

2022 Quality Payment Program Final Rule

Summary

On Tuesday, November 2, 2021, the Centers for Medicare and Medicaid Services (CMS) issued the 2022 Quality Payment Program (QPP) final rule that includes updates to the current program, the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP) framework, Alternative Payment Model (APM), and the APM Performance Pathway (APP).

The QPP encompasses the MIPS and the Alternative Payment Model (APM) programs, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It is important that radiation oncology practices understand key aspects of the QPP, which include a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

Recognizing the impact of the COVID-19 Public Health Emergency (PHE), the Agency continues to consider the extraordinary health system stresses by delaying key proposals to future performance years.

MIPS

MIPS Scoring Methodology

For the 2022 performance year, CMS finalized the following changes to the MIPS performance category weights:

- Quality – 30 percent (10% decrease from the 2021 performance year)
- Improvement Activities – 15 percent (no change)
- Promoting Interoperability – 25 percent (no change)
- Cost – 30 percent (10% increase from the 2021 performance year)

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. Also, as required by law, beginning with the 2022 performance year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. The Agency finalized its proposal to use the mean final score from the 2017 performance year, which would result in the performance threshold being set at 75 points, and an additional performance threshold would be set at 89 points for exceptional performance. The Agency notes that the 2022 performance year is the final year for an additional performance threshold or additional MIPS adjustment for exceptional performance.

The payment adjustment for 2024 (based on 2022 performance) will range from -9 percent to +9 percent, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), excluding Part B drugs.

Performance Category Reweighting

CMS continues to provide Promoting Interoperability hardship exemptions for the 2022 performance period. The following chart shows the finalized reweighting policies for the 2022 performance period:

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

The Agency will no longer require an application for clinicians and small practices seeking to qualify for the small practice hardship exemption and reweighting. Instead, CMS finalized its proposal to assign a weight of zero percent to the Promoting Interoperability performance category and redistribute its weight to another performance category (or categories) in the event no data is submitted for any of the measures for the Promoting Interoperability performance category. However, if data is submitted for a MIPS eligible clinician in a small practice, they would be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians.

The finalized redistribution for small practices is as follows:

Reweighting Scenario	Promoting Interoperability	Quality	Cost	Improvement Activities
No Promoting Interoperability	0%	40%	30%	30%
No Promoting Interoperability and no Cost	0%	50%	0%	50%

Clinician Eligibility

CMS did not change current MIPS eligibility requirements. For more information, please see ASTRO's QPP resource [page](#).

CMS finalized the addition of the following eligible clinician types beginning in 2022: clinical social workers and certified nurse midwives.

Facility-Based Measurement

CMS finalized its proposal, beginning with the 2022 performance year, that 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. The Agency would calculate two 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 did not apply. The other score would be based on the application of facility-based measurement.

Bonus Points

Complex Patients

CMS finalized the continuation of doubling the complex patient bonus for the 2021 performance period. Clinicians, groups, virtual groups and APM Entities would be able to earn up to 10 bonus points (instead of 5) to account for the additional complexity of treating their patient population due to COVID-19. These bonus points (capped at 10 points) would be added to the final score.

The Agency finalized the revision of the complex patient bonus beginning with the 2022 performance year by:

- Limiting the bonus to clinicians who have a median or higher value for at least one of the two 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 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 2023 performance year), virtual groups or APM Entities that meet the criteria above and submit data for at least one performance category.

Small Practice Bonus

CMS is retaining the small practice bonus of six points for the 2022 performance year to be applied to the 2024 payment year. The bonus will continue to be added to the Quality performance category, as it was in 2020, rather than in the MIPS final score calculation, as it was

in 2018. To receive the bonus, a small practice must submit Quality data. This applies to individual clinicians, group practices, virtual groups, or MIPS APM entities that consist of 15 or fewer clinicians.

Quality Performance Category

The Agency finalized reweighting the Quality category to 30 percent for the 2022 performance year. The reporting period for the Quality category will continue to be a full calendar year.

Given the extreme and uncontrollable circumstances policies in effect for the 2020 performance year, CMS did not finalize the use of 2019 performance period benchmarks for the 2022 performance period. Rather, the Agency will calculate benchmarks according to the standard baseline period policy and provide these benchmarks prior to the start of the 2022 performance period.

Additionally, the Agency finalized its proposal to extend the CMS Web Interface as a collection and submission type in traditional MIPS for registered groups, virtual groups, and APM Entities with 25 or more clinicians through the 2022 performance period, sunseting it with the 2023 performance period. CMS finalized its proposal to maintain the data completeness threshold at 70 percent of Medicare Part B patients for the 2021, 2022 and 2023 performance years, regardless of payer, with a minimum of 20 cases per measure. CMS did not finalize its proposal to increase the data completeness threshold to 80 percent for the 2023 performance period. The data completeness threshold will remain at 70 percent for the 2023 performance period. CMS is also maintaining the 1-point floor for measures that do not meet data completeness requirements. This policy does not apply to small practices, who will continue to earn three points for submitting measures that do not meet the data completeness threshold.

The Agency did not finalize the removal of the Oncology: Medical and Radiation – Plan of Care for Pain [NQF #0383, Q144] from the radiation oncology measure set to maintain consistency and stability. The measure has not reached the end of the topped-out lifecycle and aligns with current guidelines. For more information on the RO Model requirements, see ASTRO's [summary](#) of the final rule.

New Measures

For new measures, CMS is establishing a 7-point scoring floor for the first performance period and a 5-point scoring floor in the second performance period beginning in performance year 2022. This is a change from the proposed rule, which established a 5-point floor for the first two performance periods. For example, a new measure available for the 2022 performance year will earn 7-10 points in 2022 if a performance period benchmark can be created, and data completeness and case minimum criteria were met. The measure will then earn 5-10 points in 2023, if a performance period benchmark can be created, and data completeness and case minimum criteria were met. However, the measure would earn 7 points in the 2022 performance period, and 5 points in 2023, if no performance period benchmark could be created, and if data completeness and case minimum criteria were met. The measure will earn zero points in the 2022 and 2023 performance years if data completeness is not met. Small practices will continue to earn 3 points. The measure will earn 3 points in the 2022 performance year, if case minimum

requirements are not met. And finally, the Agency is finalizing a new policy that the measure will earn zero points in the 2023 performance year, if case minimum requirements are not met. Under this new policy, small practices will continue to earn 3 points.

	2022 Performance Year	2023 Performance Year
Performance benchmark + data completeness + case minimum	7-10 points	5-10 points
Data completeness + case minimum	7 points	5 points
No performance benchmark		
Performance benchmark + case minimum	0 points	0 points
No data completeness		
Performance benchmark + data completeness	3 points	0 points (new policy)
No case minimum		

Measures with a Benchmark

CMS is not making changes for the 2022 performance year; measures that can be scored against a benchmark will continue to have a 3-point floor. For the 2023 performance period, CMS will remove the 3-point floor (except for small practices) for measures that can be scored against a benchmark. These measures would receive 1-10 points. This policy would not apply to new measures in the first 2 performance periods available for reporting.

Measures without a Benchmark

CMS is not making changes for the 2022 performance year; measures without a benchmark will continue to earn 3 points. For the 2023 performance period, CMS finalized its proposal to remove the 3-point floor for measures without a benchmark (except for small practices). These measures would receive 0 points, while small practices would continue to earn 3 points. This policy would not apply to new measures in the first 2 performance periods available for reporting.

Measures that do not meet Case Minimums

CMS is not making changes for the 2022 performance year; measures that do not meet the case minimum will earn 3 points. CMS finalized the removal of the 3-point floor for measures that do not meet case minimums (except for small practices). These measures would receive 0 points, while small practices would continue to earn 3 points. This policy would not apply to new measures in the first 2 performance periods available for reporting, nor would it apply to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum is not set.

Topped out measures

The Agency did not finalize its proposal that for the 2022 performance year, MIPS eligible clinicians receive no more than 7 measure achievement points for each measure (except for measures in the CMS Web Interface) for which the applicable benchmark is identified as topped out for 2 or more consecutive years based on the historical benchmarks published for the 2021 performance period and continues to be identified as topped out based on the 2022 performance period. Rather, the Agency will continue its policy that the 7-point cap will be applied to measures (except for measures in the CMS Web Interface) that are identified as topped out for 2 or more consecutive years, beginning in the second year the measure is identified as topped out.

High-Priority Bonus Points

CMS finalized its proposal to remove bonus points for reporting additional outcome and high priority measures, beyond the one required.

End-to-End Electronic Reporting Bonus Points

CMS finalized its proposal to remove bonus points for measures that meet end-to-end electronic reporting criteria. The Agency is developing ways to encourage the use of CEHRT for electronic reporting without offering measure bonus points. As the program works to focus on the quality of care provided to beneficiaries, the Agency intends to score for performance on measures and not for reporting. Therefore, CMS finalized its proposal to end measure bonus points for end-to-end electronic reporting beginning in the 2022 performance period.

Quality Scoring Flexibilities

Beginning with the 2022 performance period, CMS is expanding the list of reasons a quality measure may be impacted. These reasons include errors 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; and, the inclusion of inactive or inaccurate codes.

Quality Scoring for Groups Reporting Medicare Part B Claims Measures

CMS recognizes that not all small practices that report Medicare Part B Claims measures intend to participate as a group. Therefore, the Agency finalized its proposal to only calculate a group-level quality performance category score from Medicare Part B Claims measures if the small practice submitted data for another performance category as a group, thus indicating their intent to submit as a group. This excludes those participating in MIPS as part of a virtual group because clinicians signal their intent to be scored as a virtual group through the virtual group election process.

Cost Performance Category

CMS finalized its proposal to increase the weight of the Cost category from 20 percent to 30 percent for the 2022 performance year. By law, the category must be weighted at 30 percent in

the 2022 performance year. The Cost category continues to require a full calendar year reporting period.

The Agency finalized its proposal to add five newly developed episode-based cost measures beginning with the 2022 performance period. The new measures are: Melanoma Resection, Colon and Rectal Resection, Sepsis, Diabetes, and Asthma/Chronic Obstructive Pulmonary Disease (COPD). In addition to the current cost measure development process, the Agency finalized a process of external cost measure development by stakeholders, and a call for cost measures beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period.

Total Per Capita Cost Measure (TPCC)

CMS did not propose any changes to the attribution methodology for TPCC for the 2022 performance year. The exclusions previously finalized will ensure that the TPCC measure is more accurately applied to clinicians who provide primary care services. Attributed episodes of care are excluded if they are performed by clinicians who (i) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy) or (ii) are in specialties unlikely to be responsible for providing primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology). While radiation therapy would be excluded from this measure, physician assistants and nurse practitioners that may provide services to patients receiving radiation therapy services are still included in the attribution methodology.

Medicare Spending Per Beneficiary Clinician (MSPB)

CMS did not propose any changes to the attribution methodology under the MSPB. Medical episodes are first attributed at the clinician group (TIN) level, and then at the clinician (TIN-NPI) level. A medical episode is attributed to the TIN, if the TIN bills at least 30 percent of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay. Then the episode is attributed to a clinician in the TIN, who bills at least one inpatient E/M service out of the 30 percent or more of inpatient E/M services attributed to the TIN. For example, a surgical episode is attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure. Unrelated services specific to groups of Diagnosis Related Groups (DRGs) aggregated by Major Diagnostic Category (MDC) level are excluded.

Improvement Activities Performance Category

CMS is retaining the weight for Improvement Activities performance at 15 percent, based on a selection of medium and high weighted activities. The Agency is also retaining the 90-day minimum performance period, as well as the simple attestation reporting requirement.

The Agency finalized its proposal that, beginning with the 2022 performance year, each improvement activity for which groups and virtual groups submit a “yes” response must be performed by at least 50 percent of the NPIs that are billing under the group’s TIN or virtual

group's TINs, and the NPIs must perform the same activity during any continuous 90-day period within the same performance year.

Suspension and Removal of Activities

Currently, there is no existing policy to remove or suspend activities outside of the rulemaking process. The Agency finalized its proposal 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, the improvement activity would be promptly suspended, and clinicians and the public would be notified through communication channels, such as listservs and web postings. The Agency would then propose to remove or modify the improvement activity as appropriate in the next rulemaking cycle.

Criteria for Nominating a New Improvement Activity

CMS finalized two new criteria for nominating new improvement activities:

- Improvement activities:
 - Should not duplicate other improvement activities in the inventory.
 - Should drive improvements that go beyond standard clinical practice.

The Agency also finalized its proposal that new improvement activities, must at minimum, meet the following criteria, including the two new criteria proposed above:

1. Relevance to an existing Improvement Activity 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.
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 can validate the activity.

The Agency also finalized the following optional factors that they may use to consider nominated activities:

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 improvement 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).

The Agency finalized the addition of the following activities:

1. Achieving Health Equity:
 - a. Create and Implement an Anti-Racism Plan
 - b. Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
2. Behavioral and Mental Health
 - a. Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice
 - b. Promoting Clinician Well-Being
3. Emergency Response and Preparedness
 - a. Implementation of a Personal Protective Equipment (PPE) Plan
 - b. Implementation of a Laboratory Preparedness Plan
4. Patient Safety and Practice Assessment
 - a. Application of CDC's Training for Healthcare Providers on Lyme Disease

The Agency finalized the removal of the following activities:

1. Patient Safety and Practice Assessment
 - a. Participation in CAHPS or another supplemental questionnaire
2. Beneficiary Engagement
 - a. Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms
 - b. Use of tools to assist patient self-management
 - c. Provide peer-led support for self-management
 - d. Implementation of condition-specific chronic disease self-management support programs
 - e. Improved practices that disseminate appropriate self-management materials

Promoting Interoperability (PI) Performance Category

The Agency is retaining both the 25 percent weight for the PI category and the 90-day minimum performance period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

CMS finalized its proposal to apply automatic reweighting to clinical social workers and small practices beginning with the 2022 performance period.

The Agency finalized its proposal to modify the reporting requirements for the Public Health and Clinical Data Exchange Objective to require MIPS eligible clinicians to report the following two measures (unless an exclusion can be claimed): Immunization Registry Reporting, and Electronic Case Reporting. However, the Agency is establishing a 1-year exclusion for the Electronic Case Reporting measure for the 2022 performance year. An exclusion can be applied if the MIPS eligible clinician uses CEHRT that is not certified to the electronic case reporting criterion prior

to the start of the performance period they select during calendar year 2022. The Agency believes that requiring Electronic Case Reporting, along with the 1-year exclusion will: ensure health care providers that possess certified functionality adopt and implement this functionality before 2023; and signal to EHR developers that they must prioritize adding electronic case reporting to their products to ensure their customers can report on the measure once the exclusion is no longer available.

In addition, the following measures would become optional, earning a total of 5 bonus points: Syndromic Surveillance Reporting, Public Health Registry Reporting, and Clinical Data Registry Reporting. CMS believes that this modification will support public health agencies in future health threats and a long-term COVID-19 recovery.

CMS did not finalize its proposal 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 January 1, 2016.

The Agency finalized 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). This measure would be required, but not scored, and would not affect the total number of points earned for the Promoting Interoperability performance category.

Finally, CMS finalized its proposal to modify the Prevention of Information Blocking attestation statements required by eligible clinicians.

Final Scoring Methodology for 2022 Performance Period

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Bonus: Query of PDMP	10 points <i>(bonus)</i>
Health Information Exchange OR	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
Health Information Exchange (alternative)	HIE Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	<i>Report the following two measures:</i> <ul style="list-style-type: none"> • <i>Immunization Registry Reporting</i> • <i>Electronic Case Reporting</i> 	10 points
	<i>Optional measures:</i> <ul style="list-style-type: none"> • <i>Syndromic Surveillance Reporting</i> • <i>Public Health Registry Reporting</i> • <i>Clinical Data Registry Reporting</i> 	5 points <i>(maximum, bonus)</i>
<i>Protect Patient Health Information</i>	<i>Security Risk Assessment Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)</i>	<i>Required, but not scored.</i>

Certified Electronic Health Record Technology (CEHRT)

CMS is continuing the requirement that eligible clinicians use 2015 Edition CEHRT for 2022. In May 2020, the Office of the National Coordinator for Health Information Technology (ONC) finalized additional updates to the 2015 Edition in the 21st Century Cures Act Final Rule, including an e-prescribing standard required for alignment with other CMS programs.

The 21st Century Cures Act final rule finalized updates to a number of certification criteria, which are currently associated with objectives and measures under the Promoting Interoperability Program, as well as criteria that are included in the 2015 Edition Base EHR¹ definition. In general, ONC finalized that health IT developers have until May 2, 2022 to make technology certified to these updated criteria available to their customers. During this time,

¹ 2015 Edition Base EHR means an electronic record of health-related information on an individual that:
 (1) Includes patient demographic and clinical health information, such as medical history and problem lists; (2) Has the capacity: (i) To provide clinical decision support; (ii) To support physician order entry; (iii) To capture and query information relevant to health care quality; (iv) To exchange electronic health information with, and integrate such information from other sources; and (3) Has been certified to the certification criteria adopted by the Secretary.

developers are expected to continue supporting technology certified to the prior version of certification criteria for use by their customers.

Qualified Clinical Data Registry (QCDR)

CMS finalized its proposal that beginning with the 2023 MIPS performance period, QCDRs and qualified registries must support MVPs (see below for more on the MIPS Value Pathways) that are applicable to the MVP participants on whose behalf they submit MIPS data. Additionally, the Agency finalized its proposal that beginning with the 2023 MIPS performance period, Health IT vendors must support MVPs that are applicable to the MVP participants on whose behalf they submit data. Finally, the Agency is requiring QCDRs, qualified registries, Health IT vendors, and CAHPS for MIPS survey vendors to support subgroup reporting beginning with the 2023 performance period.

MIPS Value Pathways (MVP)

CMS finalized its proposal to further delay the implementation of MVP until the 2023 performance period. CMS believes this delay will provide practices the time they need to review requirements, update workflows, and prepare their systems as needed to report MVP. For the 2023, 2024, and 2025 performance years, CMS finalized its proposal to allow individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM Entities to report MVP. For the 2026 (a one-year delay from the proposed rule) performance year and future years, CMS will require multispecialty groups to form and report as a subgroup to report through an MVP. MVP must be proposed and finalized through the notice-and-comment rulemaking process.

In addition to the guiding principles finalized in the [2021 Final Rule](#), the Agency finalized the following development criteria beginning with the 2022 performance year:

- MVP 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.

The Agency finalized seven MVP that will be available beginning in the 2023 performance year:

1. Advancing Rheumatology Patient Care

2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

Participation Options

For the 2023, 2024, and 2025 MIPS performance years, CMS finalized the following definition of an MVP Participant: individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM Entities. Beginning with the 2026 performance year, the Agency will require multispecialty groups to form subgroups to report MVP. CMS did not indicate whether all specialties will have their own MVP, or how this will be implemented.

Subgroups

CMS finalized its definition of subgroups as “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.” The Agency finalized its proposal to limit subgroup reporting only to clinicians reporting through MVP or APM Performance Pathway (APP). Voluntary reporters, opt-in eligible clinicians, and virtual groups will not be able to report through an MVP for the 2023 performance year due to implementation challenges. Subgroup reporting would be voluntary for the 2023, 2024, and 2025 performance years. Multispecialty groups that report through an MVP will have to report as subgroups beginning with the 2026 performance period.

CMS finalized its proposal that registration for subgroup participation would take place between April 1 and November 30 of the performance year. To report the CAHPS for MIPS survey associated with an MVP, a group, subgroup, or APM Entity must complete their MVP registration by June 30 of the performance year to align with the CAHPS for MIPS registration deadline.

To participate as a subgroup, each subgroup would be required to:

- Identify the MVP the subgroup will report, along with one population health measure included in the MVP and any outcomes-based administrative claims measure on which the subgroup intends to be scored, if available.
- Identify the clinicians in the subgroup by TIN/NPI.
- Provide a plain language name for the subgroup for purposes of public reporting.

Once registered, the subgroup would be assigned a unique subgroup identifier that would be separate from the individual NPI identifier, the group TIN identifier, and the MVP identifier.

MVP Participant Registration

CMS finalized its proposal that an MVP Participant would register for the MVP between April 1 and November 30 of the performance year. To report the CAHPS for MIPS Survey associated with an MVP, a group, subgroup, or APM Entity must complete their MVP registration by June 30 of the performance year to align with the CAHPS for MIPS registration deadline.

At the time of MVP registration, an MVP Participant will select:

- The MVP they intend to report.
- One population health measure included in the MVP.
- Any outcomes-based administrative claims measure on which the MVP Participant intends to be scored, if available within the MVP.

An MVP Participant will not be able to submit or make changes to the MVP they select after the close of the registration period (November 30 of the performance year) and will not be allowed to report on an MVP they did not register for.

Third Party Intermediaries

The Agency finalized its proposal to require that QCDRs, Qualified Registries, and Health IT vendors support MVP relevant to the specialties they support beginning with the 2023 performance year and that subgroup reporting begin with the 2023 performance year. They further finalized that CAHPS for MIPS survey vendors support subgroup reporting and MVP relevant to the CAHPS for MIPS measure associated with an MVP beginning with the 2023 performance year.

Reporting Requirements

CMS finalized the following reporting requirements for MVP Participants and Subgroups:

- Foundational Layer (MVP agnostic)
 - Population Health Measures: MVP Participants and Subgroups would select one population health measure, the results of which would be added to the quality score.
 - For the 2023 performance period the following population health measures will be available for selection:
 - Hospital-Wide, 30-day, All-Cause Unplanned Readmission Rate for the MIPS Eligible Clinician Groups
 - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
 - Promoting Interoperability Performance Category:
 - MVP Participants would report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualified for reweighting of the Promoting Interoperability performance category due to clinician type, special status, or an approved hardship exemption.

- Subgroups submit Promoting Interoperability data at the group level, not the subgroup level
- Quality Performance Category
 - MVP Participants will select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome isn't available or applicable). This can include an outcome measure calculated by CMS through administrative claims, if available to the MVP.
 - Subgroups would select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome measure is not available or applicable). This can include an outcome measure calculated by CMS through administrative claims, if available in the MVP.
- Improvement Activities Performance Category
 - MVP Participants would select two medium-weighted improvement activities or one high-weighted improvement activity or IA PCMH (participation in a patient-centered medical home), if the activity is available in the MVP
 - Subgroups would select two medium-weighted improvement activities or one high-weighted improvement activity or IA PCMH (participation in a PCMH), if the activity is available for the MVP.
- Cost Performance Category
 - CMS would calculate performance exclusively on the cost measures that are included in the MVP using administrative claims data.

Scoring Policies for MVP

Quality Performance Category Scoring: MVP quality performance category scoring policies will align with those used in traditional MIPS. Small practices will continue to earn 3 points for measures without a benchmark or that do not meet case minimum under MVP. If an MVP Participant reports more than the required number of quality measures, CMS will use the four highest scoring measures. Also, an MVP Participant will receive zero achievement points for the quality performance category for any required measures that are not reported. If an outcome-based administrative claims measure is available and selected by the MVP Participant to fulfill the outcome measure requirement, the measure will receive zero achievement points when the measure does not have a benchmark or meet the case minimum.

Improvement Activities Performance Category Scoring: Each medium-weighted improvement activity will be assigned 20 points, and each high-weighted improvement activity will be assigned 40 points.

Cost Performance Category Scoring: MVP cost performance scoring policies will align with those used in traditional MIPS. The Agency will score only the cost measures included in the MVP.

Foundational Layer (MVP Agnostic) Scoring: The population health measure selected by MVP Participants will be included in the Quality performance category score. These measures will be excluded from scoring if the measure does not have a benchmark or meet case minimums. However, subgroups will receive the score of the population health measure of their affiliated

group, if applicable, in the event that the measure selected by the subgroup does not have a benchmark or meet case minimums.

Measures in the Promoting Interoperability performance category are considered part of the Foundational Layer Scoring and will be scored in alignment with traditional MIPS scoring policies. Subgroups will submit Promoting Interoperability performance category data of their affiliated group.

Final Score: MVP scoring policies for determining the final score will generally align with those used in traditional MIPS across all performance categories, with few exceptions. Performance category weights will be consistent with traditional MIPS performance category weights. Reweighting policies for the redistribution of category weights will also align with traditional MIPS, with the exception that the Agency will not reweight the Quality performance category if it cannot calculate a score for the MIPS eligible clinician because there is not at least one quality measure applicable and available to the clinician.

CMS finalized the scoring hierarchy to include subgroups. A MIPS eligible clinician will receive the highest final score that can be attributed to their TIN/NPI combination from any reporting option (traditional MIPS, APP reporting, or MVP reporting) and participation option (as an individual, group, subgroup, or APM Entity) with the exception of virtual groups; clinicians that participate as a virtual group will always receive the virtual group's final score

CMS believes that including subgroups in the scoring hierarchy will allow for meaningful data collection and assessment under MVP, while applying the existing policy of allowing clinicians to receive the highest final score and payment adjustment that can be attributed to them.

Performance Feedback and Public Reporting

CMS will provide comparative performance feedback within the annual performance feedback to show the performance of like clinicians who report on the same MVP. The Agency will delay public reporting of new improvement activities and Promoting Interoperability measures and attestations reported via MVP by one year. Public reporting of subgroup-level performance information will begin with the 2024 performance year. Subgroup performance information will be publicly reported separately from individual clinician and group performance information.

Alternative Payment Models (APM)

Advanced APM

The 2022 MPFS final rule includes only a few modifications to the existing QPP APM program. They include recognition of changes to the QP status thresholds as a result of the passage of the Consolidated Appropriations Act (CAA) of 2020, modifications to the Advanced APM bonus distribution hierarchy, and clarification of the Alternative APM Pathway quality category weighting standards.

Qualified APM Participant (QP)

In the 2017 QPP final rule, CMS established Qualified APM Participant (QP) status requirements that allowed for the determination of QP status first at the APM Entity Level, after which the Agency would make further QP determinations at the individual level for Eligible Clinicians who are either participating in multiple Advanced APM Entities or are included on an Affiliated Practitioner List that is used for QP determination. The QP determination Threshold Score calculations are aggregated using data for all Eligible Clinicians participating in an APM Entity on each snapshot date (March 31, June 30, August 31, and December 31) during the QP Performance Period. If the APM Entity's Threshold Score meets the relevant QP threshold then all individual eligible clinicians in that APM Entity would receive the same QP determination.

The CAA included language that amended the QP Payment amount thresholds in payment years 2023 and 2024 (performance years 2021 and 2022). In the 2022 MPFS final rule, CMS aligned the Agency's policy with the CAA as follows:

- The Medicare Option QP thresholds are set at 50% for the payment amount method and 35% for the patient count method. The Medicare Option and All Payer Option partial QP thresholds were set at 40% for the payment amount method and 25% for the patient count method.
- To become a QP through the All Payer Combination Option, eligible clinicians must meet a minimum Medicare Option threshold set at 25% of the payment amount or 20% of patient count threshold before meeting the overall All Payer Combination Threshold as described above. For Partial QPs, those Medicare Options specific thresholds are 20% and 10%.

For performance years beginning in 2023 (corresponding with payment years beginning with 2025) the QP thresholds for the payment amount method and the patient count method will revert to the CMS schedule, which is 75% for the payment method and 50% for the patient count method. For Partial QPs the thresholds will be 50% and 35% respectively.

Advanced APM Incentive Payment

In the 2021 MPFS final rule, CMS established a hierarchy for the distribution of APM Incentive Payments. If Eligible Clinicians become QP through participation in multiple Advanced APMs, the Agency divides the APM Incentive Payment proportionally, based on payments for covered professional services during the performance period.

Over the duration of the Advanced APM program, CMS found that Eligible Clinicians may change TINs, APM Entities, or make other changes that impact their relationship with the Medicare program. Due to the two-year time lapse between the end of the performance period and the issuance of the APM Incentive Payment, these changes made it difficult for CMS to ensure that the APM Incentive Payment was received by the appropriate TIN.

In the 2021 MPFS final rule, the Agency modified its approach for identifying the TIN(s) to which it makes APM Incentive Payments. The new approach allows CMS to review a QP's

relationship with their TIN(s) over time, as well as consider the relationship the TIN(s) have with the APM Entity or Entities through which the Eligible Clinician earned QP status, or other APM Entities the QP may have joined in the interim.

In the 2022 MPFS final rule, CMS made an additional change to the APM Incentive Payment payee hierarchy. This modification will allow CMS to expand its search at each step of the hierarchy identifying potential payee TINs that are associated with the QP during the QP payment year. This proposed approach enables the Agency to make payments earlier in the year and reduces the number of QP NPIs that do not match with a payee TIN. Overall, this would reduce CMS' reliance on the public notice process to request more information.

Alternative Payment Model Performance Pathway (APP)

In the 2021 MPFS final rule, CMS established the Alternative Payment Model Performance Pathway (APP) under the MIPS program. Launched on January 1, 2021, the APP is a voluntary program that is available to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the snapshot dates (March 21, June 30, August 31 or December 31) during a performance period, as well as participants in the CMS Shared Savings Program ACOs.

The APP allows for the reporting of a single quality measure set with broad applicability. The APP establishes measures, which according to CMS address the highest priorities for quality measurement and improvement, while also reducing reporting burden, promoting alignment of measures and consolidation of reporting requirements across CMS programs. The table below describes the measures included in the APM Performance Pathway program for the 2022 performance period.

TABLE 35: Measures included in the Final APM Performance Pathway Measure Set for Performance Year 2022 and Subsequent Performance Years³

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#: 236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Prevention and Treatment of Opioid and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

³ We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) do not have benchmarks, and therefore, will not be scored for performance year 2022; they are, however, required to be reported in order to complete the Web Interface dataset.

* ACOs will have the option to report via the Web Interface for the 2022, 2023, and 2024 performance years only.

CMS will remove those quality measures that MIPS Eligible Clinicians, groups or APM Entities are unable to report on due to the size of the available patient population or because they are unable to meet the minimum case threshold for a measure.

CMS waives the Cost Performance Category for APP because APM Entities in the MIPS APMs are already subject to cost performance assessment. Additionally, CMS establishes a baseline score for each MIPS APM based on the Improvement Activity requirements of the particular MIPS APM.

In the 2022 MPFS final rule, CMS recognizes that when the APP program was established in the 2021 MPFS final rule, it did not discuss how the other category weights would change. In this

rule, the Agency clarifies that if only the cost category is weighted at zero, then the quality category would increase to 55% and the improvement activities and promoting interoperability category weights would remain the same at 15% and 30% respectively. If both the cost and interoperability categories are weighted at zero, then quality would be weighted at 85% and improvement activities would be weighted at 15%.

Additional Resources:

CMS 2022 Quality Payment Program Proposed Rule [Resources](#)

2022 Quality Payment Program [final rule](#)

ASTRO [Quality Payment Program resources](#)

ASTRO [Summary](#) of RO Model Final Rule