Changes to QPP Policies as Finalized in the CY 2022 Physician Fee Schedule (PFS) Final Rule

Merit-based Incentive Payment System (MIPS)

Policy Area	Existing Policy	CY 2022 Finalized Policies
Participation Pathways		
MIPS Value Pathways (MVPs)	N/A	We refer you to the **MVP Policies Table** in the CY 2022 PFS Final Rule QPP Resources (ZIP) for information about the finalized policies for MVPs.
APM Performance Pathway (APP)	MIPS APM participants can report the APP as an individual, a group, or APM Entity.	We've added 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 requiring ACOs to transition to reporting quality data via the new eCQM/MIPS CQM collection type.	The **CMS Web Interface** will be a reporting option for Shared Savings Program ACOs reporting via the APP in performance years 2022, 2023 and 2024. Beginning with the 2025 performance year, Shared Savings Program ACOs will be required to report the 3 electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs).

Policy Area	Existing Policy	CY 2022 Finalized Policies
Shared Savings Program Quality Performance Standard	**For performance year 2022**: Shared Savings Program ACOs are required to report on the 3 eCQMs/ MIPS CQM measures and field the CAHPS for MIPS surveys. CMS will calculate the 2 administrative claims-based measures. An ACO that achieves a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores will share in savings and avoid owing the maximum amount of shared losses, if applicable. **For performance year 2023 and subsequent years**: Shared Savings Program ACOs are required to report on the 3 eCQMs/ MIPS CQM measures and field the CAHPS for MIPS surveys. CMS will calculate the 2 claims-based measures. An ACO that achieves a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores will share in savings and avoid owing the maximum amount of shared losses, if applicable.	An ACO will meet the quality performance standard used to determine shared savings and losses if they: **For the 2022 and 2023 performance years:** • Achieves a quality performance score equivalent to or higher than the 30th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring; **or** • Reports the 3 eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements) **and** achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set **and** achieves a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least 1 of the 5 remaining measures in the APP measure set **For the 2024 performance year and subsequent performance years:** • Achieves a quality performance score equivalent to or higher than the 40th percentile across all MIPS

Policy Area	Existing Policy	CY 2022 Finalized Policies
		quality performance category scores, excluding entities/providers eligible for facility-based scoring
MIPS Eligibility		
MIPS Eligible Clinician Types	**The following clinician types are eligible for MIPS:** • Physicians ○ 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	We're **adding** the following MIPS eligible clinician types to the definition of a MIPS eligible clinician beginning with the 2022 performance year: • 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*** • 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%	**<u>We are statutorily required to weight the cost and quality performance categories equally beginning with Performance Year (PY) 2022:</u>** **Traditional MIPS: Individuals, Groups, Virtual Groups** • Quality: **30%** • Cost: **30%** • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change) **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% **Note:** The APP has different scoring weights to APM Entities participating in traditional MIPS.

Quality Performance Category Collection Types	**Available Collection Types for Groups, Virtual Groups and APM Entities Reporting Traditional MIPS 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 traditional MIPS beginning with the 2022 performance period.	**Available Collection Types for Groups, Virtual Groups and APM Entities Reporting <u>Traditional MIPS</u> for the 2022 Performance Period:** • Electronic Clinical Quality Measures (eCQMs) • Medicare Part B Claims Measures (small practices only) • MIPS Clinical Quality Measures (MIPS CQMs) • QCDR Measures • **CMS Web Interface Measures** We're **extending 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 year.
Quality Measures	There are 209 quality measures available for the 2021 performance period.	There are a total of 200 quality measures available for the 2022 performance period, which reflect: • Substantive changes to 87 existing MIPS quality measures ○ 9 of these measures won't be eligible for a historical benchmark due to the extent of changes to the specification. • Changes to specialty sets. • Removal of measures from specific specialty sets. • Removal of 13 quality measures. • Addition of 4 quality measures, including 1 new administrative claims measure.

		The following administrative claims measure will be added beginning with the 2022 performance period:
		• Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
		  • 18-case minimum
		  • 1-year performance period (January 1 – December 31
		  • Applies to MIPS eligible groups with at least 16 clinicians
		
		We **didn't** finalize the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System measure, which was proposed for the 2022 performance year.

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.	After analyzing the available data, we determined there was no need to use performance benchmarks exclusively or to use a different baseline period (such as CY 2019) to create historical benchmarks. We'll create historical benchmarks for the 2022 performance period, using data submitted for the 2020 performance period.
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	We're maintaining the current data completeness threshold at 70% for the 2022 **and 2023** performance periods.

	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.	To meet data completeness criteria for the 2022 **and 2023** performance periods, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the denominator eligible encounters as outlined in the specification. • MIPS CQM, eCQM, and QCDR measure specifications include all encounters, regardless of payer. • Only Medicare Part B claims measure specifications are limited to Medicare Part B encounters.
Quality Measure Scoring	Quality measure scoring policies:	Quality measure scoring policies:
	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** • **Beginning in PY 2022:** New quality measures ("class 4 measures") that meet data completeness criteria will have a 7-point scoring floor for their first year in the program, and a 5-point scoring floor for their second year in the program • • For example: ○ A new measure available beginning with the 2022 performance period will earn 7-10 points in PY 2022 if a performance period benchmark can be created, and data completeness and case minimum criteria were met.

		▪ The measure will earn 5 -10 points in PY 2023 if a performance period benchmark can be created, and data completeness and case minimum criteria were met. ○ When the data completeness criteria is met, the measure will earn 7 points in PY 2022 if no performance period benchmark can be created or the measure doesn't meet case minimum. ▪ When the data completeness criteria is met, the measure will earn 5 points in PY 2023 if no performance period benchmark can be created or the measure doesn't meet case minimum. ○ The measure will earn zero points in PY 2022 and PY 2023 if data completeness isn't met. ▪ Small practices will continue to earn 3 points. ▪ • Please note that this policy applies to QCDR measures, including those introduced in PY 2021; QCDR measures (that meet data completeness) in their second year in the program are subject to the 5-point scoring floor in PY 2022. • This policy doesn't apply to administrative claims measures.

	Measures that can be reliably scored against a benchmark • There is a 3-point floor for measures that can be reliably scored against a benchmark (meet case minimum and data completeness).	**Measures that can be reliably scored against a benchmark** • No change for PY 2022; we'll retain the 3-point floor for measures that can be reliably scored against a benchmark (meet case minimum and data completeness). **Beginning in PY 2023:** • **We're removing the 3-point floor** for measures that can be reliably scored against a benchmark (meet case minimum and data completeness). ○ These measures will receive 1-10 points. **Note:** This policy doesn't apply to new measures in the first 2 performance periods available for reporting.
	Measures without a benchmark • Measures without a benchmark (historical or performance period) will earn 3 points if data completeness criteria is met.	**Measures without a benchmark** • **No change for PY 2022;** measures without a benchmark (historical or performance period) will earn 3 points if data completeness criteria is met. **Beginning in PY 2023:** • **We're removing the 3-point floor** for measures without a benchmark (except small practices), even when data completeness and case minimum criteria are met. ○ These measures will receive 0 points.

		○ Small practices would continue to earn 3 points. **Note:** This policy won'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** • **No change for PY 2022;** measures that don't meet case minimum will earn 3 points. **Beginning in PY 2023:** • **We're removing the 3-point floor** for measures that don't meet case minimum (except small practices) ○ These measures will earn 0 points. ○ Small practices will continue to earn 3 points. **Note:** This policy doesn't apply to new measures in the first 2 performance periods available for reporting or to administrative claims measures. Measures calculated from administrative claims are excluded from scoring if the case minimum is not met.
	Outcome and 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	**Outcome and High-Priority Bonus Points** • **Beginning with PY 2022,** there are **no bonus points** for reporting additional outcome and high priority measures, beyond the one required.

	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** • **Beginning with PY 2022,** there are **no 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've expanded the list of reasons that a quality measure may be impacted during the performance period to include errors included in the finalized measure specifications. 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. These errors are in addition to the previously finalized changes that include updates to clinical guidelines or

	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.	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'll continue with our existing policies of: • Truncating the performance period to 9 consecutive months if there were no concerns with potential patient harm and 9 consecutive months of data are available. • Suppressing 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, beginning with the 2022 performance year, we'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits 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're adding **5 newly developed episode- based cost measures** into the MIPS cost performance category beginning with the 2022 performance period. • 2 procedural measures:

		○ Melanoma Resection ○ Colon and Rectal Resection • 1 acute inpatient measure: ○ Sepsis • 2 chronic condition measures: ○ Diabetes ○ Asthma/Chronic Obstructive Pulmonary Disease [COPD]
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're adding a process of cost measure development by stakeholders, including a call for cost measures, beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period.
Improvement Activities Performance Category	**Removal of Activities** • There is no existing policy to remove activities outside of the rulemaking process.	**Removal of Activities** • In the case of an improvement activity for which there is a reason to believe that the continued collection raises possible patient safety concerns or is obsolete, we'll 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.
	Criteria for Nominating a New Improvement Activity • Relevance to an existing improvement activities subcategory (or a proposed new subcategory).	**Criteria for Nominating a New Improvement Activity**

	• 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. • Include a public health emergency as determined by the Secretary. • CMS is able to validate the activity.	New improvement activities must at minimum meet all of the following 8 criteria, consisting of: 1. Improvement activities shouldn't duplicate other improvement activities in the Inventory. **(NEW)** 2. Improvement activities should drive improvements that go beyond standard clinical practices. **(NEW)** 3. Relevance to an existing improvement activities subcategory (or a proposed new subcategory). 4. Importance of an activity toward achieving improved beneficiary health outcomes. 5. 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. 6. Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes. 7. Can be linked to existing and related MIPS quality, Promoting Interoperability, and cost measures, as applicable and feasible. 8. CMS is able to validate the activity. We may also consider the following 6 optional factors when reviewing 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 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 adding 7 new improvement activities, 3 of which are related to promoting health equity. • We're modifying 15 current improvement activities, 11 of which address health equity. • We're removing 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	**Reweighting** In addition to the existing special statuses/clinician types, we'll **apply automatic reweighting** to the following, beginning with the 2022 performance period: • Clinical social workers • Small practices No automatic reweighting for certified nurse-midwives.

	• 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 **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're modifying the reporting requirements for this objective and **requiring MIPS eligible clinicians to report the following 2 measures** (unless an exclusion can be claimed): • Immunization Registry Reporting • Electronic Case Reporting

		We believe this modification will support public health agencies (PHAs) in future health threats and a long-term COVID-19 recovery. Beginning with the 2022 performance period, the following measures are optional; clinicians, groups and virtual groups that report a "yes" response for any of these measures will earn 5 bonus points: • Public Health Registry Reporting measure • Clinical Data Registry Reporting measure • Syndromic Surveillance Reporting measure **Note:** Reporting more than one of these optional measures **won't** result in more than 5 bonus points.
	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 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	**Measures** • **Provide Patients Electronic Access to their Health Information Measure** ○ We **didn't finalize** our 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. • **Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)** ○ **New required measure**

	of the Application Programming Interface (API) in the MIPS eligible clinician's CEHRT.
	
	• **Electronic Case Reporting**
	  ○ There are 3 exclusions for this measure:
	  ▪ Doesn't treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period.
	  ▪ Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period.
	  ▪ Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.
		○ MIPS eligible clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides).
		
		• **Electronic Case Reporting**
		  ○ We're adding a 4th exclusion (in addition to the existing exclusion criteria) for PY 2022 only:
		  ▪ Uses certified electronic health record technology (CEHRT) that isn't certified to the electronic case reporting certification criterion at 45 CFR 170.315(f)(5) prior to the start of the performance period they select in CY 2022.

	Attestations
	
	• In addition to reporting the required measures, MIPS eligible clinicians must also submit:
	  ○ Prevention of Information Blocking attestation
	  ○ ONC Direct Review attestation
		Attestations
		
		• We've renamed the Prevention of Information Blocking attestation and modified the attestation statements. The attestation is now called the **Actions to Limit or**

		Restrict Compatibility or Interoperability of CEHRT attestation and consists of a single statement.
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: 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.	Because of the concerns of the direct and indirect effects of the COVID-19 PHE, we'll **continue to double the complex patient bonus available for the 2021 MIPS performance year/2023 MIPS payment year**. These bonus points (capped at 10-points) would be added to the final score. We've revised the complex patient bonus beginning with the 2022 MIPS performance year/2024 MIPS payment year by: • **Limiting the bonus** to clinicians who have a median or higher value for at least 1 of the 2 risk indicators (Hierarchical Condition Category score and proportion of patients dually eligible for Medicare and Medicaid benefits). • **Updating the formula** to standardize the distribution of 2 two risk indicators so that the policy can target clinicians who have a higher share of socially and/or medically complex patients. • **Increasing the bonus** to a maximum of 10.0 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.

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.	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'll calculate 2 final scores for clinicians and groups who are facility-based: • One score will be based on the performance and weights of the performance categories if facility-based measurement didn't apply. • The other score will 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're finalizing the following performance category reweighting and redistribution policies for small practices to put more emphasis on the improvement activities performance category:
		• When the Promoting Interoperability performance category is reweighted:
		  ○ The quality performance category will be weighted at 40%.
		  ○ The cost performance category will be weighted at 30%.

		○ The improvement activities performance category will be weighted at 30%. • When both the cost and the Promoting Interoperability performance categories are reweighted: ○ The quality performance category will be weighted at 50%. ○ The improvement activities performance category will be weighted at 50%. Under our existing policies, when both quality and the Promoting Interoperability performance categories are reweighted, the cost and improvement activities performance categories will be equally weighted at 50%. (**Note**: This policy applies regardless of small practice status.)
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%**. • 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%.	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. • We're using the **mean final score from the 2017 performance year/2019 MIPS payment year** to establish the performance threshold. • For the 2022 performance year (2024 payment year) ○ The performance threshold is set at **75 points**. ○ An additional performance threshold is set at **89 points** for exceptional performance.

		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.

Advanced Alternative Payment Models (APMs) Overview

Policy Area	Existing Policy	Finalized Policies
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 Taxpayer Identification Numbers (TINs) using base year claims, in the event that the Qualifying APM Participant's (QP) original TIN is no longer active and associated with the QP. This process has improved our ability to make more payments to TINs with which QPs have valid, up-to-date affiliations. In this year's rule we're finalizing a policy to extend the hierarchy to include billing TINs that are active only during the payment year. Because such TINs are active within the same year payments are to be made, adding this step to the processing hierarchy will make it easier for us to complete payments to more QPs in our first round of QP Incentive Payments. We're finalizing our proposal to add this step to the current regulatory hierarchy for processing the QP Incentive Payment. This will enable us to look for payee TINs that are active in the base year or the payment year for each step of the hierarchy.

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** Care Compare will display affiliations with 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
	N/A	**MVPs and Subgroup Performance** We're delaying public reporting of new improvement activities and Promoting Interoperability measures and attestations reported via MVP by one year (beginning with the 2024 performance year). We'll publicly report subgroup-level performance information beginning with the 2024 performance year on the compare tool hosted by CMS.

Policy Area	Existing Policy	CY 2022 Proposed
		Subgroup performance information will be publicly reported separately from individual clinician and group performance information.

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
3/11/2022	Updated name of the Prevention of Information Blocking Attestation Clarified quality scoring policies for new measures in their first and second year in the program
11/2/2021	Original posting