Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2022 Measures and Activities for Gastroenterology Professionals

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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How to Use This Guide

How to Use This Guide

Table of Contents

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Please note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

Quality Payment PROGRAM

What is MIPS?

The Merit-based Incentive Payment System (MIPS) is one of the two tracks of the Quality Payment Program (QPP), which implements provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve QP status, you may be eligible for a 5% incentive payment, and you will be excluded from MIPS.

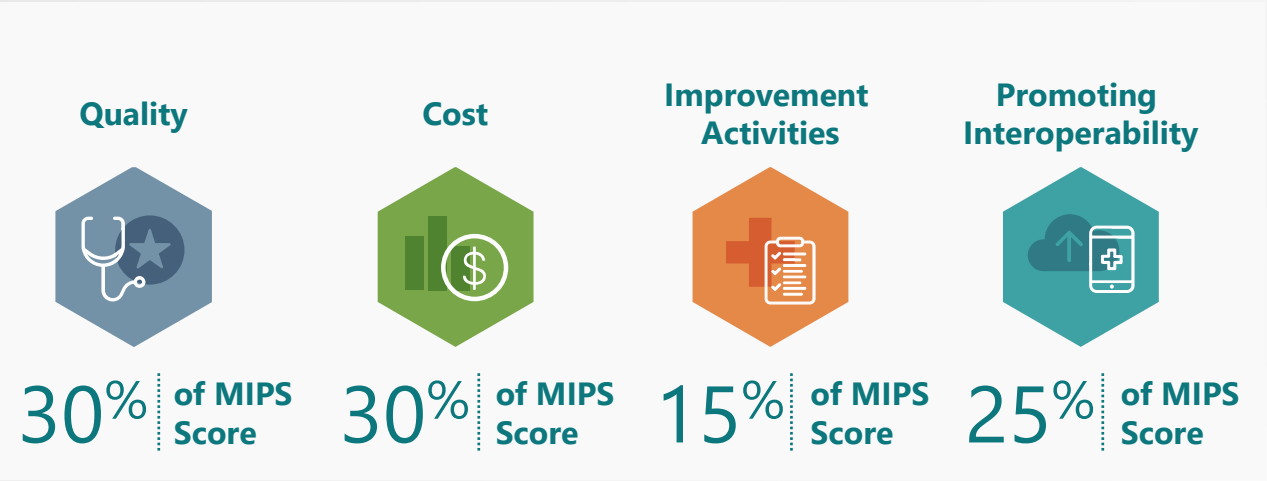
Visit QPP.cms.gov to understand program basics, including submission timelines and how to participate.

Note: This guide only covers **traditional MIPS**, which was established in the first year of the Quality Payment Program and is the original framework for collecting and reporting data to MIPS. In addition to traditional MIPS, two other MIPS reporting frameworks will be available to clinicians:

- **Alternative Payment Model Performance Pathway (APP):** a streamlined reporting framework beginning with the 2021 performance year for clinicians who participate in a MIPS APM. The APP is designed to reduce burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs):** a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving 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. **There are 7 MVPs that will be available for reporting in the 2023 performance year.**

What are the Measures and Activities I Must Submit to Successfully Participate in MIPS?

If you are participating in the Quality Payment Program through MIPS, your Medicare payment adjustment in 2024 will be based on submitting data and your performance for the following MIPS performance categories for the 2022 performance period:



What Measures and Activities Do I Submit for Each Category in 2022?

This resource provides a non-exhaustive sample of measures and activities that may apply to gastroenterologists. Make sure to consider your data submission type, practice size, patient demographic, and performance period to select the measures and activities that best suit you. See a full list of measures and activities by accessing the Quality Payment Program website at QPP.cms.gov. Please note that performance category weights differ for clinicians in MIPS APMs who participate via traditional MIPS or the APP. The full specifications can be downloaded from the Quality Payment Program Resource Library.

Performance Categories

Performance Categories

Quality Payment PROGRAM

Quality Performance Category

Assess the value of care to ensure patients get the right care at the right time

- Advance care plan for patients aged 65 years or older **(Identifier [ID]: 047)**
- Body mass index (BMI) screening/follow-up, tobacco screening/cessation, blood pressure screening/follow-up, help for adolescents quitting tobacco, alcohol use screening/counseling **(ID: 128, 226, 317, 402, 431)**
- Documentation of current medications **(ID: 130)**
- Age-appropriate screening colonoscopy **(ID: 439)**
- Colonoscopy interval for patients with a history of adenomatous polyps **(ID: 185)**
- Inflammatory Bowel Disease (IBD): Assessment of hepatitis B virus (HBV) status before initiating anti-TNF (Tumor Necrosis Factor) therapy **(ID: 275)**
- Hepatitis C screening patients with cirrhosis, photodocumentation of cecal intubation **(ID: 401, 425)**
- Appropriate follow-up interval for colonoscopy, receipt of specialist report **(ID: 320, 374)**

30% of final score
for most MIPS eligible clinicians, groups, and virtual groups

In addition, MIPS eligible clinicians, groups, and virtual groups may want to consider applicable gastroenterology-specific Qualified Clinical Data Registry (QCDR) measures that are available via the QCDR collection type only. The 2022 QCDR measure specifications are found on the Quality Payment Program Resource Library.

The Gastroenterology Specialty Set contains relevant quality measures to the gastroenterology specialty. CMS solicits stakeholder recommendations for potential consideration of new specialty measure sets and/or revisions to existing specialty measure sets on an annual basis. All stakeholder feedback and submissions received are considered for the next performance year's rulemaking and are made evident through publications of the Quality Payment Program proposed and final rules. CMS encourages stakeholders to work with your specialty society to provide applicable measure recommendations during the specialty measure set solicitation process. Stakeholder feedback/recommendations for a particular specialty set should be submitted during the Call for Specialty Sets at the beginning of the calendar year.

Performance Categories

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Quality Performance Category (Continued)

Getting Started with Quality

1. Understand Your Reporting Requirements
   - To meet the quality performance category requirements, you have to report:

6 quality measures (including at least 1 outcome measure or high-priority measure in absence of an applicable outcome measure)	OR	**A defined specialty measure set or sub-specialty measure set** (if the measure set has fewer than 6 measures, you need to submit all applicable measures within that set)	OR	**All quality measures included in the CMS Web Interface*** (an internet-based application available to groups and virtual groups with 25 or more eligible clinicians—advanced registration is required)

2. Choose Your Quality Measures
   - Use the 2022 Quality Measures List to identify:
     - The available collection type(s) for each measure
     - Measure type (outcome, patient experience, etc.)
     - Specialty sets associated with each measure

Did you know?
- **Collection Type** refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.
- **For example:** You are looking for a quality measure to report on the Use of High-Risk Medications in Older Adults (ID: 238). The measure is available as two distinct collections types with two distinct specifications: MIPS CQM (clinical quality measure) and eCQM (electronic clinical quality measure). You would use the measure specification that corresponds with how you choose to collect your data.
- You can report measures from multiple collection types to meet quality reporting requirements (Exceptions noted in the 2022 Quality Quick Start Guide).

*Beginning with the 2023 performance period, the CMS Web Interface collection type will no longer be an available collection type.

Quality Performance Category (Continued)

3. Collect Your Data
   - Up until December 31, 2022
   - You should **start data collection on January 1, 2022** to meet data completeness requirements. If you fail to meet data completeness requirements, you will receive 0 points for the measure unless you are small practice, who will still receive 3 points.
   - In 2020, the **data completeness requirement was increased to 70%**, which means that you need to report performance or exclusion/exception data for at least 70% of patients that are eligible for the measure's denominator.
   - If you are working with a vendor or third party intermediary to collect and submit data, make sure you work with them throughout the year on data collection.
4. Submit Your Data
   - The data submission period will begin on **January 3, 2023** and end no later than **March 31, 2023**. If reporting Medicare Part B claims measures, submission will be continuous throughout the performance period.
5. Review Performance Feedback
   - Preliminary scoring information will be available beginning **January 3, 2023**, once data has been submitted.
   - Your final performance feedback will be available in **July 2023**.
   - You can review your performance feedback by signing in to the Quality Payment Program website at QPP.cms.gov.

Did you know?

The level at which you participate in MIPS (individual, group, or virtual group) applies to all performance categories. We will not combine data submitted at the individual, group, and/or virtual group level into a single final score.

For example:

- If you submit any data as an individual, you will be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
- If a clinician has multiple final scores, CMS will use the following hierarchy to assign the final score and determine the payment adjustment:
  - Virtual group final score
  - Highest available final score from the group or individual participation

Performance Categories

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Promoting Interoperability Performance Category

Promote patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT)

In order to earn a score greater than zero for the Promoting Interoperability performance category, MIPS eligible clinicians, groups, and virtual groups must:

- ☑ Report measures from each of the 4 scored Promoting Interoperability performance category objectives, unless an exclusion is claimed, for a continuous 90-days or more; AND
- ☑ Did not take actions to limit or restrict the compatibility or interoperability of CEHRT; AND
- ☑ Submit a "yes" to the ONC Direct Review Attestation, if applicable; AND
- ☑ Submit a "yes" that they have completed the Security Risk Analysis measure during the calendar year in which the MIPS performance period occurs; AND
- ☑ Submit a "yes" or "no" to conducting annual assessment using the High Priority Practices Guide of the SAFER Guides.

25% of final score
for most MIPS eligible clinicians, groups, and virtual groups

Clinicians may use technology certified to the 2015 Edition certification criteria, technology certified to the 2015 Edition Cures Update certification criteria, or a combination of both to collect and report their Promoting Interoperability data. The 2022 Promoting Interoperability performance category scored objectives are:

- e-Prescribing*
- Health Information Exchange*
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange*

*Measure exclusions may be applicable. Please review the individual measure specifications to see if you meet the exclusion criteria. You must claim an exclusion to have the measure points redistributed to another measure. The measure specifications can be found on the QPP Resource Library.

Performance Categories

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Promoting Interoperability Performance Category (Continued)

Bonus points (10 points) are available under the e-Prescribing objective:

- Query of Prescription Drug Monitoring Program (PDMP) measure
  - This measure is optional for the 2022 performance period.

Bonus points (5 points) are available under the Public Health and Clinical Data Registry Reporting objective:

- Public Health Registry Reporting, Clinical Data Registry Reporting, OR Syndromic Surveillance Reporting measures
  - These measures are optional for the 2022 performance period.

Reweighting the Promoting Interoperability performance category:

- **Small practices that don't submit any data for the Promoting Interoperability performance category will have the weight of the performance category automatically redistributed.**
  - Certain MIPS eligible clinician types qualify for automatic reweighting of the Promoting Interoperability performance category for the 2022 performance period in the event that the clinician type submits no data for any of the measures in the Promoting Interoperability performance category. These clinician types include:

Promoting Interoperability Performance Category (Continued)

Qualifying hospital-based, ASC-based, or non-patient facing MIPS eligible clinicians, groups, and virtual groups will automatically have their Promoting Interoperability performance category score reweighted to 0% of the final score.

- A **hospital-based** MIPS eligible clinician is defined as furnishing 75% or more of their covered professional services in either the off-campus outpatient hospital (Place of Service 19), inpatient hospital (Place of Service 21), on-campus outpatient hospital (Place of Service 22), or emergency department (Place of Service 23) setting.
  - A group or virtual group is considered hospital-based when more than 75% of the clinicians in the group or virtual group are hospital-based MIPS eligible clinicians.

- A **non-patient facing** MIPS eligible clinician is defined as an individual MIPS eligible clinician who bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act), during the MIPS determination period.
  - To qualify as a non-patient facing group or virtual group, more than 75% of the clinicians in the group or virtual group must meet the definition of a non-patient facing individual MIPS eligible clinician.

- In the case of reweighting to 0%, CMS will assign the 25% from the Promoting Interoperability performance category to another performance category.
- Eligible clinicians, groups, and virtual groups that qualify for reweighting of the Promoting Interoperability performance category can still choose to report if they would like, and if data is submitted, CMS will score their performance and weight their Promoting Interoperability performance accordingly.

See the 2022 Promoting Interoperability Quick Start Guide for more information on Promoting Interoperability performance category objectives and measures, reporting requirements, scoring, and reweighting. The 2022 Promoting Interoperability Performance Category User Guide is available on the QPP Resource Library. Comprehensive information about hardship exceptions for the 2022 Promoting Interoperability performance category will be available on the QPP Resource Library later in the year.

Performance Categories

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Improvement Activities Performance Category

15% of final score
for most MIPS eligible clinicians, groups, and virtual groups

Encourage your participation in activities that improve clinical practice, such as:

- Ongoing care coordination
- Clinician and patient shared decision making
- Using quality improvement best practices and validated tools
- Regularly using patient safety best practices
- Making progress in achieving health equity

During the 2022 performance year, MIPS eligible clinicians, groups, and virtual groups will be able to choose from 100+ activities.

Some examples of the types of activities you may select to show your performance in 2022 are listed below. The full inventory from which MIPS eligible clinicians, groups, and virtual groups select their improvement activities in 2022 is available here. The MIPS data validation criteria document, which provides guidance on documentation requirements for improvement activities, is available here. Additionally, the 2022 Improvement Activities Quick Start Guide is available here.

Clinicians choose activities in which they may participate from the posted inventory. Currently available activities:

- IA_AHE_6 – Provide education opportunities for new clinicians
- IA_BE_6 – Regularly assess patient experience of care and follow up on findings
- IA_BE_15 – Engage patients, family, and caregivers in developing a plan of care
- IA_BE_25 – Provide financial counseling to patients or their caregiver about costs of care and an exploration of different payment options
- IA_BMH_12 – Promote clinician well-being
- IA_CC_13 – Practice improvements for bilateral exchange of patient information
- IA_CC_18 – Participate in a training on relationship-centered care
- IA_PM_15 – Provide episodic care management, including management across transitions and referrals
- IA_PSPA_17 – Implementation of analytic capabilities to manage total cost of care for practice population
- IA_PSPA_19 – Implement formal quality improvement methods, practice changes, or other practice improvement processes

Please note: The activities listed above are suggestions, not requirements or preferences on the part of CMS. MIPS eligible clinicians, groups, and virtual groups can choose activities that are most appropriate for their practice/patient population.

Performance Categories

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Cost Performance Category

30% of final score
for most MIPS eligible clinicians, groups, and virtual groups

Helps create efficiencies in Medicare spending

- The 2022 performance period includes two population-based cost measures:
  - Medicare Spending Per Beneficiary Clinician measure, which assesses costs surrounding a hospital stay.
  - Revised Total Per Capita Cost measure, which assesses overall cost of care.
- It also includes 23 episode-based cost measures across a range of procedures, acute inpatient medical conditions, and chronic conditions.
  - A full list of the episode-based cost measures is available on the Quality Payment Program Resource Library.
- Data for cost measurement are collected from Medicare Parts A and B claims submitted by MIPS eligible clinicians, groups, and virtual groups. Certain measures also incorporate Part D costs. Clinicians, groups, and virtual groups do not have to submit any additional data.
- For a cost measure to be scored, a MIPS eligible clinician, group, or virtual group must have enough attributed cases to meet or exceed the case minimum for that measure.
- For MIPS eligible clinicians, groups, and virtual groups who do not have a cost performance category score assigned, the majority of the cost weight goes to the quality performance category. This is true if only the cost performance category is reweighted.
  - Beginning with the 2022 performance period, small practices are automatically reweighted in Promoting Interoperability performance category; therefore, if the cost performance category is reweighted as well, the quality and improvement activities performance categories are equally reweighted at 50%.
- Benchmarks based on data from the performance period will be established for each cost measure. Since the benchmark is not based on a historical baseline period, CMS can't publish the actual numerical benchmarks for the cost measures before the start of each performance period.
  - A MIPS eligible clinician, group, or virtual group can compare their costs for each measure with the benchmark information provided in their performance feedback to better understand their performance relative to their peers.

Cost Performance Category (Continued)

- CMS will automatically reweight the cost performance category for MIPS eligible clinicians, groups, and virtual groups who are located in a CMS-designated region or locale that has been affected by extreme and uncontrollable circumstances.
    - For MIPS eligible clinicians, groups, and virtual groups that are designated in the extreme and uncontrollable circumstances auto policy, they will not receive a score for the cost performance category, regardless of whether they have applicable cost measures.

Additional information for the Cost performance category can be found in the 2022 Cost Performance Category Quick Start Guide in the Quality Payment Program Resource Library.

Did you know?

If only 1 cost measure can be scored, that cost measure's score will serve as the performance category score. If 3 out of 25 cost measures are scored, the **cost performance category score is the equally-weighted average of the 3 scored measures**. If none of the 25 measures can be scored, the MIPS eligible clinician, group, or virtual group will not be scored on cost, and the weight of the cost performance category would generally be reweighted to the quality performance category.

Help, Resources, and Version History

Help, Resources, and Version History

Quality Payment PROGRAM

Where Can I Get Help?

Contact the Quality Payment Program Service Center at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m.- 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Help, Resources, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Description
03/30/2022	Original Posting.