Quality Payment Program—Year 6
2022 Proposed Rule Overview

On July 13, 2021, CMS released the 2022 Medicare Physician Fee Schedule (MPFS) proposed 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 provides an overview of the proposed changes to the Quality Payment Program Year 6. In-depth guides on each of the categories of MIPS and other elements of the program will be available once the final rule is issued.

Additional details on the QPP are available on the ASCRS ASOA MACRA Center website at ascrs.org/macracenter.

Key Proposed Changes to the QPP

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

- CMS has proposed to lower the weight of the Quality category to 30% in 2022 and beyond. Cost will increase to 30% for the 2022 performance year. **CMS is statutorily required to weight the cost and quality performance categories equally beginning with Performance Year 2022.**
- The implementation of MIPS Value Pathways (MVPs) remains part of a greater effort to sunset traditional MIPS after the end of the 2027 performance period/2029 payment year. CMS did not propose the timeframe in which MVP reporting would no longer be voluntary and indicated any proposal to sunset traditional MIPS will be made in final rulemaking.
- CMS proposes to begin transitioning to MVPs in the 2023 MIPS performance year. No ophthalmology MVP is proposed to be introduced in the 2023 performance year.

As required by statute, beginning with the 2022 performance year/2024 payment year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. Therefore, CMS is proposing to use the mean final score from the 2017 performance year/2019 MIPS payment year.

- **The 2022 MIPS performance threshold is proposed to 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 (exceptional) performance threshold would be established at 89 points.

2022 Performance Period for 2024 Payment (Proposed)

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 (Proposed)

As a reminder, as of 2021, MPS finalized that 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

For 2022, CMS is proposing to revise the definition of a MIPS eligible clinician to include:

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

Final Score and 2022 Performance Threshold (Proposed)

As required by statute, beginning with the 2022 performance year/2024 payment year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. Therefore, CMS is proposing to use the mean final score from the 2017 performance year/2019 MIPS payment year.

The 2022 MIPS performance threshold is proposed to 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 (exceptional) performance threshold would be established at 89 points.

CMS notes that 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 bonus for exceptional performance.

CMS will continue providing certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians. Updates include:

CMS is proposing to update the redistribution policies for small practices:

- When the Promoting Interoperability performance category is reweighted:
  - The Quality performance category would be weighted at 40%.
  - The Cost performance category would be weighted at 30%.
  - The Improvement activities performance category would be weighted at 30%.
- When both the Cost and the Promoting Interoperability performance categories are reweighted:
  - The Quality performance category would be weighted at 50%.
  - The Improvement activities performance category would be weighted at 50%.

- CMS is proposing to maintain the small practice bonus of 6 points that is included in the Quality performance category score. CMS also continues to award small practices 3 points for submitted quality measures that do not meet case minimum requirements or do not have a benchmark.

- In previous MIPS performance years, small practices had been allowed to submit Quality measure data via claims reporting rather than registry-based reporting. The 2022 Proposed Rule continues to allow claims submission for small practices, but CMS proposes to require that claims-reporting small practices who wish to submit MIPS data as a group must signal their intention to participate as a group by submitting either Improvement Activities, Promoting Interoperability measures, or MIPS Clinical Quality Measures (CQMs) as a group. If they do not report another performance category as a group, they would be considered individual submitters.

Low-Volume Threshold and MIPS Opt-In

CMS has not proposed any changes to the low-volume threshold criteria as previously established. To be excluded from MIPS in 2022, clinicians or groups would need to meet one of the following three criteria: have ≤ $90K in allowed charges for covered professional services, provide covered care to ≤ 200 beneficiaries, or provide ≤ 200 covered professional services under the Medicare Physician Fee Schedule. CMS proposes no changes to the opt-in policy established, which allows physicians who meet some, but not all, of the low-volume threshold criteria to opt in to participate in MIPS.

Complex Patient Bonus Points (Proposed)

Because of the concerns of the direct and indirect effects of the COVID-19 public health emergency, CMS proposes to continue doubling the complex patient bonus for the 2021 MIPS performance year/2023 MIPS payment year. These bonus points (capped at 10-points) would be added to the final score.

Additionally, CMS is proposing to revise 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 one of the two risk indicators (HCC and dual proportion).
- 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.

MIPS Performance Categories (Proposed)

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Promoting Interoperability (EHR), and Improvement Activities.

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

In previous years, non-benchmarked measures which met data completeness were eligible to receive 3 points, with the possibility of a higher score if enough data was received to establish a same-year benchmark. Benchmarked measures were scored between 3 and 10 points if they met data completeness.

Beginning with performance year 2022, CMS proposes the following changes:

- Change the scoring range for benchmarked measures to 1 to 10 points, doing away with the 3-point floor.
- Score non-benchmarked measures at 0 points, even if data completeness is met. Small practices would continue to earn 3 points.
- For new measures which do not yet have a benchmark, the scoring floor will be raised to 5 points for their first two years in the MIPS program. These new measures will still be able to achieve higher points if a same-year benchmark is established, but if a benchmark isn't established after 2 years in the program, that measure will not achieve any points. A new measure available beginning with the 2022 performance period could earn 5 – 10 points in the 2022 and 2023 performance periods if a performance period benchmark could be created.
    - The exception to this rule is small and rural practices, who will be awarded 3 points for measures which either do not have a benchmark or do not meet case minimum.
- CMS has also proposed to end the practice of awarding bonus points for additional high priority measures submitted beyond the required 1.

CMS also proposes to:

- Use performance period benchmarks, or a different baseline period, such as calendar year 2019, for scoring quality measures in the 2022 performance period.
- Extend the CMS Web Interface as a quality reporting option for registered groups, virtual groups, or other APM Entities for the 2022 performance period.
- Update the quality measure inventory (a total of 195 proposed for the 2022 performance period)
  - Substantive changes to 84 existing MIPS quality measures
  - Changes to specialty sets
  - Removal of measures from specific specialty sets
  - Removal of 19 quality measures
  - Addition of 5 quality measures, including 2 administrative claims measures:
    - Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System
    - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
- Maintain the current data completeness threshold at 70% for the 2022 performance period.
  - Increase the data completeness requirement to 80% **beginning with the 2023 performance period**.

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

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

- CMS also proposes to:
  - Add 5 new episode-based cost measures:
    - 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])
  - The 5 new episode-based cost measures have the following case minimums calculated with administrative claims data:
    - Asthma/COPD: 20 episodes
    - Colon and Rectal Resection: 20 episodes
    - Diabetes: 20 episodes
    - Melanoma Resection: 10 episodes
    - Sepsis: 20 episodes

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

CMS proposes to:

- Apply automatic reweighting to clinical social workers and small practices.
- Revise reporting requirements in the following ways:
  - Revise reporting requirements for the Public Health and Clinical Data Exchange objective to support public health agencies (PHAs) in future health threats and a long-term COVID-19 recovery.
  - Add a requirement in the Provide Patients Electronic Access to Their Health Information measure that patients have access to their health information indefinitely, for encounters on or after January 1, 2016.
  - Require MIPS eligible clinicians to attest to conducting an annual assessment of the High-Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides) beginning with the

CY 2022 performance period.
- Modify the Prevention of Information Blocking attestation statements to distinguish this from separate information blocking policies under the Office of the National Coordinator for Health Information Technology (ONC) requirements established in the 21st Century Cures Care Act final rule.

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

CMS proposes to:

- Update the improvement activities inventory for the 2022 performance year, including adding new improvement activities about health equity and standardizing language related to equity across the improvement activities inventory:
- Add 7 new improvement activities, 3 of which are related to promoting health equity.
- Modify 15 current improvement activities, 11 of which address health equity. Modifying these activities will more explicitly focus them on addressing health equity and, in some cases, specifically add requirements to address racial equity.
- Remove 6 previously adopted improvement activities

Proposed Changes to Ophthalmology Measures

CMS proposes to:

Remove two measures from the Ophthalmology set:

- **#14** Age-Related Macular Degeneration (AMD): Dilated Macular Examination: CMS proposes the removal of this measure as a quality measure from the MIPS program because this measure has reached the end of the topped-out lifecycle.
- **#19** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care: CMS proposes the removal of this measure as a quality measure from the MIPS program because this measure does not align with the Meaningful Measures Initiative. Additionally, the MIPS CQMs Specifications collection type is in the third year of the topped-out lifecycle.

CMS is also proposing changes to the following measure:

- **#191** Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery. CMS proposes to update the eCQM Specification's collection type denominator exclusion coding to add appropriate coding for other relevant "disorders of visual field defects" and "disorders of visual cortex" diagnosis codes. The denominator exclusion coding was updated for all collection types removing diagnosis of episcleritis as a denominator exclusion. CMS also proposed to update the denominator exclusion for the MIPS CQMs Specifications collection type to include appropriate coding for conditions to ensure the appropriate patient population is being included in the eligible denominator patient population for assessment of the clinical quality action.

MIPS Value Pathways (MVPs) (Proposed)

CMS has developed 7 new MVPs and proposes they be available beginning with the 2023 performance year, which does not include Ophthalmology. The addition of MVPs is part of a greater effort to sunset traditional MIPS after the end of the 2027 performance period/2029 payment year. CMS did not propose the timeframe in which MVP reporting would no longer be voluntary and indicated any proposal to sunset traditional MIPS will be made in final rulemaking.

CMS proposes the following additions to the MVP development criteria beginning with the 2022 performance year/2024 payment year:

- MVPs must include at least one outcome measure that is relevant to the MVP topic, so MVP Participants are measured on outcomes that are meaningful to the care they provide.
- Each MVP that is applicable to more than one clinician specialty should include at least one outcome measure that is relevant to each clinician specialty included.
- In instances when outcome measures are not available, each MVP must include at least one high priority measure that is relevant to the MVP topic, so MVP Participants are measured on high-priority measures that are meaningful to the care they provide.
- Allow the inclusion of outcomes-based administrative claims measures within the quality component of an MVP.
- Each MVP must include at least one high priority measure that is relevant to each clinician specialty included.
- To be included in an MVP, a qualified clinical data registry (QCDR) measure must be fully tested.

For the 2023 and 2024 performance years, CMS proposes MVP Participants to mean 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 2025 performance year, CMS proposes that multispecialty groups would be required to form subgroups in order to report MVPs.

Incentives and Penalties (Proposed)

CMS estimates approximately 782,517 clinicians will be **MIPS eligible in 2022**: approximately 67.5 percent of eligible clinicians who submit data will receive a positive or neutral payment adjustment, the mean final score would be 75.86, the median would be 80.30, **the maximum positive payment adjustment would be 6.6 percent, and the maximum penalty would be 9 percent (subject to variations from final calculations and COVID-19 impacts).**

Advanced Alternative Payment Models (APMs) (Proposed)

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

For payment years 2019 through 2024, Qualifying APM Participants (QPs) receive a 5 percent APM Incentive Payment. Starting in payment year 2026, the update to the Medicare Physician Fee Schedule Conversion Factor (PFS CF) for QPs will be 0.75%. The Consolidated Appropriations Act, 2021, froze the APM payment incentive thresholds for performance years 2021 and 2022 (payment years 2023 and 2024). Therefore, in CY 2022, the QP payment amount threshold will remain at 50 percent of Medicare payments and the QP patient count threshold will remain at 35 percent of Medicare patients.

APM Incentive Payment Recipient

- CMS proposes to revise their decision hierarchy for making APM payments so that the Agency would first seek to identify a TIN associated with the QP during the base year, and if no such TIN is identified in the base year, CMS would then seek to identify a TIN associated with the QP during the payment year.

APM Performance Pathway (APP) (Proposed)

As a reminder CMS finalized a new APM Performance Pathway (APP) in 2021. This new Pathway is complementary to MVPs. The APP is available only to participants in MIPS APMs and may be reported by the individual eligible clinician, group (TIN), or APM Entity.

CMS is proposing to allow MIPS eligible clinicians 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 would 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 would inherit the eligibility and special status determinations of the affiliated group (identified by TIN).

To participate as a subgroup, the TIN would have to exceed the low-volume threshold at the group level, and the subgroup would inherit any special statuses held by the group, even if the subgroup composition would not meet the criteria.

- CMS notes that, as proposed, subgroups would not be required to register for reporting the APP.

CMS is also proposing to extend the CMS Web Interface as a collection type for the Quality Payment program for Shared Savings Program ACOs reporting under the APP.

They are proposing to make the CMS Web Interface available for performance years 2022 and 2023.

CMS proposes no change to the performance weight categories for the APP: Individuals, Groups, APM Entities:

- Quality: 50%
- Cost: 0%
- Promoting Interoperability: 30%
- Improvement Activities: 20%

MIPS APMs (Proposed)

Beginning in performance year 2021, CMS finalized that Accountable Care Organizations (ACOs) participating in the **Medicare Shared Savings Program** would be required to report quality measure data for purposes of the Shared Savings Program via the new APP, instead of the CMS Web Interface.

CMS is proposing to extend the CMS Web Interface as a collection type for the Quality Payment program for Shared Savings Program ACOs reporting under the APP. They are also proposing to make the CMS Web Interface available for performance years 2022 and 2023.

CMS is also proposing a longer transition to ACO eCQM/MIPS CQM quality measure reporting, which require all-payer data, by extending the CMS Web Interface as an option for two years for ACOs. Additionally, they are proposing an additional one-year freeze before the phase-in of the increase in the quality performance standard ACOs must meet to share in savings and an additional revision in the quality performance standard to encourage ACOs to report all-payer measures.

Additional Resources

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