Key Takeaways from the CY 2022 Physician Fee Schedule Proposed Rule Updates to the MACRA Quality Payment Program

Comments due September 13, 2021 by 5:00 p.m. EDT

On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule on the Medicare Physician Fee Schedule (PFS) updates for calendar year (CY) 2022.[1] The PFS Proposed Rule announces planned policies for the sixth and future years of the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[2] The Proposed Rule is available here and a detailed fact sheet is available here.

Under the framework established by MACRA, eligible clinicians participate in one of two tracks of the QPP in CY 2022:

(1) An Advanced Alternative Payment Model (APM), which provides a flat 5% incentive payment on allowable Part B charges in CY 2022 in lieu of a Merit-based Incentive Payment System (MIPS) payment adjustment;[3] or

(2) MIPS, which provides **up to a positive or negative 9% payment** adjustment on allowable Part B service charges in CY 2023.[4]

In addition to MACRA, the Bipartisan Budget Act of 2018 (BBA) directs CMS to retain a number of lenient policies for the first 5 years of the program.[5] Notably, as we enter the sixth year of the program, the agency has adjusted several of its targets to compensate for the effects of the COVID-19 public health emergency (PHE). Also as a result of the BBA, the MIPS payment adjustments apply only to charges for Part B professional services, and not to drugs, biologics, or other separately billed items.[6]

The Proposed Rule principally applies to CY 2022 (the sixth performance year of the QPP), which corresponds to payment adjustments in CY 2024. The Proposed Rule announces several planned changes for the sixth year of the program as well as the continuation of a number of existing policies. Key proposals include:

- **Increase the minimum MIPS score**, or "performance threshold," to 50 points and keep the bonus threshold at 85 points;
- **Increase focus on health equity**, including a Request for Information (RFI) regarding data collection as it pertains to health disparities;
- **Transition to digital quality measures in CMS quality reporting and value-based purchasing programs**; and
- **Begin the transition to Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)** during the 2023 MIPS performance year.

The agency will continue to develop the MVP framework and proposes several additional MVP development criteria that would begin in the 2022 performance year. Significantly, these criteria focus on requiring outcome measures and high priority measures that are relevant to the clinician specialties included in the MVP. These proposed measures are a reflection of feedback the agency received from stakeholders that MIPS does not adequately reflect the differences in performance between specialties and practices.

Proposed changes to the current policies are outlined in the remainder of this document, organized by the two tracks of the QPP and the overall reach of the program.

Anticipated Impact

For their performance in CY 2022, MIPS participants can earn anywhere from a negative 9% to a positive 9% payment adjustment in CY 2024, as well as a share of $500 million (in aggregate) for exceptional performance,[7] although the vast majority will likely earn a modest positive adjustment.[8]

In the aggregate, CMS estimates that under the proposed rule assumptions:

- Approximately 810,000 clinicians will be eligible for MIPS in CY 2022;[9]
- **More than 780,000 will participate**;[10] and
- **More than 67% will earn a neutral to positive update** in CY 2024; and 17% of those earning a positive adjustment will also earn a share of the exceptional performance bonus.[11]

For reference, between CY 2017 and CY 2018, the program saw an overall increase in clinicians earning neutral or positive adjustments:

- In CY 2019, 99% of clinicians earned neutral or positive adjustments for CY 2021;[12] and
- In CY 2018, 98% of clinicians earned positive adjustments for CY 2020.[13]

CMS estimates that under the proposed model, $587 million would be redistributed for purposes of budget neutrality while $425 million would be distributed to those clinicians who met or exceeded the additional performance threshold.[14] CMS estimates that **between 225,000 and 290,000 clinicians will be exempt from MIPS as qualifying participants (QPs) of Advanced APMs** in CY 2022.[15] These QPs are expected to earn a total of approximately $600 million to $750 million in CY 2024.[16]

Policy Topic	Current Policy	CY 2022 Proposed Change
	MIPS	
Cost Performance Category	**20%**	**30%***
	CMS increased the Cost performance weight by 5% in CY 2021 to avoid a two-fold increase to reach the statutorily required 30% weight by CY 2022.[17] The agency also added costs associated with telehealth services to the previously established cost measures. These new codes had either recently been added to the Medicare telehealth services list through the two interim final rules CMS released as part of its response to the COVID-19 pandemic[18] or were previously not commonly billed and therefore had not been considered for inclusion.[19] In the CY 2020 proposed rule, CMS acknowledged that the ongoing PHE will prevent the agency from reliably calculating scores for the cost measures in performance year 2020. As such, CMS determined that it would assign a weight of zero percent for the cost performance category for CY 2020.	**Seeks comment on factors negatively impacting the ability of the agency to reliably calculate cost measure scores.** CMS recognizes that current challenges exist in reliably calculating the cost performance category and is considering whether to reweight the category under its authority provided in regulation (42 C.F.R. § 414.1380(c)(2)(i)(A)(*2*)) in the future.[20] **Adds 5 new episode-based cost measures**. These would include two procedural measures (melanoma resection, colon and rectal resection), one acute patient measure (sepsis), and two chronic condition measures (diabetes, asthma/chronic obstructive pulmonary disease [COPD]).[21] **Establishes an external process for stakeholders to develop cost measures to ensure consistency across measures**. This process would supplement the process for cost measure development currently in existence. These externally developed measures would be incorporated into the MIPS program by CY 2024 at the earliest.[22]
Quality Performance Category	**40%**	**30%***
	CMS had proposed to use performance benchmarks for the CY 2021 performance period	**Performance period benchmarks, or a different baseline period such as calendar year 2019, would be used in scoring quality measures**.

	in lieu of historical benchmarks based on 2019 data in an effort to accommodate data submission challenges arising from the COVID-19 PHE. After additional consideration, the agency determined that sufficient data exists to create historical benchmarks based on 2019 data.[23] For CY 2021, CMS finalized several changes to the specialty measure sets, including modifications to existing sets as well as the addition of new sets. More information on these specialty measure sets can be found in Table Groups A through D of Appendix 1 of the CY 2021 rule.[24] CMS also expanded available reasons for impacted quality measures and added new approaches to the truncation of performance periods. CMS finalized a policy, with modification, to truncate a performance period, or to suppress a quality measure,[25] if "revised clinical guidelines, measure specifications or codes impact clinician's [sic] ability to submit information on the measure or [might] lead to potentially misleading results."[26] A truncated performance period limits analysis to 9 months of consecutive data, while suppressing the measure reduces the achievement points available from the quality performance category by 10 points for each submitted and impacted measure.[27] CMS finalized its proposal to sunset the CMS Web Interface as a collection or submission type for ACOs, groups, and virtual groups; however, the agency determined that it would delay sunsetting	The agency anticipates that the flexibilities offered in light of the COVID-19 PHE will result in fewer submissions for the CY 2020 performance period.[29] **Retains current threshold for data completeness at 70% for CY 2022.** Increases the data completeness requirement to 80% in CY 2023.[30] **Proposes a measure set of 195 MIPS quality measures for CY 2022.** The proposed quality measures can be found in Table Group A of Appendix 1 of the proposed rule.[31] Nineteen quality measures are proposed for removal, and five for addition, including two proposed administrative claims measures (Risk-standardized acute unplanned cardiovascular-related admission rates for patients with heart failure; Clinician and clinician group risk-standardized hospital admission rates for patients with multiple chronic conditions). **Proposes to change several policies tied to the transitional phase of MIPS.**[32]

	the program until the 2022 reporting year, and allowing use of the CMS Web Interface in 2021, to accommodate complications from the PHE.[28] Once this change is implemented, groups and virtual groups will be able to: select their own quality measures instead of reporting on the pre-determined set of measures established under the CMS Web Interface; report 6 as opposed to 10 measures with the ability to report on all-payer data; and report on the eCQM or MIPS CQM version of the same primary care measures previously reported through the CMS Web Interface, if desired.	
Improvement Performance Category	**15%**	**15%***
	For the CY 2019 performance period, CMS added 4 months to the submission period for nominations of new and modified improvement activities (from February 1 through March 1 to February 1 through June 30).[33] In light of the COVID-19 PHE, CMS finalized its proposal to accept nominations for the duration of the PHE provided the improvement activity remains relevant.[34] Criteria and other elements of the Annual Call for Activities process are unaffected.[35] The agency has provided a list of criteria stakeholders should apply when submitting future nominations for improvement activities. Similarly, CMS finalized its proposal to extend the period in which it will consider HHS-nominated	**Updates the current improvement activities.** For the CY 2022 performance year, CMS proposes to modify 15 current improvement activities.[37] Importantly, 11 of these activities focus on health equity.[38] The changes CMS has proposed, such as those targeting beneficiary engagement and care coordination, are intended to better tailor these activities to address issues of health and racial equity.[39] CMS also proposes to remove six existing improvement activities. Details of these modifications can be found in Appendix 2 of the proposed rule. **Adds seven new improvement activities.** In keeping with the modifications noted above, several of these new activities are also focused on issues of equity in health care, including "Create and Implement an Anti-Racism Plan," and "Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols."[40] **Proposes additional changes to nomination process**. CMS proposes revise the timeframe for stakeholders to nominate improvement

	improvement activities, accepting nominations throughout the year.[36] In the CY 2021 Proposed Rule, CMS requested comment on these nominations, particularly with respect to whether the measure would support the goals of improving clinical practice or the delivery of care. The agency removed one obsolete improvement activity and modified two existing activities, the details of which are included in Appendix 2 of the CY 2021 Final Rule.	activities during a public health, allowing for nominations to be submitted by January 5th of the year in which the activity is meant to be implemented.[41]
Promoting Interoperability Performance Category	**25%**	**25%***
	CMS elected to keep the Query of Prescription Drug Monitoring Programs (PDMP) measure optional due to challenges resulting from the variety of PDMPs among states and the integration of PDMPs and EHR systems. The agency changed the name of Support Electronic Referral Loops by Receiving and Incorporating Health Information to "Support Electronic Referral Loops by Receiving and *Reconciling* Health Information" (emphasis added). To encourage the use of bi-directional HIEs, CMS added a new, optional measure for these systems under the HIE objective. This measure provides an	**Revises certain patient-information access requirements.** CMS proposes to add a requirement to the Provide Patients Electronic Access to Their Health Information measure that would require MIPS eligible clinicians to ensure that patients or patient-authorized representatives are able to access their patient health information indefinitely, using an application of their choice that meets certain standards, for encounters that occur on or after January 1, 2016.[43] The agency also proposes to modify the Prevention of Information Blocking to distinguish it from other information blocking policies such as those included in the 21st Century Cures Act. **Applies automatic reweighting to certain providers.** CMS would apply automatic reweighting to small practices and clinical social workers.[44] **Makes changes to support responses to future health threats.** The agency proposes to revise reporting requirements for the Public Health and Clinical Data Exchange Objective to better support public health

	alternative to the current HIE measures, and is worth 40 points.[42]	agencies in their responses to future health threats.[45] This would make two of the measures associated with this objective mandatory: the Immunization Registry Reporting and Electronic Case Reporting.[46] This change is intended to support long-term recovery efforts from COVID-19. The Clinical Data Registry Reporting, Syndromic Surveillance Reporting, and the Public Health Registry Reporting measures would be optional and available for bonus points. CMS proposes that MIPS eligible clinicians may earn 5 bonus points if they report a "yes" response for any of these three optional measures. Reporting on more than one would not result in additional bonus points.[47] **Require a new annual safety assessment.** The agency proposes a new measure for 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).
MIPS Value Pathways (MVPs)		
MIPS Value Pathways	CMS delayed the implementation of the MIPS Value Pathways (MVPs) framework. Despite this delay, the agency announced that it would continue to develop the MVP framework by proposing various updates designed to refine underlying principles.	**Lays out a timeline for implementation of MVPs.** CMS proposes to begin the transition to MVPs in the MIPS 2023 performance year.[48] The agency proposes to define MVP Participants in the 2023 and 2024 performance years as individual clinicians, multispecialty and single specialty groups, subgroups, and APM entities.[49] In CY 2025, the agency proposes to require multispecialty groups to form subgroups in order to report MVPs.[50] **Establishes a timeframe for MVP participant registration.** In order to report an MVP, CMS proposes that a participant must generally register for the MVP between April 1 and November 30 of the performance year.[51] Participants would not be able to change their MVP selection after the close of this registration period, nor would they be able to report on an MVP which they had not registered for.[52] The rule also includes a recommended June 30th registration deadline to report the CAHPS for the MIPS Survey associated with an MVP.[53]

		Proposes seven MVPs for the CY 2023 performance period.[54] These MVPs align with the following clinical topics: • Rheumatology • Stroke Care and Prevention • Heart Disease • Chronic Disease Management • Emergency Medicine • Lower Extremity Joint Repair • Anesthesia **Proposes new requirements for third party intermediaries.** CMS proposes to require third party intermediaries (such as Qualified Clinical Data Registries (QCDRs), Qualified Registries, and Health IT vendors) to support MVPs relevant to the specialties they support, as well as subgroup reporting, beginning in CY 2023. The agency also proposes to require that, beginning in performance year 2023, CAHPS for MIPS survey vendors support subgroup reporting as well as MVPs that are relevant to the CAHPS for MIPS measure.[55] **Requests comment regarding the sunsetting of traditional MIPS after performance year 2027.** The agency requests comment on a future proposal to sunset traditional MIPS and notes that it is not proposing a timeframe in which to make MVP reporting mandatory.[56]
Other Notable MIPS Policies		
Other Notable MIPS Policies	While CMS had proposed to reduce the 2021 performance period threshold to 50 points (in light of the COVID-19 PHE) from the 60 points previously finalized, the agency decided to adhere to the 60 point threshold.[57] CMS declined to finalize its proposal to revisit and potentially revise its performance threshold estimate for CY 2022.	**Expands the definition of MIPS eligible clinician.** The proposed definition would expand to include clinical social workers and certified nurse midwives.[61] **Proposes performance threshold of 75 points for the 2023 MIPS payment year**.[62] **The additional performance threshold for exceptional performance**

	As a result, the performance threshold estimate for CY 2022 remained at 74.01 points.[58] The agency also retained the previously finalized additional performance threshold of 85 points.[59] CMS expanded the use of the APM Entity submitter type and ended the APM Scoring Standard.[60] The agency also finalized proposals for new factors aimed at improving partnerships with third party intermediaries. These include Qualified Clinical Data Registries (QCDRs) and Qualified Registries, among others. CMS finalized a variety of ways to compensate for the challenges providers and entities are facing as a result of the COVID-19 crisis. These include an increase to the complex patient bonus as well.	**would increase to 89 points**.[63] **Continues to double the complex patient bonus for CY 2021**. In light of continued strain caused by the COVID-19 PHE, CMS has proposed to continue doubling the complex patient bonus for MIPS performance year 2021. The complex patient bonus would be **capped at 10 points**.[64] **Proposes changes to the complex patient bonus formula as well as other scoring measures to move out of the transitional phase of MIPS.** CMS proposes to make the complex patient bonus formula more stringent and incorporate social complexity factors. The agency also proposes to end measure bonus points for end-to-end electronic reporting and high-priority measure bonus points. This change, along with the removal of the 3-point floor for scoring measures (with some exceptions for small practices), is intended to simplify the scoring standard and move out of the transitional phase of MIPS.[65]
Advanced APMs & MIPS APMs		
Clinicians who receive a sufficient proportion of their Medicare revenue or Medicare patients through an "Advanced APM" are exempted from MIPS and receive an APM incentive payment in lieu of a MIPS payment adjustment. Through CY 2023, qualifying Advanced APM participants (QPs) are awarded a 5% bonus on their Medicare reimbursement for Part B professional services, and thereafter an increased annual update. The bonus does not apply to payment for separately billed items, such as Part B drugs.		
	The agency corrected attribution issues for APMs so that Medicare patients who have been prospectively attributed to an APM Entity would not be attribution-eligible for other Advanced APM participating APM Entities if that is not intended. CMS made this change to correct an issue with the calculation in which CMS was including attribution-eligible beneficiaries in the	**Adding a Taxpayer Identification Number (TIN) identification step to the QP Incentive Payment Process.** In CY 2021, the agency finalized a hierarchy to identify potential payee TINs when a Qualifying APM Participant's (QP) TIN is no longer active. In light of the success of this process, the agency proposes to add such a step to the current approach used to process the QP Incentive Payment. The agency notes that this would help to streamline the process and allow the agency to make payments to more QPs in the first round of payments.[70]

	denominator for APM Entities despite policies to not include these individuals in the numerator.[66] CMS also implemented a review process for certain circumstances relating to QP determinations. This process allows clinicians to alert CMS to potential errors, and if the agency determines that an error was made, allow for adjustment to the "most favorable QP status" at the APM Entity level.[67] The agency also prohibited further review of its QP determinations after the allowed time for review has ended. The agency determined it would not reconsider Advanced APM determinations for those APMs that had been evaluated and approved for CY 2020 even if those APMs make changes to their governing documents that would normally result in their failure to meet the Advanced APM criteria.[68] Nor would the agency revoke the QP status of eligible clinician participants as a result of changes to an APM's governing documents that would normally constitute a termination.[69]	**Clarifying that MIPS APM participants are not required to register as subgroups to report the APP.** Because the agency already identifies MIPS eligible clinicians who participate in MIPS APM by the Participation Lists for each APM, CMS noted that it was unnecessary to require these participants to register as a subgroup to report the APP.[71] **Extending the CMS Web Interface.** CMS has proposed to extend the availability of the CMS Web Interface as a quality reporting option for registered groups and virtual groups for the 2022 performance period.[72] For performance year 2022, ACOs would either report 3 eCQMs/MIPS CQMs or 10 CMS Web Interface measures. For performance year 2023, ACOs would be required to report either 10 CMS Web Interface measures as well as at least one eCQM/MIPS CQM measure or to report the 3 eCQMs/MIPS CQMs.[73] Notably, three CMS Web Interface measures, Quality IDs 438, 370, and 236, do not have benchmarks for 2022 and will not be scored as a result.[74] These measures must still be reported, however, to complete the CMS Web Interface dataset.[75] **RFIs focusing on equity**. CMS requests information relating to data collection as well as the revision of various CMS programs to improve reporting of "health disparities based on social risk factors, race and ethnicity more comprehensive and actionable for clinicians."[76] This is part of a wider initiative the agency is undertaking to improve health equity. CMS is also seeking comments with respect to other possible efforts it might undertake within the MIPS program to further bridge the equity gap.

* Weights of performance category specified in statute for CY 2022 and future years.

Commenting on the Proposed Rule

- The deadline for submitting comments is **5:00 p.m. EDT on September 13, 2021.** Commenters must refer to file code CMS-1751-P when commenting on the Proposed Rule. Interested stakeholders can submit comments electronically by visiting Regulations.gov. Alternatively, comments can be submitted by mail to the following addresses:

Regular Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Express or Overnight Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

[1] Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, Proposed Rule, Unpublished, *available at* https://www.federalregister.gov/public-inspection/2021-14973/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part [hereinafter "Proposed Rule"].

[2] The Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (2015) [hereinafter "MACRA"].

[3] *Id*. at § 101(a)(2)(C).

[4] *Id*. at § 101(c)(1).

[5] Bipartisan Budget Act, § 51003(a)(1), Pub. L. No. 115-123 (2018) [hereinafter "BBA"].

[6] *Id*. at § 51003(a)(1)(A).

[7] Proposed Rule at 39457; 39553.

[8] *Id*. at 39455.

[9] *Id.* at 39548.

[10] *Id*. at 38549, tbl. 129.

[11] *Id*. at 39555, tbl. 131.

[12] CMS, Quality Payment Program Participation in 2019: Results At-A-Glance, *available at* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1190/QPP%202019%20Participation%20Results%20Infographic.pdf.

[13] 85 Fed. Reg. 50,074, 50,276.

[14] Proposed Rule at 1243–44.

[15] *Id.* at 39,553.

[16] *Id*.

[17] 85 Fed. Reg. 84,472, 84,843 (Dec. 28, 2020) [hereinafter "CY 2021 Final Rule"].

[18] 85 Fed. Reg. 19,230 (April 6, 2020); 85 Fed. Reg. 27,550 (May 8, 2020).

[19] 85 Fed. Reg. 50,294.

[20] *Id.* at 39,448.

[21] CMS, Calendar Year (CY) 2022 Physician Fee Schedule Notice of Proposed Rule Making: Quality Payment Program (QPP) Proposals Overview, *available at* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1517/2022%20QPP%20Proposed%20Rule%20Overview%20Fact%20Sheet.pdf [hereinafter "CY 2022 Fact Sheet"].

[22] CMS, Changes to QPP Policies Proposed in the CY 2022 Physician Fee Schedule (PFS) Notice of Proposed Rulemaking (NPRM), *available at* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1514/2022%20QPP%20Proposed%20Rule%20Resources.zip.

[23] CY 2021 Final Rule at 84,903.

[24] *Id.* at 85,045–369.

[25] 85 FR 50074, 50306 (Aug. 17, 2020) [hereinafter "CY 2021 Proposed Rule"].

[26] CY 2021 Final Rule at 84,899.

[27] *Id.*

[28] *Id.* at 84,862.

[29] CY 2022 Fact Sheet at 12.

[30] Proposed Rule at 39,338.

[31] *Id.* at 39392.

[32] *Id.* at 39437.

[33] CY 2021 Final Rule at 84,882.

[34] *Id.*

[35] *Id.*

[36] *Id.* at 84,884–85.

[37] Proposed Rule at 39,408.

[38] CY 2022 Fact Sheet at 13.

[39] *Id.*

[40] Proposed Rule at 39857–58, Appendix A.

[41] *Id.* at 39406–07.

[42] Final Rule at 84,888 –93.

[43] Proposed Rule at 39411; CY 2022 Fact Sheet at 13.

[44] CY 2022 Fact Sheet at 13.

[45] *Id.*

[46] Proposed Rule at 39,413.

[47] *Id.* at 39414.

[48] *Id.* at 39,355–56.

[49] *Id.* at 39,355.

[50] *Id.*

[51] *Id.* at 39,374.

[52] CY 2022 Fact Sheet at 5.

[53] *Id.*

[54] Proposed Rule at 39,370; see also Appendix 3.

[55] CY 2022 Fact Sheet at 6.

[56] Proposed Rule at 39,356; CY 2022 Fact Sheet at 4.

[57] CY 2021 Final Rule at 84,920–23.

[58] *Id.* at 84,920, tbl. 55.

[59] CY 2021 Proposed Rule at 50,388.

[60] Quality Payment Program Fact Sheet, *2021 Quality Payment Program Final Rule Overview Fact Sheet* at 4, *available at* https://qpp.cms.gov/about/resource-library.

[61] CY 2022 Fact Sheet at 10.

[62] Proposed Rule at 39,339.

[63] *Id.*

[64] *Id.* at 39440.

[65] *Id.* at 39437.

[66] CY 2021 Final Rule at 84,952–53.

[67] *Id*.

[68] *Id.* at 50,335.

[69] *Id*.

[70] CY 2022 Fact Sheet at 14.

[71] Proposed Rule at 39,358.

[72] CY 2022 Fact Sheet at 15.

[73] *Id.*

[74] Proposed Rule at 39,267.

[75] *Id.*

[76] CY 2022 Fact Sheet at 2.