Changes to QPP Policies Proposed in the CY 2022 Physician Fee Schedule (PFS) Notice of Proposed Rule Making (NPRM)

Merit-based Incentive Payment System (MIPS)

Policy Area	Existing Policy	CY 2022 NPRM Proposals
Participation Pathways		
MIPS Value Pathways (MVPs)	N/A	We refer you to the **MVP Proposals Table** in the CY 2022 PFS Proposed Rule QPP Resources (ZIP) for information about the proposals related to MVPs.
APM Performance Pathway (APP)	MIPS APM participants can report the APP as an individual, a group, or APM Entity.	We are proposing to add subgroups as a participation option for reporting the APP beginning with the 2023 performance year.
	Shared Savings Program ACOs can report the CMS Web Interface measures for performance year 2021 only. Beginning in performance year 2022, the CMS Web Interface would be removed as a collection type moving ACOs to report quality data via the new Clinical Quality Measures collection type.	We are 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. We are proposing to make the CMS Web Interface available for performance years 2022 and 2023.
MIPS Eligibility		
MIPS Eligible Clinician Types	**The following clinician types are eligible for MIPS:** • Physicians	We are proposing to **add** the following MIPS eligible clinician types beginning with the 2022 performance year:

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	○ 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
MIPS Performance Categories		
Performance Category Weights	**<u>For Performance Year (PY) 2021:</u>** **Traditional MIPS: Individuals, Groups, Virtual Groups** • Quality: 40% • Cost: 20% • Promoting Interoperability: 25% • Improvement Activities: 15% **Traditional MIPS: APM Entities***	**We are statutorily required to weight the cost and quality performance categories equally beginning with Performance Year (PY) 2022:** **Traditional MIPS: Individuals, Groups, Virtual Groups** • Quality: **30%** • Cost: **30%** • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change)

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	• Quality: 55% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 15% ***Note:** We've issued a clarification about PY 2021 performance category weights for APM Entities in this proposed rule. **APM Performance Pathway (APP): Individuals, Groups, APM Entities** • Quality: 50% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 20%	**Traditional MIPS: APM Entities (no change)** • Quality: 55% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 15% **APP: Individuals, Groups, APM Entities (no change)** • Quality: 50% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 20%
Quality Performance Category Collection Types	**Available Collection Types for Groups and Virtual Groups for the 2022 Performance Period:** • Electronic Clinical Quality Measures (eCQMs) • Medicare Part B Claims Measures • MIPS Clinical Quality Measures (MIPS CQMs) • QCDR Measures We previously finalized that we would sunset the CMS Web Interface as a collection type and submission type for	**CMS Web Interface** • We are proposing **to extend the CMS Web Interface** as a collection type and submission type in traditional MIPS for registered groups, virtual groups and APM Entities with 25 or more clinicians for the 2022 performance period.

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	traditional MIPS beginning with the 2022 performance period.	
Quality Measures	There are 206 quality measures available for the 2021 performance period.	We are proposing a total of 195 quality measures for the 2022 performance period, which reflect proposals on: • 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 new administrative claims measures. The 2 proposed administrative claims measures are: 1. Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System a. 21-case minimum b. 1-year performance period (January 1 – December 31) c. Applies to MIPS eligible clinicians, groups, and virtual groups. 2. Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions a. 18-case minimum

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		b. 1-year performance period (January 1 – December 31 c. Applies to MIPS eligible groups with at least 16 clinicians
Quality Measure Benchmarks	After analyzing the available data, we did not finalize our proposal to use performance period benchmarks exclusively for the 2021 performance period.	Given the extreme and uncontrollable circumstances policies in effect for PY 2020, we are proposing to **use performance period benchmarks for the 2022 performance period, or a different baseline period (such as CY 2019),** pending analysis of the 2020 performance period data.
Data Completeness	Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the denominator eligible encounters. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry picking"), would not be considered true, accurate, or complete and may subject you to an audit.	We are proposing to maintain the current data completeness threshold at 70% for the 2022 performance period. We are proposing to **increase the data completeness threshold to 80% for the 2023 performance period**.

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Quality Measure Scoring	Quality measure scoring policies:	Beginning with the 2022 performance period, we are proposing the following changes to quality measure scoring to align with our proposals for scoring MVPs:

	New measures
	• No existing policy specific to new measures other than our general policy to award 3 points to measures without a benchmark.
		New measures
		• **Establish a 5-point floor** for the first 2 performance periods for new measures.
		• For example:
		  ○ 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 measure would earn 5 points in the 2022 and 2023 performance periods if no performance period benchmark could be created, if data completeness and case minimum criteria were met.

	Measures with a benchmark • There is a 3-point floor for measures that can be scored against a benchmark.	**Measures with a benchmark** • **Remove the 3-point floor** for measures that can be scored against a benchmark. ○ These measures would receive 1-10 points. **Note:** This proposal would not apply to new measures in the first 2 performance periods available for reporting.

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	Measures without a benchmark
	• Measures without a benchmark (historical or performance period) will earn 3 points.
		Measures without a benchmark
		• **Remove the 3-point floor** for measures without a benchmark (except small practices)
		  ○ These measures would receive 0 points.
		  ○ Small practices would continue to earn 3 points.
		
		Note: This proposal wouldn't apply to new measures in the first 2 performance periods available for reporting.

	Measures that don't meet case minimum
	• Measures that don't meet case minimum (20 cases) will earn 3 points.
	
	Note: This policy only applies to quality measures submitted by clinicians. Measures calculated from administrative claims are excluded from scoring if the case minimum isn't met.
		Measures that don't meet case minimum
		• **Remove 3-point floor** for measures that don't meet case minimum (except small practices)
		  ○ These measures would earn 0 points.
		  ○ Small practices would continue to earn 3 points.
		
		Note: This proposal would not apply to new measures in the first 2 performance periods available for reporting. This proposal would not apply to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum is not met.

	High-Priority Bonus Points • Each additional outcome or patient experience measure, beyond the one required outcome measure, receives 2 bonus points if data completeness criteria	**High-Priority Bonus Points** • **Remove bonus points** for reporting additional outcome and high priority measures, beyond the 1 required.

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	and case minimum are met. (Measures must have a performance rate greater than 0%, or less than 100% for inverse measures.) • Each additional high-priority measure, beyond the one required outcome measure, receives 1 bonus point if data completeness criteria and case minimum are met. (Measures must have a performance rate greater than 0%, or less than 100% for inverse measures.)	
	End-to-End Electronic Reporting Bonus Points • Each measure that meets end-to-end electronic reporting criteria receives 1 bonus point. • Measures do not have to meet data completeness or case minimum.	**End-to-End Electronic Reporting Bonus Points** • Remove bonus points for measures that meet end-to-end electronic reporting criteria.
Quality Scoring Flexibilities	We increased our previously established scoring flexibility by: • Expanding the list of reasons that a quality measure may be impacted during the performance period. • Revising when we will allow scoring of the measure with a performance period truncation (to 9 months) or the complete suppression of the measure if 9 months of data isn't available. Potential changes that may impact quality measures during the performance period include updates to clinical guidelines	We are proposing to expand the list of reasons that a quality measures may be impacted to include errors included in the measure specifications as finalized as cause to suppress or truncate a measure. These errors include, but are not limited to: • Changes to the active status of codes. • The inadvertent omission of codes. • The inclusion of inactive or inaccurate codes.

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	or measure specifications, such as revisions to medication lists, codes, and clinical actions. Based on the timing of the change and the availability of data, we will: • Truncate the performance period to 9 consecutive months if there were no concerns with potential patient harm and 9 consecutive months of data are available. • Suppress the measure from scoring (0 achievement points and total measure achievement points reduced by 10 for each measure submitted that is impacted) if 9 consecutive months of data are not available.	
Quality Scoring for Groups Reporting Medicare Part B Claims Measures	We will automatically calculate a quality performance category score at the individual and group levels when Medicare Part B Claims measures have been reported by small practices.	We recognize that not all small practices that report Medicare Part B Claims measures intend to participate as a group. Therefore, we are proposing that we would **only calculate a group-level quality performance category score** from Medicare Part B Claims measures if the **practice submitted data for another performance category as a group** (signaling their intent to participate as a group).
Cost Performance Category	**Measures** • Total Per-Capita Costs (TPCC) • Medicare Spending per Beneficiary Clinician (MSPB Clinician) measure • 18 episode-based measures	**Measures** • We are proposing to add 5 newly developed episode-based cost measures into the MIPS cost performance category beginning with the CY 2022 performance period.

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		○ 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]
Cost Measure Development Process	In the current measure development process, all cost measures are developed by CMS's measure development contractor.	In addition to the current process, we are 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.
Improvement Activities Performance Category	**Removal of Activities** • There is no existing policy to remove activities outside of the rulemaking process.	**Removal of Activities** • We are proposing a policy to suspend improvement activities. Specifically, we are proposing that 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, we would promptly suspend the improvement activity and immediately notify clinicians and the public through the usual communication channels, such as listservs and Web postings. We would then propose to remove or modify the improvement activity as appropriate in the next rulemaking cycle.

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	Criteria for Nominating a New Improvement Activity • Relevance to an existing improvement activities subcategory (or a proposed new subcategory). • Ability to link to existing and related MIPS quality and cost measures, as applicable and feasible. • Importance of an activity toward achieving improved beneficiary health outcomes. • Importance of an activity that could lead to improvement in practice to reduce health care disparities. • Aligned with patient-centered medical homes. • Focus on meaningful actions from the person's and family's point of view. • Supportive of the patient's family or personal caregiver. • Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care). • Feasible to implement, recognizing importance in minimizing burden, especially 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.	**Criteria for Nominating a New Improvement Activity** We are proposing **2 new criteria** for nominating new improvement activities: **Improvement activities:** • Shouldn't duplicate other improvement activities in the Inventory. • Should drive improvements that go beyond standard clinical practices. We are also proposing that **new improvement activities must at minimum meet all of the following 8 criteria**, consisting of: the 2 proposed criteria above and these 6 existing criteria: 1. Relevance to an existing improvement activities subcategory (or a proposed new subcategory). 2. Importance of an activity toward achieving improved beneficiary health outcomes. 3. 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.

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	• Include a public health emergency as determined by the Secretary. • CMS is able to validate the activity.	4. Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes. 5. Can be linked to existing and related MIPS quality, Promoting Interoperability, and cost measures, as applicable and feasible. 6. CMS is able to validate the activity. Finally, we are proposing 6 optional factors that we may use to consider nominated activities (made up of previously finalized criteria): 1. Alignment with patient-centered medical homes. 2. Support for the patient's family or personal caregiver. 3. Responds to a public health emergency as determined by the Secretary. 4. Addresses improvements in practice to reduce health care disparities. 5. Focus on meaningful actions from the person and family's point of view. 6. Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care).
		Activity Inventory • We're proposing the addition of 7 new improvement activities, 3 of which are related to promoting health equity.

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		• We're also proposing to modify 15 current improvement activities, 11 of which address health equity. • We're proposing to remove 6 previously adopted improvement activities.
Promoting Interoperability Performance Category	**Reweighting** We continue to apply automatic reweighting to the following clinician types: • Nurse practitioners • Physician assistants • Certified registered nurse anesthesiologists • Clinical nurse specialists • Physical therapists • Occupational therapists • Qualified speech-language pathologist • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals We continue to apply automatic reweighting to MIPS eligible clinicians, groups and virtual groups with the following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing	**Reweighting** We are proposing to **apply automatic reweighting** to the following, beginning with the 2022 performance period: • Clinical social workers • Small practices

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	Small Practices Small practices (15 or fewer eligible clinicians) may apply for a hardship exception so that the Promoting Interoperability performance category will be reweighted to another performance category.	
	Public Health and Clinical Data Exchange Objective MIPS eligible clinicians must report to 2 different public health agencies or clinical data registries for any of the following measures, unless they can claim an exclusion(s): • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	**Public Health and Clinical Data Exchange Objective** We are proposing to modify the reporting requirements for this objective and **require MIPS eligible clinicians to report the following 2 measures** (unless an exclusion can be claimed): • Immunization Registry Reporting • Electronic Case Reporting We believe this modification will support public health agencies (PHAs) in future health threats and a long-term COVID-19 recovery.
	Measures • **Provide Patients Electronic Access to their Health Information Measure** ○ Measure Description: For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible	**Measures** • **Provide Patients Electronic Access to their Health Information Measure** ○ We're proposing to modify the Provide Patients Electronic Access to Their Health Information measure to require patient health information to remain available to the patient (or patient-authorized representative) to access indefinitely, starting with a date of service of

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	clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's CEHRT.	January 1, 2016. This timeline also aligns with the timeline established in the Interoperability and Patient Access final rule. • **Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)** ○ We're also proposing **a new measure** where 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).
	Attestations • In addition to reporting the required measures, MIPS eligible clinicians must also submit: ○ Prevention of Information Blocking attestation ○ ONC Direct Review attestation	**Attestations** • We're proposing to modify the **Prevention of Information Blocking** attestation statements required by eligible clinicians.
Final Scoring		
Complex Patient Bonus	Provided that a MIPS eligible clinician, group, virtual group or APM entity submits data for at least one MIPS performance category for the applicable performance period for the MIPS payment year, a complex patient bonus will be added to the final score for the MIPS payment year using the following formula:	Because of the concerns of the direct and indirect effects of the COVID-19 PHE, we propose 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.

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	Average hierarchical condition category (**HCC**) risk score + (the ratio of your dual eligible patients x 5) The complex patient bonus cannot exceed 5.0 points, except for the 2020 MIPS performance year/2022 payment year when we doubled the bonus to 10 points.	We are also 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 10.0 points.
Facility-based Measurement	The MIPS quality and cost performance category scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher combined MIPS quality and cost performance category score through another MIPS submission.	We are proposing that, beginning with the 2022 performance year, for facility-based clinicians and groups: • The MIPS quality and cost performance category scores will be based on the facility-based measurement scoring methodology **unless a clinician or group receives a higher MIPS final score** through another MIPS submission. We would calculate 2 final scores for clinicians and groups who are facility based: • One score would be based on the performance and weights of the performance categories if facility-based measurement didn't apply.

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		• The other score would be based on the application of facility-based measurement.

Redistributing Performance Category Weights for Small Practices	Small practices are reweighted under the same redistribution policies as other MIPS eligible clinicians.	We are 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%.

Performance Threshold / Additional Performance Threshold / Payment Adjustment	**For the 2021 performance year (2023 payment year):** • The performance threshold is set at **60 points**. • An additional performance threshold is set at **85 points** for exceptional performance. • As required by statute, the maximum negative payment adjustment is **-9%**.	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.

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	• Positive payment adjustments can be up to 9% (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9%.	• We are proposing to use the **mean final score from the 2017 performance year/2019 MIPS payment year**, which would result in: ○ The performance threshold would be set at **75 points**. ○ An additional performance threshold would be set at **89 points** for exceptional performance, which is the 25th percentile of actual 2017 final scores above 75 points. We note that the 2022 performance year/2024 payment year is the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

Quality Payment Program CY 2022 NPRM: Advanced APM Overview

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Advanced APMs: Qualifying APM Participant (QP) Incentive Payment		In the 2021 PFS Final Rule, we finalized a hierarchy that we use to identify potential payee TINs in the event that Qualifying APM Participant's (QP) original TIN is no longer active. This process has improved our ability to make more payments to TINs with which QPs have valid, up-to-date affiliations. Because such TINs are active within the same year the payments are to be made, adding this step to the processing hierarchy would make it easier for us to complete

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		successful payments to more QPs in our first round of QP Incentive Payments. We are proposing to add this step to the current regulatory hierarchy for processing the QP Incentive Payment.

Quality Payment Program CY 2022 Proposals: Public Reporting via Clinicians and Doctors Care Compare Overview

Policy Area	Existing Policy	CY 2022 Proposed
Public Reporting	**Facility Affiliations** Care Compare currently displays hospital affiliations on clinician and group profile pages and connects to the relevant hospital profile pages.	**Facility Affiliations** We are proposing to add affiliations for the following facility types: • Long-Term Care Hospitals • Inpatient Rehabilitation Facilities • Inpatient Psychiatric Facilities • Skilled Nursing Facilities • Home Health Agencies • Hospice • End-Stage Renal Disease Facilities We are also seeking comment on the appropriate number of procedures done or conditions treated at one of the above facility types to link from the clinician profile page to the facility page.

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	N/A	**Utilization Data** We are seeking public comment through a Request for Information (RFI) on the types of utilization data that could be added to Care Compare to inform patients' health care decisions.
	N/A	**MVPs and Subgroup Performance** We are proposing that subgroup scores be publicly reported, beginning with the 2024 performance year, separately from group scores.

We Want to Hear from You

We welcome your feedback on the proposed policies for the 2022 performance year of the Quality Payment Program. Please note that the official method for commenting is outlined below.

How Do I Comment on the CY 2022 Proposed Rule?

The proposed rule includes directions for submitting comments. Comments must be received within the 60-day comment period.

FAX transmissions won't be accepted. Use one of the following ways to officially submit your comments:

- Electronically through regulations.gov
- Regular mail
- Express or overnight mail
- Hand or courier

The proposed rule can be accessed through the “Regulatory Resources” section of the QPP Resource Library.

Contact Us

We will continue to provide support to clinicians who need assistance. While our support offerings will reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance to help them successfully participate.

We also encourage clinicians to contact the QPP Service Center at 1-866-288-8292, Monday through Friday, 8am – 8pm ET or by email at QPP@cms.hhs.gov. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History Table

Date	Change Description
07/13/2021	Original posting