

AN OVERVIEW OF

MIPS 2022

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ELIGIBILITY

Eligibility for MIPS

The following clinician types are eligible in 2022:

- | | |
|--|---|
| PHYSICIAN | OCCUPATIONAL THERAPIST |
| PHYSICIAN ASSISTANT | QUALIFIED SPEECH-LANGUAGE PATHOLOGIST |
| NURSE PRACTITIONER | QUALIFIED AUDIOLOGIST |
| CLINICAL NURSE SPECIALIST | CLINICAL PSYCHOLOGIST |
| CERTIFIED REGISTERED NURSE ANESTHETIST | REGISTERED DIETITIAN
OR NUTRITION PROFESSIONAL |
| PHYSICAL THERAPIST | CHIROPRACTOR |
| OSTEOPATHIC PRACTITIONER | CLINICAL SOCIAL WORKERS |
| | CERTIFIED NURSE MIDWIVES |

You must also:

- | |
|--|
| Bill Medicare more than \$90,000 annually |
| — AND — |
| Provide care for more than 200 Medicare patients a year |
| — AND — |
| Provide 200 or more covered professional services to Medicare patients |

If you do not meet **all three** of these requirements, then you are **excluded from MIPS for 2022**.

However, you may opt in as long as you meet any one of those requirements. If you don't meet any of those requirements, then you cannot opt-in to the program.

Also note, if you are an Eligible Clinician in your first year of Medicare you are not eligible.

MIPS Participation Eligibility

CMS puts Eligible Clinicians into one or more categories.

To find out your participation framework you must [check your eligibility on the QPP website](#). You will see your participation categorization. The categories are:

Not eligible:

Clear enough.

MIPS Eligible Clinician Individual:

As an individual clinician you are required to report to MIPS.

MIPS Eligible Clinician Group:

As an eligible clinician you are required to report to MIPS, and you are able to report as part of a group. Groups are made up of clinicians who all bill with the same Tax ID (TIN).

MIPS Eligible Clinician Virtual Group:

As an eligible clinician you are required to report to MIPS, and you are able to report as part of a virtual group. Virtual groups must be comprised of 10 or fewer Eligible Clinicians and, as a group, exceed the low-volume threshold.

MIPS Participation

MIPS Eligibility: INDIVIDUAL GROUP

REPORTING REQUIREMENTS

This clinician is required to report because they are a MIPS eligible clinician type, have been enrolled in Medicare for greater than a year, and exceed the individual low-volume threshold.

REPORTING OPTIONS

This clinician can report as part of a group, or as an individual, or both ways.

PAYMENT ADJUSTMENT INFORMATION

If the practice reports as a group, this clinician will receive a payment adjustment based on the group score. If they report as an individual, they will receive a payment adjustment based on their individual score. If they report in both ways, the clinician will receive a payment adjustment based on the higher of the two scores.

Qualifying APM Participant (QP):

This clinician is a part of an *Advanced APM* Entity and therefore does not have to report to MIPS and automatically receives a +5% payment.

MIPS Participation

MIPS Eligibility: INDIVIDUAL GROUP

REPORTING REQUIREMENTS
This clinician is not required to report because they are a Qualifying APM Participant (QP)
REPORTING OPTIONS
This clinician may voluntarily report as an individual or group, and receive performance feedback.
PAYMENT ADJUSTMENT INFORMATION
This clinician will automatically receive a 5% APM Incentive Payment. If they voluntarily report as an individual, this will not impact their 5% incentive payment.

MIPS APM Participant:

This clinician is part of an APM Entity, but it is not an Advanced APM, therefore they still must submit data for MIPS.

MIPS Participation

MIPS Eligibility: MIPS APM

REPORTING REQUIREMENTS
This clinician is required to report because they participate in one or more MIPS APM entities that exceed the low-volume threshold.
REPORTING OPTIONS
This clinician should submit Promoting Interoperability (PI) data at the group level (unless otherwise exempt from reporting this category). The APM entity should submit Quality data.
PAYMENT ADJUSTMENT INFORMATION
This clinician will receive a payment adjustment based on scoring under the APM scoring standard.

APM Entities:

The CMS participation statuses apply to the NPI associated with the provider. This eBook also references APM Entities. An APM Entity is responsible for reporting to this program on behalf of their participants.

Advanced APM Entity:

An organization that takes on some form of financial risk.
These organizations do not have to report to MIPS.

Other APM Entity:

Those organizations not designated as advanced. ACOs make up a good portion of these types of organizations.

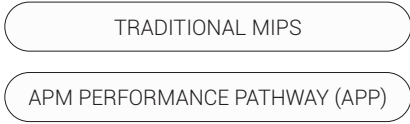
As an individual clinician you may have relied on your ACO to report on your behalf.



REPORTING FRAMEWORKS

Reporting Framework

There are two MIPS frameworks in 2022. Each framework has slightly different requirements and different category weights.



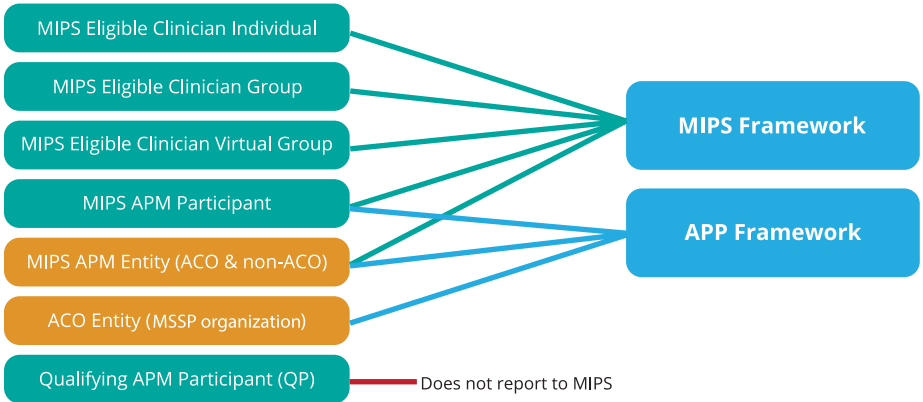
Traditional MIPS Framework

This is the usual MIPS framework made up of four categories and a composite score.

APM Performance Pathway (APP) Framework

The APP Framework is new and is available to MIPS APM entities and required for ACOs if they are part of MSSP.

Here is a matrix of which framework you can report to based on your status.



NOTE: This eBook covers only the requirements for the Traditional MIPS reporting method. APP reporting is covered separately.



CATEGORY REQUIREMENTS

MIPS Categories

Each category of MIPS has a different set of requirements that you must complete in order to achieve a high MIPS score and earn incentive money. There are four categories that make up the MIPS program.



Quality



Promoting Interoperability



Improvement Activities



Cost

Category Weights

Each of these categories carries a different weight. Your score in each category will be totaled into one final MIPS score.



Quality Category

MIPS Framework



Category Weight

30% OF TOTAL MIPS SCORE

Performance Period

365 DAYS

Requirements

- Submit 6 measures one of which is an outcome measure or high priority measure
- Report data for at least 70% of patients who qualify for a measure
- You may use a combo of collection types (listed below)
- Three administrative quality claims measures are calculated automatically
- CAHPS for MIPS survey

Measure list

Quality Measures:

- There are 200 quality measures available in 2022 [and can be found here.](#)

Claims Measures:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Groups. This measure is replacing the All-Cause Hospital Readmission (ACR) measure.
 1. 200 case minimum
 2. 1-year measurement period
 3. Only applies to groups, and virtual groups, and APM entities with 16 or more clinicians and that meet the case minimum
- Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for MIPS
 1. 25 case minimum
 2. 3-year measurement period
 3. Applies to individual clinicians, groups and virtual groups that meet the case minimum
- **New** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
 1. 18 case minimum
 2. 1-year measurement period
 3. Applies to MIPS eligible groups with at least 16 clinicians

CAHPS for MIPS Survey

Quality Category

MIPS Framework



Available collection types

eQMs
(Electronic Clinical Quality Measures)

CSM Web Interface measures

MIPS CQMs
(previously called Registry measures)

Administrative claims
quality measures*

QCDR measures
(Qualified Clinical Data Registry)

CAHPS for MIPS survey

**Only small practices may submit
quality measures using claims*

Other Considerations

Submitting the CAHPS for MIPS Survey will count as reporting one high priority measure. Select five other Quality measures to report, including an outcome measure if available.

There are no bonus points awarded for reporting additional outcome and high priority measures beyond the required one.

If you submit a new quality measure, there is 7-point minimum score awarded for submission in the measure's first year and a 5-point minimum score awarded in its second year.

There is a 3-point floor for any measures submitted (with or without a benchmark).

Data Completeness Requirements

If a measure does not meet the 70% data completeness threshold, the measure will earn 0 points in 2022.

Case Minimum

If a measure does not meet case minimum requirements, the measure will earn 3 points in 2022.

Promoting Interoperability Category

MIPS Framework



Category Weight

25% OF TOTAL MIPS SCORE

Performance Period

90 DAYS

Requirements

- Submit the required measures (measure list below)
- Attest to these two measures: Prevention of Information Blocking and ONC Direct Review
- Collect your data in EHR technology certified to the 2015 Edition or 2015 Cures Edition Update, or a combination of both
- Provide your EHR's CMS Identification code from the Certified Health IT Product List (CHPL)
- Conduct or review a security risk analysis on your CEHRT functionality on an annual basis

Measure list

Promoting Interoperability Measures

1. e-Prescribing
2. Support Electronic Referral Loops by Sending Health Information
3. Support Electronic Referral Loops by Receiving and Reconciling Health Information
 - a. Optional: Instead of measures 2 & 3 you may submit the Health Information Exchange (HIE) bi-directional exchange measure
4. Provide Patients Electronic Access to Their Health Information
5. **New** Attest to conducting an annual assessment of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)
6. Report the following two measures:
 - a. Immunization Registry Reporting
 - b. Electronic Case Reporting



Promoting Interoperability Category

MIPS Framework

Other Considerations

If your APM Entity is reporting your quality and improvement activities data, you will still need to submit your Promoting Interoperability data at the individual or group level for traditional MIPS.

If you do meet all requirements listed above (or if you do not claim an exclusion) you will receive a total score of zero in this category.

CMS will automatically assign a weight of zero to this category for the following titles:

- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Certified Registered Nurse Anesthesiologists (CRNAs)
- Clinical Nurse Specialists (CNSs)
- Physical Therapists
- Occupational Therapists
- Qualified Speech-language Pathologists
- Qualified Audiologists
- Clinical Psychologists
- Registered Dieticians or Nutrition Professionals
- Clinical social workers
- Small practices

Bonus Points

For an additional 5 bonus points you may report for any of these measures (5-point max):

- 1.Public Health Registry Reporting
- 2.Clinical Data Registry Reporting
- 3.Syndromic Surveillance Reporting

The Query of Prescription Drug Monitoring Program (PDMP) measure will remain as an optional measure worth 10 bonus points.

Improvement Activities Category



MIPS Framework

Category Weight

15% OF TOTAL MIPS SCORE

Performance Period

90 DAYS

Requirements

- Submit one of the following combinations of activities
 - 2 high-weighted activities,
 - 1 high-weighted activity and 2 medium-weighted activities, or
 - 4 medium-weighted activities

Measure list

Improvement Activities Measures

- [The 2022 measures can be found here.](#)

Other Considerations

If you're a clinician in any APM who is participating in traditional MIPS, you'll earn half credit (50%) automatically for the IA category.

If you are submitting as a group at least 50% of your group's clinicians must attest to completing the same improvement activity for 90 consecutive days. The activity may be completed anytime within the calendar year so long as each person attesting completes the activity for 90 consecutive days.

Patient-Centered Medical Homes

If you are a Patient-Centered Medical Home and more than 50% of your practices are recognized as a PCMH, you automatically receive full credit for this category.

Cost Category

MIPS Framework



Category Weight

30% OF TOTAL MIPS SCORE

Performance Period

365 DAYS

Requirements

- CMS will evaluate your performance on these two measures: Medicare Spending per Beneficiary (MSPB) and Total Per Capita Cost.
- CMS will evaluate your performance on these 23 episode-based measures.

Measure list

Cost Measures

- Total Per Capita Costs (TPCC)
- Medicare Spending Per Beneficiary (MSPB)
- There are 23 episode-based cost measures evaluated in 2022. [The measure list can be found here.](#)

Other Considerations

CMS requires a case minimum of 35 for the MSPB measure and 20 for the Total Per Capita Cost measure.

CMS also requires a minimum of 10 episodes for the procedural measure types and 20 episodes for the acute inpatient medical condition measure types.

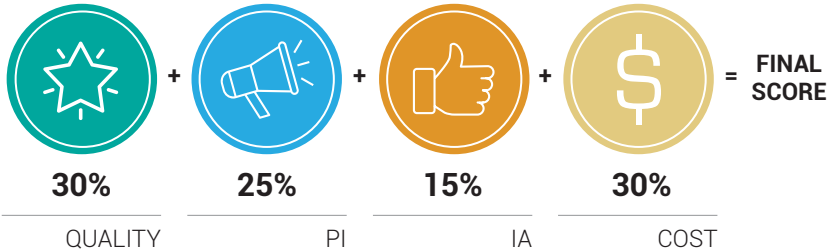
CMS is adding telehealth services directly applicable to existing episode-based cost measures and the TPCC measure.



CALCULATING YOUR SCORE

MIPS Final Score

MIPS Framework Calculation



MIPS 2022 Score Threshold

To avoid a -9% penalty, you must score at least **75 points**.

75
PTS.

To be eligible for the Exceptional Performance bonus money you must score at least **89 points** (Exceptional Performance Bonus).

89
PTS.

Note: This is the last year for the Exceptional Performance Bonus funds.

Your Score will be Posted Publicly

CMS will post your aggregate MIPS score, and also include the minimum, maximum and final scores.

Reweighting Your Score

CMS is allowing any practice that has been significantly impacted by COVID-19 to request reweighting for any or all MIPS performance categories. As with any reweighting scenario, the weight from the categories you opt out of will then be redistributed across your remaining categories, causing the value of each remaining category to rise. Check out the example below of how this might put a practice over the 2022 threshold—and even help a practice earn a score of 89 or more, thus giving them access to the Exceptional Performance Bonus.

Claiming EUC for Cost

Imagine you score 50 out of 60 possible points in the Quality category and ace your IA and PI scores. Will it be enough? Yes...if you claim EUC for Cost.

	Before Reweighting	After Reweighting
Quality Score: 50 out of 60	25 points (30% of score)	45.83 points (55% of score)
IA Score: 40 out of 40	15 points (15% of score)	15 points (15% of score)
PI Score: 100 out of 100	25 points (25% of score)	30 points (30% of score)
Total MIPS Score	65 - 75 points (65 points + 0-10 Cost points)	90.83 points

Reweighting Your Score

2022 Performance Category Reweighting Policies

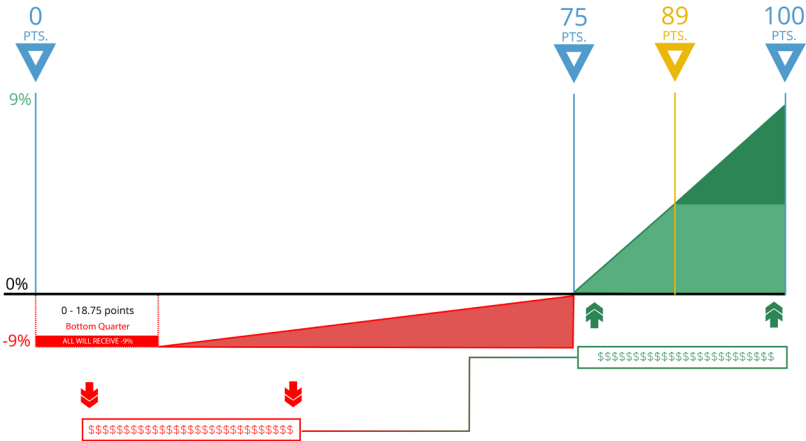
Performance Category Redistribution Policies Finalized for the CY 2022 Performance Period/2024 MIPS Payment Year and for Future MIPS Performance Periods/MIPS Payment Years

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
Scores for all four performance categories	30%	30%	15%	25%
Reweight One Performance Category				
No Cost	55%	0%	15%	30%
No Promoting Interoperability	55%	30%	15%	0%
No Quality	0%	30%	15%	55%
No Improvement Activities	45%	30%	0%	25%
Reweight One Performance Category				
No Cost and no Promoting Interoperability	85%	0%	15%	0%
No Cost and no Quality	0%	0%	15%	85%
No Cost and no Improvement Activities	70%	0%	0%	30%
No Promoting Interoperability and no Quality	0%	50%	50%	0%
No Promoting Interoperability and no Improvement Activities	70%	30%	0%	0%
No Quality and no Improvement Activities	0%	30%	0%	70%

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REIMBURSEMENTS

Reimbursement Funds



0-18.75 points

If your score is between 0 and 18.75 points, you will lose -9% from your 2024 Medicare fee schedule (in red above).

18.76-74.99 points

If your score is between 18.76 and 74.99 points you will receive a reduction to your 2024 Medicare fee schedule between -8.99% and 0%

75-100 points

CMS will take the funds of those who did not meet the threshold (in red) and distribute them among those who did meet the threshold (in green). Anyone whose MIPS score is between 75 and 100 points will receive some portion of those funds – up to a 9% increase to their 2024 Medicare fee schedule.

89 points and above

By scoring at least 89 points, you'll be eligible for the Exceptional Performance bonus money (on the right). CMS has set aside an additional \$500 million to distribute to anyone who scores between 89 – 100 points. This is on top of whatever portion of money you receive from those who do not participate (in red).

Note: This is the last year for the exceptional performance bonus.



**BONUS
POINTS**

2022 Bonus Points

There are many opportunities to get bonus points within the MIPS program.



Quality Improvement Bonus

Clinicians will be rewarded if they demonstrate any improvement to their 2022 Quality score over last year (pending there is enough data for comparison).



Complex Case Bonus

For clinicians who work with patients that have more complex cases, CMS will award up to 10 points to account for the additional complexity of treating their patient population.



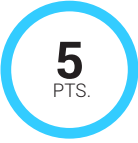
Small Practice Bonus

An additional 6 bonus points will be added to the numerator of the Quality category for anyone qualifying as a small practice (<=15 providers)



PDMP Measure Bonus

Report on the Query of Prescription Drug Monitoring Program measure to receive 10 bonus points.



Extra Public Health Registry

Report to an extra public health registry and receive up to 5 bonus points added to the PI score.



End-to-End Electronic

Bonus Eliminated



Additional Outcome Measure

Bonus Eliminated



High Priority Measure

Bonus Eliminated



DEADLINES

Dates to Remember

The important dates you need to remember are as follows.



Quality & Cost Category

January 1, 2022

This is the start date to track **365 days** of Quality and Cost category measures.



PI & IA Category

January 1 - October 2, 2022

For the PI and the IA category, you may start between **January 1 and October 2, 2022** to track your measures for a minimum of 90 days.



End Date

December 31, 2022

The last day to submit a hardship application to CMS is December 31, 2022.



End Date

March 31, 2023

The last day to submit all of your performance data is March 31, 2023.

MEDISOLV CAN HELP

Medisolv MIPS Package

Medisolv's quality reporting software, ENCOR, is designed to meet your MIPS reporting needs. We consistently hear from our clients that the biggest differentiator between Medisolv and other vendors is the level of one-on-one support. Especially if you use an EHR vendor right now, you'll notice a huge difference.

- We help troubleshoot technical and clinical issues to improve your measures.
- We keep you on track for your submission deadlines and ensure you don't miss critical dates
- We help you select and set up measures that make sense based on your hospital's situation.
- You receive one consultant that you can call anytime with questions or concerns.

[CONTACT US](#)



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