Quality Payment Program – Year 6
2022 Final Rule Overview

On November 2, 2021, CMS released the 2022 Medicare Physician Fee Schedule (MPFS) final rule, which includes the Quality Payment Program (QPP) Year 6, beginning January 1, 2022, and impacting 2024 payments. The QPP includes both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

This guide summarizes the Quality Payment Program Year 6. Full details on the QPP are available on the ASCRS ASOA MACRA Center website at ascrs.org/macracenter.

Key Changes to the QPP

The 2022 MPFS final rule maintains the following:

- **Continuing to provide certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians.**
- In consideration of the COVID-19 public health emergency (PHE), CMS will continue to offer the application- based **Extreme and Uncontrollable Circumstances (EUC) Policy.**

The 2022 MPFS final rule includes the following modifications to the QPP:

- Beginning in 2022, the performance threshold must be the "mean or median of the composite performance scores for all MIPS eligible professionals" from a prior period. CMS is establishing the performance threshold for the 2022 performance year/2024 payment year using the mean final score from the 2017 performance year/2019 MIPS payment year. Therefore, the **2022 MIPS performance threshold will increase from 60 points in 2021 to 75 points in 2022.** Physicians and practices must score at least 75 total points to avoid a maximum 9% penalty in 2024
- **The additional performance threshold is set at 89 points.** The additional MIPS adjustment factors for exceptional performance are available through the 2022 performance year/2024 MIPS payment year, **making this the last year of the additional performance threshold and the associated additional MIPS adjustment factors for exceptional performance.**
- CMS is statutorily required to weigh the cost and quality performance categories equally beginning with Performance Year 2022:
    - Traditional MIPS: Individuals, Groups, Virtual Groups
        - Quality: 30%
        - Cost: 30%
        - Promoting Interoperability: 25% (no change)
        - Improvement Activities: 15% (no change)

- Revised Quality scoring policies, including the introduction of a floor for new measures and removal of outcome/high priority measure bonus points and end-to-end electronic reporting bonus points

2022 Performance Period for 2024 Payment

For full participation in the MIPS program in 2022, for 2024 payment, the performance period for the Quality and Cost categories is a full year, and any period of at least 90 days for the Promoting Interoperability and Improvement Activities categories.

MIPS Participation and Reporting

All MIPS eligible clinicians, including those in a MIPS APM, may choose to participate in MIPS as:

- An individual
- A group
- A virtual group
- An APM Entity

Beginning in 2022, CMS has revised the definition of a MIPS eligible clinician to also include:

- Clinical social workers.
- Certified nurse mid-wives.

Final Score and 2021 Performance Threshold

Beginning in 2022, the performance threshold must be the "mean or median of the composite performance scores for all MIPS eligible professionals" from a prior period. CMS is establishing the performance threshold for the 2022 performance year/2024 payment year using the mean final score from the 2017 performance year/2019 MIPS payment year.
Therefore, the 2022 MIPS performance threshold will increase from 60 points in 2021 to 75 points in 2022. Physicians and practices must score at least 75 total points to avoid a maximum 9% penalty in 2024.

The additional performance threshold is set at 89 points. The additional MIPS adjustment factors for exceptional performance are available through the 2022 performance year/2024 MIPS payment year, **making this the last year of the additional performance threshold and the associated additional MIPS adjustment factors for exceptional performance.**

Scoring Updates finalized for the Quality performance category

- Removed end-to-end electronic and high-priority/outcome measure bonus points.
- New quality measures will have a 7-point floor for their first year in the program, and a 5-point floor for their second year in the program. In their first year, new measures will earn 7 points if no benchmark can be created, provided the case minimum and data completeness are met. In their second year, these measures will earn 5 points if no benchmark can be created, provided the case minimum and data completeness are met.
    - New measures that can be scored against a benchmark will earn 5 – 10 points.
- Beginning in performance year 2023, quality measures that don't have a benchmark or meet the case minimum will earn 0 points (small practices will continue to earn 3 points).
- Beginning in performance year 2023, quality measures that can be scored against a benchmark will be eligible for 1 – 10 points.

Scoring Updates Finalized for the Promoting Interoperability performance category

- Small practices and clinical social workers will now receive automatic reweighting in this performance category.
- Revised the Public Health and Clinical Data Exchange objective to require that MIPS eligible clinicians report the Immunization Registry Reporting and Electronic Case Reporting measures.
    - The remaining measures are now optional; MIPS eligible clinicians who report any of these optional measures will earn 5 bonus points.

CMS will continue providing certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians. Beginning with the 2022 performance year, these include:

- Automatically reweighting the Promoting Interoperability performance category to 0% for small practices, regardless of whether they choose to participate as individuals or as a group.
- Small practices will no longer need to submit a Promoting Interoperability Hardship Exception Application to request reweighting in this performance category.
    - Small practices can still choose to submit Promoting Interoperability data, which would void reweighting of that performance category. CMS will score any data that is submitted.
- CMS will no longer automatically score Part B claims measures, reported by small practices, at the individual and group level.
    - CMS will only calculate a group-level quality score from Part B claims measures as a group if the practice submits group-level data in another performance category.
- Finalized performance category reweighting and redistribution policies, specifically for small practices. Under the revised methodology, CMS will increase the weight of the Improvement Activities performance category when other performance categories are reweighted to 0%. Specifically:
    - When the Promoting Interoperability performance category is reweighted:
        - Quality will be weighted at 40%.
        - Cost will be weighted at 30%.
        - Improvement Activities will be weighted at 30%.
    - When both the Cost and the Promoting Interoperability performance categories are reweighted:
        - Quality and Improvement Activities will be equally weighted at 50%.
    - When both the Quality and the Promoting Interoperability performance categories are reweighted:
        - Cost and Improvement Activities will be equally weighted at 50%.
        - Note: **This applies to all MIPS participants, regardless of small practice status.**

Low-Volume Threshold and MIPS Opt-In

CMS maintained the low-volume threshold of $90,000 in allowed Part B charges or 200 patients, or 200 or fewer covered professional services. If a physician falls below at least one of these criteria, he or she is considered low volume. Physicians falling below the low-volume threshold are exempt from MIPS and would not receive a 2024 payment adjustment. **APM Entities are no longer evaluated for the low-volume threshold.**

CMS will continue to allow physicians who exceed at least one of the criteria of the low-volume threshold to opt into MIPS and be eligible for payment adjustments.

Complex Patient Bonus Points

CMS revised the complex patient bonus beginning with the 2022 MIPS performance year/2024 MIPS payment year by:

- **Limiting the bonus** to clinicians who have a median or higher value for at least 1 of the 2 risk indicators (Hierarchical Condition Category score and proportion of patients dually eligible for Medicare and Medicaid benefits).
- **Updating the formula** to standardize the distribution of 2 two risk indicators so that the policy can target clinicians who have a higher share of socially and/or medically complex patients.
- **Increasing the bonus** to a maximum of 10 points.
- This bonus will be available to clinicians, groups, subgroups (beginning with the 2021MIPS performance year/2023 payment year), virtual groups or APM Entities that meet the criteria above **and** submit data for at least one performance category.

MIPS Performance Categories

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Promoting Interoperability (EHR), and Improvement Activities. Performance category weights for individuals, groups, and virtual groups reporting traditional MIPS for the 2022 performance period are:

- Quality: 30% **(down from 40% for CY 2021)**
- Cost: 30% **(up from 20% for CY 2021)**
- Promoting Interoperability: 25% (no change)
- Improvement Activities: 15% (no change)

Quality: 30% of Total Score in Year 6 (2022)

CMS finalized the following:

- A new policy to establish:
    - A 7-point floor for new measures in their first year in MIPS
    - A 5-point floor for new measures in their second year in MIPS
- Inclusion of 200 quality measures including:
    - Substantive changes to 87 existing MIPS quality measures
    - Changes to specialty sets
    - Removal of measures from specific specialty sets
    - Removal of 13 quality measures
    - Addition of 4 quality measures, including 1 new administrative claims measure:
        - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
- Established historical benchmarks for the 2022 performance period, using data submitted in the baseline period (2020 performance period.)
- Maintaining the current data completeness threshold at 70% for the 2022 and 2023 performance periods.
- Beginning with PY 2022, CMS will remove bonus points for reporting additional outcome and high-priority measures, beyond the 1 required.
- Beginning with PY 2022, CMS will remove bonus points for measures that meet end-to-end electronic reporting criteria.

MIPS Performance Categories

Cost: 30% of Total Score in Year 6 (2022)

CMS finalized the following:

- The Cost performance category will be weighted at 30% (10% increase from PY 2021)
- Added 5 newly developed episode- based cost measures into the MIPS cost performance category beginning with the 2022 performance period.
    - 2 procedural measures:
        - Melanoma Resection
        - Colon and Rectal Resection
    - 1 acute inpatient measure:
        - Sepsis
    - 2 chronic condition measures:
        - Diabetes
        - Asthma/Chronic Obstructive Pulmonary Disease [COPD]

CMS is also adding a process of cost measure development by stakeholders, including a call for cost measures, beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period.

Promoting Interoperability (PI): 25% of Total Score in Year 6 (2022)

CMS finalized the following:

- Reweighting
    - In addition to the existing special statuses/clinician types, CMS will **apply automatic reweighting** to the following, beginning with the 2022 performance period:
        - Clinical social workers
        - Small practices

No automatic reweighting for certified nurse-midwives.

- **Public Health and Clinical Data Exchange Objective**
    - Modifying the reporting requirements for this objective and **requiring MIPS eligible clinicians to report the following 2 measures** (unless an exclusion can be claimed):
        - Immunization Registry Reporting
        - Electronic Case Reporting

- Beginning with the 2022 performance period, the following measures are optional; clinicians, groups and virtual groups that report a "yes" response for any of these measures will earn 5 bonus points:
    - Public Health Registry Reporting measure
    - Clinical Data Registry Reporting measure
    - Syndromic Surveillance Reporting measure

Note: Reporting more than one of these optional measures **won't** result in more than 5 bonus points.

- **New required measure: Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)**
    - MIPS eligible clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides).

- Electronic Case Reporting
    - **Added a 4th exclusion (in addition to the existing exclusion criteria) for PY 2022 only:**
        - Uses certified electronic health record technology (CEHRT) that isn't certified to the electronic case reporting certification criterion at 45 CFR 170.315(f)(5) prior to the start of the performance period they select in CY 2022.

- **Attestations**
    - Modified the required **Prevention of Information Blocking** attestation statements.

Improvement Activities: 15% of Total Score in Year 6 (2022)

CMS finalized the following:

- **Removal of 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, CMS will **suspend the improvement activity** and immediately notify clinicians and the public through the usual communication channels, such as listservs and Web postings. The activity would then be proposed for removal or modification as appropriate in the next rulemaking cycle.
- **Criteria for Nominating a New Improvement Activity**
    - New improvement activities must at minimum meet all of the following 8 criteria, consisting of:
        - Improvement activities shouldn't duplicate other improvement activities in the Inventory. **(NEW)**
        - Improvement activities should drive improvements that go beyond standard clinical practices. **(NEW)**
        - Relevance to an existing improvement activities subcategory (or a proposed new subcategory).

- Importance of an activity toward achieving improved beneficiary health outcomes.
- 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.
- Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.
- Can be linked to existing and related MIPS quality, Promoting Interoperability, and cost measures, as applicable and feasible.
- CMS is able to validate the activity.

- **Activity Inventory**
  - Adding 7 new improvement activities, 3 of which are related to promoting health equity.
  - Modifying 15 current improvement activities, 11 of which address health equity.
  - Removing 6 previously adopted improvement activities.

Changes to Ophthalmology Measures

CMS also finalized changes to several individual measures, which are outlined below:

- **#14 Age-Related Macular Degeneration (AMD): Dilated Macular Examination**: Removed from Claims because it is at the end of topped-out lifecycle. Maintained in MIPS CQM collection type.
- **#19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.** Maintained for all collection types (removal not finalized). CMS alluded to possible future measure modification or removal.
- **#117 Diabetes Eye Exam: Added coding to identify patients with advanced illness and frailty:** Added guidance to allow interpretation using AI. Added denominator exclusion for patients receiving palliative care.
- **#191 Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**: Denominator exclusion removed: episcleritis. Denominator exclusion added: homonymous bilateral field defects and generalized contraction of visual field. eCQM denominator exclusion: visual cortex disorders in inflammatory disorders. MIPS CQM denominator exclusion: Sector or arcuate defects, other localized visual field defects, heteronymous bilateral field defects.

MIPS Value Pathways (MVPs)

CMS will begin transitioning to MVPs in the 2023 MIPS performance year. For the 2023, 2024, and 2025 performance years, MVP Participants are identified as individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM entities that are assessed on an MVP for all MIPS performance categories. Beginning in the 2026 performance year, multispecialty groups will be required to form subgroups in order to report MVPs.

CMS finalized 7 MVPs that will be available, **beginning with the 2023 performance year**. Each MVP includes complementary measures and activities and supports patient-centered care and a continued emphasis on the importance of patient outcomes, population health, health equity (including measures and activities that assess health disparities and socioeconomic factors), interoperability, and reduced reporting burden for clinicians.

The 7 MVPs for the 2023 performance year are the following:

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine (finalized with modification)
- Improving Care for Lower Extremity Joint Repair (finalized with modification)
- Support of Positive Experiences with Anesthesia (finalized with modification)

Through the MVP development work, CMS will gradually implement MVPs for more specialties and subspecialties that participate in the program.

For the 2023, 2024, and 2025 performance years, MVP participants will be defined as:

- Individual clinicians
- Single specialty groups
- Multispecialty groups
- Subgroups
- APM Entities

Incentives and Penalties

Based on the MACRA statute, MIPS participants will receive a positive, negative, or neutral payment adjustment based on their final score. The negative adjustment will be capped at 9% in 2024.

CMS estimates approximately 773,911 clinicians will be **MIPS eligible in 2022.** The maximum MIPS penalties and incentive payments is 9 percent in 2024, which is tied to the 2022 performance year. CMS estimates 91.7 percent of eligible clinicians who submit data will be eligible for a neutral payment adjustment or incentive payment, and 42.4 percent will be eligible for an additional bonus for exceptional performance. CMS notes these estimates are based on 2019 data and do not account for disruptions due to the COVID-19 PHE.

Advanced Alternative Payment Models (APMs)

Qualifying APM Participant (QP) Incentive Payment

In the 2021 Final Rule, CMS finalized a hierarchy used to identify potential payee Taxpayer Identification Numbers (TINs) using base year claims, in the event that the Qualifying APM Participant's (QP) original TIN is no longer active and associated with the QP**. In 2022, CMS will extend the hierarchy to include billing TINs that are active only during the payment year. This step will be added to the current regulatory hierarchy for processing the QP Incentive Payment.**

There continues to be no ophthalmology specific Advanced APMs.

APM Performance Pathway (APP)

CMS finalized a new reporting framework, the APM Performance Pathway (APP), which began in 2021. This Pathway is complementary to MVPs. The APP is available only to participants in MIPS APMs and can reported by the individual eligible clinician, group, or APM Entity. Quality scores for ACOs that have been reported through the APP will also be used for purposes of the Shared Savings Program, thus satisfying reporting requirements for both programs.

MIPS eligible clinicians will be allowed to report the APP as a subgroup, **beginning with the 2023 performance year.** The definition of a subgroup and eligibility to participate as a subgroup are the same for MVP and APP reporting.

- Subgroups will consist of "a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician's NPI."
- Subgroups will inherit the eligibility and special status determinations of the affiliated group (identified by TIN). To participate as a subgroup, the TIN will have to exceed the low-volume threshold at the group level, and the subgroup will inherit any special statuses held by the group, even if the subgroup composition won't meet the criteria.
- Subgroups won't be required to register for reporting the APP.

MIPS APMs

CMS finalized a longer transition for Shared Savings Program ACOs by extending the CMS Web Interface as a reporting option for 3 years through performance year 2024. ACOs will be able to continue to use the CMS Web Interface to report 10 quality measures for the 2022, 2023 and 2024 performance years under the APP. The CMS Web Interface will sunset after the 2024 performance year and all ACOs will be required to report the 3 eCQMs/MIPS CQMs beginning with the 2025 performance year.

For the 2022 and 2023 performance years:

- An ACO will meet the quality performance standard used to determine shared savings and losses if the ACO:
    - Achieves a quality performance score equivalent to or higher than the 30th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; or
    - Reports the 3 eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements) and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4outcome measures in the APP measure set and achieves a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least 1 of the remaining 5 measures in the APP measure set. Consequently, the ACO would be required to meet the performance benchmark on either 2 outcome measures (one measure at the 10th percentile and the other at the 30th percentile) or 1 outcome measure at the 10th percentile and any other measure in the APP measure set at the 30th percentile.

For the performance years 2022, 2023, and 2024, if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey, the ACO would not meet the quality performance standards.

Additional Resources

For additional information, ASCRS ASOA members may contact Jennifer Gallihugh, ASOA Sr. Manager of Strategic Initiatives, at jgallihugh@asoa.org or 703-788-5741.