeneration: Dilated Macular Exam (Medicare Part B Claims)*
- ID# 21 Perioperative Care: Selection of Prophylactic Antibiotic
- ID# 23 Perioperative Care: Venous Thromboembolism VTE Prophylaxis
- ID# 44 Coronary Artery Bypass Graft: Preoperative beta-blocker
- *ID# 50 Urinary Incontinence: Plan of care in women aged 65 and older (Medicare Part B Claims)*
- ID# 67 Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- ID# 70 Hematology: Chronic Lymphocytic Leukemia Baseline Flow Cytometry
- ID# 154 Falls: Risk Assessment
- ID# 195 Radiology: Stenosis measurements in carotid imaging
- ID# 225 Radiology: Reminder system for screening mammograms
- ID# 337 Psoriasis: TB prevention
- ID# 342 Pain brought under control within 48 hours
- ID# 429 Pelvic Organ Prolapse: Preoperative Screening for uterine malignancy
- ID# 434 Proportion of patient sustaining a ureter injury at time of repair
- ID# 444 Medication Management for people with Asthma

New Administrative Claims Measure

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

- 18-case minimum
- 1-year performance period
- Applies to MIPS eligible groups with at least 16 clinicians



Scoring

New measures introduced into the program will have a 7-point scoring floor for the first performance period and a 5-point scoring floor in the second performance period.

Measures with a benchmark remain the same in 2022

Measures without a benchmark will continue to earn 3 points

Measures that don't meet case minimum will earn 3 points

Beginning in 2022, there are no bonus points for reporting additional outcome and high priority measures, beyond the one required. Additionally, there are no bonus points for measures that meet end-to-end electronic reporting criteria.

Measure Scoring

CMS determines measure achievement points by comparing performance on a measure to a measure benchmark.

Measure Title	Collection Type	Measure Type	High Priority	Points given based on Performance							Decile 10	
				Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9		
Controlling High Blood Pressure	MIPS CQM	Intermediate Outcome	Y	20.00 - 29.99	30.00 - 39.99	40.00 - 49.99	50.00 - 59.99	60.00 - 69.99	70.00 - 79.99	80.00 - 89.99	>= 90.00	N
Controlling High Blood Pressure	eCQM	Intermediate Outcome	Y	51.06 - 56.30	56.31 - 60.13	60.14 - 63.63	63.64 - 67.04	67.05 - 70.64	70.65 - 74.94	74.95 - 80.83	>= 80.84	N

Scoring against a benchmark means:

- A benchmark is available.
- Has at least 20 cases.
- Meets the data completeness requirement standard, which is 70%.

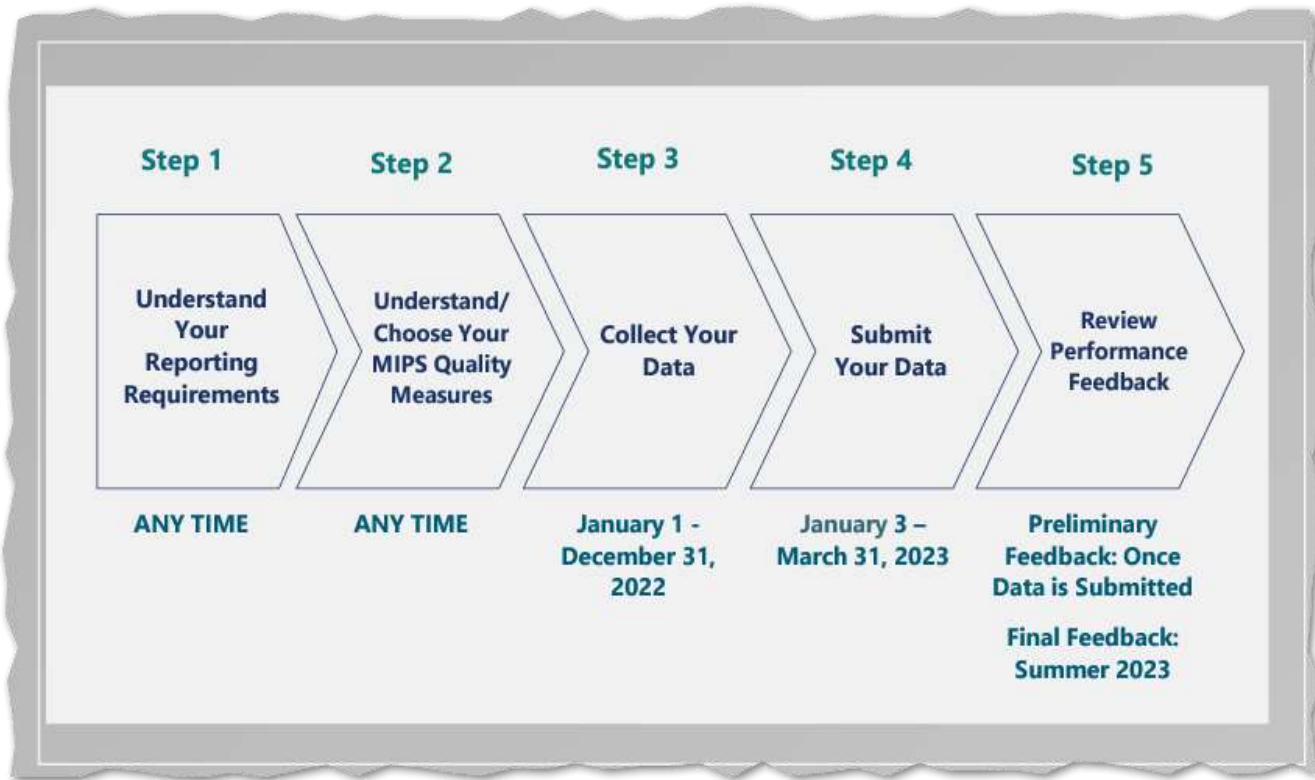
Data Completeness

Refers to the volume of performance data reported for the eligible population/denominator as outlined in the measure's specification.

Must report performance met or not met, or denominator exceptions for at least 70% of the denominator eligible encounters.

- MIPS CQM, eCQM, and QCDR measure specifications include all encounters, regardless of payer.
- Only Medicare Part B claims measure specifications are limited to Medicare Part B encounters.

Quality Summary



COST

2022 Updates

CMS added 5 new episode-based cost measures

2 procedural measures:

Melanoma Resection

Colon & Rectal Resection

1 acute inpatient measure:

Sepsis

2 chronic condition measures:

Diabetes

Asthma/COPD

Improvement Activities

Updates for 2022



7 new activities added



3 of these new activities focus on promoting health equity



Modifications to 15 activities



Removal of 6 activities

New Activities:

High Priority:

- Create and Implement and Anti-Racism Plan
- Promoting Clinician Well Being

Medium Weight:

- Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
- Implementation of Trauma Informed Care
- Implementation of a Personal Protective Equipment Plan
- Implementation of a Laboratory Preparedness Plan
- Application of CDC's Training for Healthcare Providers on Lyme Disease

Measures Removed

BE 13: Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms

PSPA 11: Participation in CAHPS or other supplemental questionnaire

BE 17: Use of tools to assist patient self-management

BE 18: Provide peer led support for self-management

BE 20: Implementation of condition-specific chronic disease self-management support programs

BE 21: Improved practices that disseminate appropriate self-management materials

Promoting Interoperability

Promoting Interoperability 25% of Final Score

New in 2022:

CMS updated automatic reweighting for the Promoting Interoperability performance category. Clinical social workers and small practices (less than 15 providers) now qualify for automatic reweighting and don't have to submit a Promoting Interoperability Hardship Exception application.

CMS added a **new required**, but unscored attestation measure, the High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure.



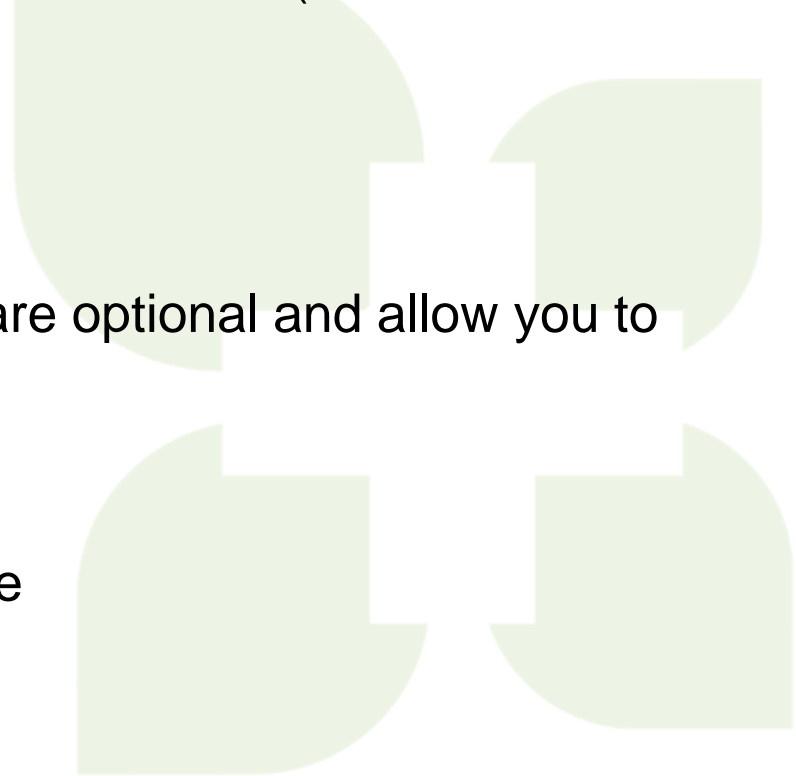
Public Health and Clinical Data Exchange

CMS is requiring eligible clinicians to report 2 measures (unless an exclusion can be claimed):

- Immunization Registry Reporting
- Electronic Case Reporting

Beginning in 2022, the following measures are optional and allow you to earn 5 bonus points if submitted:

- Public Health Registry Reporting measure
- Clinical Data Registry Reporting measure
- Syndromic Surveillance Reporting measure



Self Attestation Measures

New Required Measure for 2022



Safety Assurance Factors for EHR: Conduct an annual self-assessment using the High Priority Practices Guide at any point during the calendar year in which the performance period occurs.

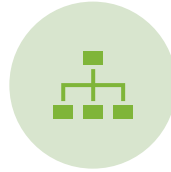


The intent of the safer guides is to identify practices that lead to the safety and safe use of the electronic health record (EHR)

3 Groups Contain 9 Different Guides



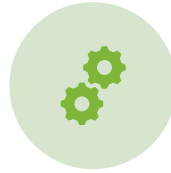
Foundational Guides:



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



Safer Guides Information

- SAFER Guides begins with a Checklist of recommended practices.
- SAFER Guides provide fillable circles that can be used to indicate the extent to which each recommended practice has been implemented.
- After Checklist is completed, a Practice Worksheet gives rationale and examples of how to implement each recommended practice as well as likely sources of input into assessment of each practice, and fillable fields to record team members and follow-up action.

ONC Checklist Breakdown

The *Checklist* is structured as a quick way to enter and print your self-assessment. Your selections on the checklist will automatically update the related section of the corresponding *Recommended Practice Worksheet*.


The *Domain* associated with the *Recommended Practice(s)* appears at the top of the column.

The *Recommended Practice(s)* for the topic appear below the associated *Domain*.


Recommended Practices for <u>Domain 1 — Safe Health IT</u>		Implementation Status				
		Fully in all areas	Partially in some areas	Not implemented	reset	
1.1	The EHR supports and uses standardized protocols for exchanging data with other systems.	Worksheet 1.1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	reset
1.2	Established and up-to-date versions of operating systems, virus and malware protection software, application software, and interface protocols are used.	Worksheet 1.2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	reset
1.3	System-to-system interfaces support the standard clinical vocabularies used by the connected applications.	Worksheet 1.3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	reset
1.4	System-to-system interfaces are properly configured and tested to ensure that both coded and free-text data elements are transmitted without loss of or changes to information content.	Worksheet 1.4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	reset
1.5	The intensity and the extent of interface testing is consistent with its complexity and with the importance of the accuracy, timeliness, and reliability of the data	Worksheet 1.5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	reset

Select the level of implementation achieved by your organization for each *Recommended Practice*. Your *Implementation Status* will be reflected on the *Recommended Practice Worksheet* in this PDF.

Self Assessment Section



Team Worksheet

[> Table of Contents](#) | [> About the Checklist](#) | [> Team Worksheet](#) | [> About the Practice Worksheets](#) | [> Practice Worksheets](#) 

A multi-disciplinary team should complete this self-assessment and evaluate potential health IT-related patient safety risks addressed by this specific SAFER Guide within the context of your particular healthcare organization.

This Team Worksheet is intended to help organizations document the names and roles of the self-assessment team, as well as individual team members' activities. Typically, team members will be drawn from a number of different areas within your organization, and in some instances, from external sources. The Suggested Sources of Input section in each Recommended Practice Worksheet identifies the types of expertise or services to consider engaging. It may be particularly useful to engage specific clinician and other leaders with accountability for safety practices identified in this guide.

The Worksheet includes fillable boxes that allow you to document relevant information. The Assessment Team Leader box allows documentation of the person or persons responsible for ensuring

that the self-assessment is completed. The section labeled Assessment Team Members enables you to record the names of individuals, departments, or other organizations that contributed to the self-assessment. The date that the self-assessment is completed can be recorded in the Assessment Completion Date section and can also serve as a reminder for periodic reassessments. The section labeled Assessment Team Notes is intended to be used, as needed, to record important considerations or conclusions arrived at through the assessment process. This section can also be used to track important factors such as pending software updates, vacant key leadership positions, resource needs, and challenges and barriers to completing the self-assessment or implementing the Recommended Practices in this SAFER Guide.

Assessment Team Leader

Assessment Completion Date

Assessment Team Members

Recommended Practices Section

Each *Recommended Practice Worksheet* provides guidance on implementing a specific *Recommended Practice*, and allows you to enter and print information about your self-assessment.

The *Rationale* section provides guidance about "why" the safety activities are needed.

Enter any notes about your self-assessment.

Enter any follow-up activities required.

Enter the name of the person responsible for the follow-up activities.

Recommended Practice

1.4 System-to-system interfaces are properly configured and tested to ensure that both coded and free-text data elements are transmitted without loss of or changes to information content.^{16, 17}
Checklist

Rationale for Practice or Risk Assessment

Maintaining a system-to-system interface within a rapidly evolving clinical information system environment is challenging, in part because many changes are required. Without the ability to implement and test these changes prior to go-live, and a consistent practice of doing so, a healthcare organization would be placed at significantly increased risk of data loss, corruption, or theft, which could negatively impact patient safety. Failure to test system interface components is one of the leading causes of EHR-related patient safety events.¹⁸

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

Implementation Status

Suggested Sources of Input

EHR developer
Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- System-to-system interfaces are tested before going into production and after changes to hardware, software, or content (e.g., the allowable list of data elements to be exchanged) on either side of the interface.
- Free text data fields accessible to clinical end users of one system are transferred without corruption or truncation of characters to the other system.¹⁹
- Free text data fields that are not supported by the system-to-system interface should be avoided, if at all possible, and clearly marked as such for all users if they exist.
- The organization (or interface developer) should develop a reference or validation data set that includes boundary cases (i.e., data that are slightly below, at, and slightly above key thresholds). These test data are run through the interface repeatedly after any change to the hardware or software on either end of the interface to document that the interface is continuing to work appropriately.

The *Suggested Sources of Input* section indicates categories of personnel who can provide information to help evaluate your level of implementation.

The *Examples* section lists potentially useful practices or scenarios to inform your assessment and implementation of the specific *Recommended Practice*.

Additional Self Attestation Measures

New in 2022 single statement: Prevention of Information Blocking Attestation:

“I attest to CMS that I - did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology. ”

Security Risk Analysis:

Conduct or review a security risk analysis in accordance with the requirements including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

Additional requirements needed to earn a score greater than 0 in the category:

- Use 2015 Edition CEHRT, 2015 Edition Cures Update CEHRT, or a combination of both
- Submit data for a continuous 90-day performance period
- Attest to work in good faith with ONC, if you get a request from ONC to assist in its review of potential non-conformities in health information technology
- Meet all required measures or qualify and claim exclusions

MVP Program

MIPS Value Pathways = MVP Program



Program aims to align and connect measures and activities across the MIPS performance categories of quality, cost, and improvement activities for different specialties or conditions.

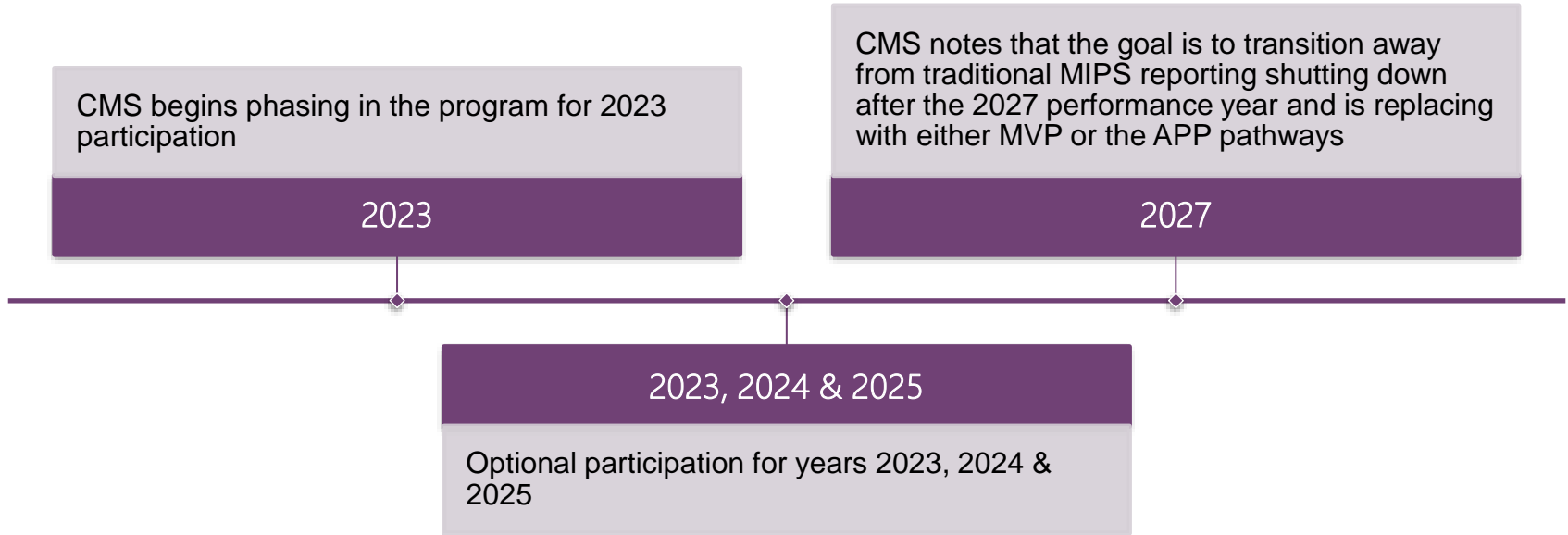


Leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities and reduce reporting.



Goal is to achieve better patient health outcomes and lower costs

MVP Program Start





The 7 MVPs to take effect in 2023

Rheumatology

Stroke Care & Prevention

Heart Disease

Chronic Disease Management

Emergency Medicine

Lower Extremity Joint Repair

Anesthesia

Category Breakdown

There are 5 categories included in the MVP program.

The measures in the first three categories would be specific to your pathway and based on a list provided by CMS related to your MVP.

MVP Layer

1. Quality
2. Improvement Activities
3. Cost

The foundational layer contains your population health and promoting interoperability measures. These measure lists are the same regardless of which MVP you've chosen.

Foundational Layer

4. Population Health
5. Promoting Interoperability

MVP Reporting Requirements

MVP Layer

Quality

- Submit 4 quality measures and note one selected measure must be an outcome measure

Improvement Activities

- Select and submit 2 medium-weight or 1 high-weight improvement activity

Cost

- CMS will calculate performance using administrative claims data

Foundational Layer

Population Health

- Select and submit 1 measure, this performance result will be added to the quality score

Promoting Interoperability

- Submit the 4-5 required measures
- Submit your EHR's CEHRT ID
- Conduct a security risk analysis on your 2015 Edition CEHRT functionality annually
- Attest to the Prevention of Information Blocking and ONC direct review.
- Attest to the Safety Assurance Factors for EHR Resilience Guides (SAFER)



***MVP Heart Disease Breakdown
Example***



Quality

(*) Q005: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
(eCQM Specifications, MIPS CQMs Specifications)

(*) Q007: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
(eCQM Specifications, MIPS CQMs Specifications)

(*) Q008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
(eCQM Specifications, MIPS CQMs Specifications)

(!) Q047: Advance Care Plan
(Medicare Part B Claims Measure Specifications, 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)

(*)(!) Q238: Use of High-Risk Medications in Older Adults
(eCQM Specifications, MIPS CQMs Specifications)

(!) Q243: Cardiac Rehabilitation Patient Referral from an Outpatient Setting
(MIPS CQMs Specifications)

(!!) Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
(MIPS CQMs Specifications)

Improvement Activities

IA_BE_12: Use evidence-based decision aids to support shared decision-making
(Medium)

IA_BE_15: Engagement of patients, family and caregivers in developing a plan of care
(Medium)

IA_BE_24: Financial Navigation Program
(Medium)

IA_BE_25: Drug Cost Transparency
(High)

(-) IA_CC_9: Implementation of practices/processes for developing regular individual care plans
(Medium)

(*)(-) IA_CC_14: Practice improvements that engage community resources to support patient health goals
(High)

IA_EPA_4: Additional improvements in access as a result of QIN/QIO TA
(Medium)

IA_PM_14: Implementation of methodologies for improvements in longitudinal care management for high risk patients
(Medium)

IA_PSPA_4: Administration of the AHRQ Survey of Patient Safety Culture
(Medium)

(-) IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements
(Medium)

IA_PSPA_30: PCI Bleeding Campaign
(High)

Cost

Elective Outpatient Percutaneous Coronary Intervention (PCI)

ST Elevation Myocardial Infarction (STEMI) with PCI

Total Per Capita Cost (TPCC)

Foundational Layer

Population Health Measures

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

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

Promoting Interoperability

- Prevention of Information Blocking
- e-Prescribing
- Query of the Prescription Drug Monitoring Program (PDMP) (Optional)
- 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
- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting
- Security Risk Analysis
- (^) Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)

Time to Prepare for 2023



CMS is providing a full year to choose your pathway, review your selected pathway's reporting requirements, update your internal workflows and to prepare your health IT reporting systems.



For the 2023 and 2024 performance reporting years, the seven pathways would be open to individual providers, single & multi-specialty group practices, subgroups, and alternative payment model entities.



In 2025, CMS would require multi-specialty group practices to break down into subgroups to participate in one of the seven pathways.

2022 Preparation Year



Begin to familiarize yourself with the MVPs program & category requirements



Review and update your internal workflows to capture the data



Review & decide if one of the seven MVPs is right for you



If needed, update your health IT systems to report the quality measure on your pathway

Questions:



References & Resources



Quality Payment Program: <https://qpp.cms.gov/>

Quality Payment Program resource library:
<https://qpp.cms.gov/resources/resource-library>

MIPS Value Pathways (MVP):
<https://qpp.cms.gov/mips/mips-value-pathways>

Health IT.gov safer-guides:
<https://www.healthit.gov/topic/safety/safer-guides>

2022 Final Rule: <https://www.federalregister.gov/>

CMS: www.cms.gov