Quality Payment PROGRAM

Calendar Year (CY) 2022 Physician Fee Schedule Final Rule: Quality Payment Program (QPP) Policies Overview

Future Direction of the Quality Payment Program (QPP)

The Quality Payment Program (QPP) policies finalized in the CY2022 Physician Fee Schedule (PFS) Final Rule will continue moving the program forward, toward more meaningful participation for clinicians and improved outcomes for patients. We're also looking for ways to leverage this program to advance health equity and address social determinants of health. The MIPS Value Pathways (MVPs) and the Alternative Payment Model (APM) Performance Pathway (APP) will be key program changes that support our efforts to move the needle forward on value.

In 2022, we're implementing certain statutory requirements, including setting the performance threshold at either the mean or median of the final scores for all Merit-based Incentive Payment System (MIPS) eligible clinicians for a prior period. As a result, we anticipate clinicians will start to see greater returns on their investment in the program. Additionally, changes from the rule will result in a more equitable distribution within our scoring system, with small practices no longer bearing the greatest share of the negative payment adjustments.

MIPS aims to drive value through the collection, assessment, and public reporting of data that informs and rewards the delivery of high-value care. Within MIPS, we intend to pay for healthcare services in a way that drives value by linking performance on cost, quality, and the patients' experiences of care. We've heard from clinicians that traditional MIPS requirements are confusing as well as burdensome. Additionally, it's difficult to choose measures that are meaningful to how

they practice and directly benefit patients from the several hundred MIPS and qualified clinical data registry (QCDR) quality measures.

We've also heard concerns from stakeholders that MIPS doesn't allow for sufficient differentiation of performance across practices, due in part to clinician quality measure selection bias. These aspects detract from the program's ability to effectively measure and compare performance across clinician types, provide meaningful feedback, and incentivize quality. To address this and simplify the MIPS clinician experience, improve value, reduce burden, and better inform patient choice in selecting clinicians, we intend to focus the future of MIPS on development and implementation of MVPs.

In the CY 2022 PFS Final Rule, we've finalized 7 MVPs along with policies that support implementation beginning in the 2023 performance year. We believe this delayed timeframe will provide clinicians the time needed to understand MVP requirements and plan for any operational considerations.

Quality Payment Program CY 2022 Overview

To help us progress toward the future state of MIPS, we focused the majority of our policies on MVPs. With the balance, we aim to reduce burden, respond to feedback that we have heard from clinicians and stakeholders, and align with statutory requirements.

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This section provides a highlight of our finalized policies on these topics.

For more details, refer to the QPP Proposals Comparison Table, MVP Guide, and MVP Proposals Table in the CY 2022 PFS Final Rule Resources (ZIP).

MIPS Value Pathways (MVPs)

MVPs allow for a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to a specialty, medical condition, or episode of care. The MVPs include the Promoting Interoperability performance category and population health claims-based measures as foundational elements, along with relevant measures and activities for the quality, cost, and improvement activities performance categories. The MVP framework aims to provide meaningful data and feedback to clinicians and patients by comparing the performance of like clinicians who report on the same MVP and enhancing information provided to patients through public reporting.

In the CY 2021 PFS Final Rule, we established a set of criteria for use in the development and selection of MVPs. Specifically, we finalized that we aren't prescriptive on the number of quality measures that are included in an MVP. In the CY 2022 PFS Final Rule, we finalized the reporting requirements for MVPs and discussed the allowance of clinician choice in selecting which quality measures and improvement activities to report. We believe that it's important to provide clarity in our expectations on the number of quality measures and improvement activities that are available for an MVP Participant to choose.

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

- MVPs must include at least one outcome measure that's relevant to the MVP topic, so MVP Participants are measured on outcomes that are meaningful to the care they provide.
- Each MVP that's applicable to more than one clinician specialty should include at least one outcome measure that's relevant to each clinician specialty included.
- In instances when outcome measures aren't available, each MVP must include at least one high-priority measure that's relevant to the MVP topic, so MVP Participants are measured on high-priority measures that are meaningful to the care they provide.
- Each MVP that is applicable to more than one clinician specialty must include at least one high priority measure that is relevant to each clinician specialty included, if an outcome measure is not available.
- Allow the inclusion of outcomes-based administrative claims measures within the quality component of an MVP.
- To be included in an MVP, a qualified clinical data registry (QCDR) measure must be fully tested at the clinician level.
- In order to determine whether a QCDR measure may be finalized within an MVP, we will need to receive QCDR measure testing data for review by the end of the self-nomination period, that is no later than September 1 of the year prior to the applicable performance period.

To the extent feasible, we encourage QCDRs to share testing data for their fully tested QCDR measures at the time of MVP candidate submission which may be prior to the September 1st deadline.

Timeline

To provide clinicians and third party intermediaries with sufficient time to prepare for a shift to this new participation framework, we'll begin transitioning to MVPs in the 2023 MIPS performance year. Our intent is to provide practices, health care organizations, and third party intermediaries with the time they need to review requirements, update workflows, and prepare their systems as needed to report MVPs.

For the 2023, 2024, and 2025 performance years, MVP Participants are identified as individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM entities that are assessed on an MVP for all MIPS performance categories. Beginning in the 2026 performance year, multispecialty groups will be required to form subgroups in order to report MVPs.

We recognize that there are many types of MVPs we need to develop, and that the traditional MIPS framework is needed until we have a sufficient number of MVPs available. Through the MVP development work, we'll gradually implement MVPs for more specialties and subspecialties that participate in the program. We understand that the transition to MVPs will take time and we'll continue to evaluate the readiness of clinicians in making this transition, while balancing our strong interest in improving measurement, making MIPS more focused on value, and providing relevant, more granular data to patients to help them choose a clinician.

MVP Registration (Participant and Subgroup)

To report an MVP, an MVP Participant and subgroup must register for the MVP between April 1 and November 30 of the performance year, or a later date as specified by CMS. To report the Consumer Assessment of Healthcare Providers and Systems (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 Survey registration deadline.

At the time of MVP registration, an MVP Participant would 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 **won't** 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).
- Allowed to report on an MVP for which they didn't register.

To participate as a subgroup, each subgroup will 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 Taxpayer Identification Number (TIN) / National Provider Identifier (NPI).
- Provide a plain language name for the subgroup for purposes of public reporting.

Upon successful registration submission, we'll assign a unique subgroup identifier that will be separate from the individual NPI identifier, the group TIN identifier, and the MVP identifier.

Appendix A provides an overview of MVP reporting requirements, Appendix B provides an overview of the registration timeline, and Appendix C presents a crosswalk of the various clinician types, the information expected at the time of registration, and a reminder of the MVP reporting requirements.

Third Party Intermediary Support

For third party intermediaries, we'll:

- Require that QCDRs, Qualified Registries, and Health IT vendors support:
    - MVPs relevant to the specialties they support, beginning with the 2023 performance year.
    - Subgroup reporting, beginning with the 2023 performance year.
- Require that CAHPS for MIPS Survey vendors support subgroup reporting for the CAHPS for MIPS measure associated with an MVP, beginning with the 2023 performance year.

Finalized MVPs

We finalized 7 MVPs that will be available, beginning with the 2023 performance year. Each MVP includes complementary measures and activities and supports patient-centered care and a continued emphasis on the importance of patient outcomes, population health, health equity (including measures and activities that assess health disparities and socioeconomic factors), interoperability, and reduced reporting burden for clinicians.

The 7 MVPs for the 2023 performance year are the following:

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 (finalized with modification)
6. Improving Care for Lower Extremity Joint Repair (finalized with modification)
7. Support of Positive Experiences with Anesthesia (finalized with modification)

Reporting Requirements

MVP reporting requirements for all MVP Participants (individual eligible clinicians, groups, subgroups, and APM Entities) include:

- **Quality Performance Category**
  - MVP Participants will select 4 quality measures available. One measure must be an outcome measure (or a high-priority measure if an outcome measure isn't 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 will select 2 medium-weighted improvement activities **OR** one high-weighted improvement activity **OR** IA_PCMH (participation in a patient-centered medical home (PCMH)), if the activity is available in the MVP.

- **Cost Performance Category**
  - MVP Participants will be calculated on the cost measures included in the MVP.

- **Foundational Layer (MVP agnostic)**
  - Population Health Measures
    - MVP Participants will select, at the time of MVP Participant registration, one population health measure to be calculated on. The results will be

added to the quality score. For the 2023 performance year, we anticipate 2 population health measures will be available for selection.

- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups (finalized in CY 2021 Final Rule)
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (finalized)

- Promoting Interoperability Performance Category
  - MVP Participants will report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualify for reweighting of the Promoting Interoperability performance category due to clinician type, special status, or an approved Promoting Interoperability Hardship Exception Application.
  - **Note: Subgroups will submit Promoting Interoperability data at the group level, not the subgroup level.**

Subgroups

We've heard from patients, clinicians, and other stakeholders that they would like more comprehensive and granular reporting from the MIPS program. To that end, we're establishing subgroup reporting to provide patients and clinicians with information that's clinically meaningful at a more granular level. To support clinicians in their transition to subgroup reporting, subgroup reporting will be voluntary for the 2023, 2024, and 2025 performance years.

Subgroups are defined 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."

Subgroups will inherit the eligibility and special status determinations of the affiliated group (identified by TIN). To participate as a subgroup, the TIN will have to exceed the low-volume threshold at the group level, and the subgroup will inherit any special statuses held by the group, even if the subgroup composition doesn't meet the criteria.

We'll limit subgroup reporting only to clinicians reporting through MVPs or the APP. Voluntary reporters, opt-in eligible clinicians, and virtual groups won't be able to report through an MVP for the 2023 performance year, due to implementation challenges.

Scoring

MVP scoring policies generally will align with those used in traditional MIPS across all performance categories, with a few exceptions noted below. 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 we

won't reweight the quality performance category if we can't calculate a score for the MIPS eligible clinician because there isn't at least one quality measure applicable and available to the clinician.

The MVP scoring policies by performance category are listed below.

- **Quality Performance Category**
  - The following scoring policy changes were finalized for the quality performance category, which will also apply to MVPs.
    - Beginning with the 2023 performance period, remove the 3-point floor for quality scoring from traditional MIPS. Except as noted below, no 3-point floor will be available under MVPs.
      - Measures without a benchmark or that don't meet case minimum will earn zero points. (This includes outcome-based administrative claims measures, if available and selected by the MVP Participant.)
        - **Exception:** Small practices will continue to earn 3 points for these measures under traditional MIPS and MVPs.
      - Measures that can be reliably scored against a benchmark (meet case minimum and data completeness criteria) will earn 1-10 points.
    - Beginning with the 2022 performance period, we're introducing a new policy for scoring new measures without a benchmark:
      - In the first year in MIPS, there will be a 7-point scoring floor for new measures that meet data completeness criteria (they'll receive 7 to 10 points if they can be reliably scored against a benchmark),
      - In the second year in MIPS, there will be a 5-point scoring floor for new measures that meet data completeness criteria (they'll receive 5 to 10 points if they can be reliably scored against a benchmark).
    - Beginning with the 2022 performance period, there are no bonus points for reporting additional outcome and high- priority measures, beyond the one required.
    - Beginning with the 2022 performance period, there are no bonus points for measures that meet end-to-end electronic reporting criteria.
  - Similar to our quality scoring policies for traditional MIPS:
    - If an MVP Participant reported more than the required number of quality measures, we'll use the 4 highest scoring measures.

        - An MVP Participant will receive zero achievement points for the quality performance category for any required measures that weren't 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 doesn't have a benchmark or meet the case minimum.
            - **Note:** If an MVP Participant is unsure whether a selected outcomes-based administrative claims measure score is attainable, we encourage the selection and reporting of an additional outcome measure to decrease the likelihood that they receive a score of zero for an unreported outcome measure.
- **Improvement Activities Performance Category**
    - Assign 20 points for each medium-weighted improvement activity and 40 points for each high-weighted improvement activity for all MVP participants. (This scoring differs from traditional MIPS.)
- **Cost Performance Category**
    - Score only the cost measures included in the MVP.
- **Foundational Layer (MVP agnostic)**
    - The population health measures selected by MVP Participants will be included in the quality performance category score.
        - Similar to our policies for administrative claims measures in traditional MIPS, these measures will be excluded from scoring if the measure doesn't have a benchmark or meet the case minimum.
        - **Exception:** 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 doesn't have a benchmark or meet the case minimum.
    - Measures in the Promoting Interoperability performance category will be scored in alignment with traditional MIPS scoring policies. Subgroups will submit the Promoting Interoperability performance category data of their affiliated group.

Subgroup performance will be assessed at the:

- Subgroup level for 3 performance categories (quality, cost, and improvement activities).
- Group level for the Promoting Interoperability performance category.

Additionally, clinicians in a subgroup will continue to be included in group-level reporting if the practice also chooses to participate in traditional MIPS as a group.

Lastly, we finalized the update of the scoring hierarchy to include subgroups. This means that 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.

We believe that including subgroups in the scoring hierarchy will allow for meaningful data collection and assessment under MVPs, while applying our 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

To provide meaningful feedback to MVP Participants, we'll provide comparative performance feedback within the annual performance feedback to show the performance of like clinicians who report on the same MVP.

To give MIPS eligible clinicians time to familiarize themselves with MVPs and subgroup reporting, we'll delay public reporting of new improvement activities and Promoting Interoperability measures and attestations reported via MVPs by one year. We'll publicly report subgroup-level performance information, beginning with PY 2024, on the compare tool hosted by CMS.

We'll create a separate subgroup workflow that will allow subgroup performance information to be publicly reported in an online location that can be navigated to from an individual clinician or group profile page. This process aligns with the historical approach to report performance information at the level that it's submitted.

APM Performance Pathway (APP)

We'll allow MIPS eligible clinicians to report the APP as a subgroup, beginning with the 2023 performance year. The definition of a subgroup and eligibility to participate as a subgroup are the same for MVP and APP reporting.

- Subgroups will consist of "a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician's NPI."
- Subgroups will inherit the eligibility and special status determinations of the affiliated group (identified by TIN). To participate as a subgroup, the TIN will have to exceed the low-volume threshold at the group level, and the subgroup will inherit any special statuses held by the group, even if the subgroup composition won't meet the criteria.

We note that subgroups won't be required to register for reporting the APP.

Traditional MIPS Policies

MIPS Eligible Clinician Definition

We're revising the definition of a MIPS eligible clinician to include:

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

This update aligns with the APM eligible clinician definition and is responsive to stakeholder requests to be included in the program.

We believe that both the clinical social workers and certified nurse mid-wives will have an appropriate level of quality measures to report in performance year 2022, including an existing Clinical Social Worker Specialty Measure Set and a newly finalized Certified Nurse Midwife Specialty Measure Set. Improvement activities for both clinician types will be applicable and available.

- Note: We'll automatically reweight the Promoting Interoperability performance category to 0% for clinical social workers.

Performance Threshold

The Bipartisan Budget Act of 2018 requires a "gradual and incremental transition" for raising the performance threshold during the first 5 years of the MIPS program. The performance threshold must be the "mean or median of the composite performance scores for all MIPS eligible professionals" from a prior period beginning in Year 6, which is the 2022 performance year/2024 payment year.

We're establishing the performance threshold for the 2022 performance year/2024 payment year using the mean final score from the 2017 performance year/2019 MIPS payment year.

- **The performance threshold is set at 75 points.**
    - This is an increase of 15 points from the previous year, which is in line with prior year increases.

The statute requires that an additional performance threshold be set at (1) the 25th percentile of the range of possible final scores above the performance threshold or (2) the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold with respect to a prior period (Social Security Act § 1848(q)(6)(D)(ii)).

- **The additional performance threshold is set at 89 points.**
    - This is the 25th percentile of actual 2017 final scores above 75 points.

We note that under section 1848(q)(6)(C) of the Act, **the additional MIPS adjustment factors for exceptional performance are available through the 2022 performance year/2024 MIPS**

payment year, making this the last year of the additional performance threshold and the associated additional MIPS adjustment factors for exceptional performance.

Performance Category Weights

For the 2022 performance year/2024 payment year, the performance category weights are:

- 30% for the quality performance category.
- 30% for the cost performance category.
- 15% for the improvement activities performance category.
- 25% for the Promoting Interoperability performance category.

The performance category weights are specified in statute, and we codified them in prior rulemaking. As a result, they weren't proposals available for comment.

Performance Category Requirements

For the **quality performance category,** we're finalizing our proposals to:

- Update quality measure scoring to remove end-to-end electronic reporting and high priority/outcome measure bonus points, beginning with the 2022 performance period.
- Remove the 3-point floor for scoring measures (with some exceptions for small practices), **beginning with the 2023 performance period**.
    - These changes help us move away from the policies established for the transitional period of MIPS and toward a more simplified scoring standard focused on measure achievement.
    - There are also exceptions for new measures in their first and second year in the program.
- Extend the CMS Web Interface as a quality reporting option for registered groups, virtual groups, or other APM Entities for the 2022 performance period. (Please refer to the Medicare Shared Savings Program Policies section of this resource for information about CMS Web Interface reporting under the APP.)
- Update the quality measure inventory so that there will be a total of 200 quality measures available for the 2022 performance period.

We **didn't** finalize the following quality proposals:

- Use of performance period benchmarks, or a different baseline period, such as calendar year 2019, for scoring quality measures in the 2022 performance period.
    - Based on our analysis, we can create reliable historical benchmarks using 2020 performance period data.
- Increase in the data completeness requirement to 80%, beginning with the 2023 performance period.

- We're maintaining the 70% data completeness requirement in the 2023 performance period in response to stakeholder comments.

For the **cost performance category,** we're adding 5 new episode-based cost measures:

- 2 procedural measures
  - Melanoma Resection
  - Colon and Rectal Resection
- 1 acute inpatient measure
  - Sepsis
- 2 chronic condition measures
  - Diabetes
  - Asthma/Chronic Obstructive Pulmonary Disease [COPD]

The 5 new episode-based cost measures have the following case minimums (calculated using administrative claims data):

- Asthma/COPD: 20 episodes
- Colon and Rectal Resection: 20 episodes
- Diabetes: 20 episodes
- Melanoma Resection: 10 episodes
- Sepsis: 20 episodes

We're also establishing a new cost measure development process. Under the current measure development process, all cost measures are developed by CMS's measure development contractor. Under the new process, stakeholders can develop cost measures to expand the inventory of episode-based cost measures. As part of this process, we are adding a measure call for cost measures, beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period. Expanding the range of procedures and the acute and chronic conditions covered will enable more MIPS eligible clinicians from different specialties and subspecialties to have their cost performance assessed under clinically relevant episode-based measures.

Due to COVID-19, we couldn't reliably calculate the cost measure scores for the 2020 MIPS performance year/CY2022 payment year, so we've assigned a weight of 0% to the cost performance category. We sought comments on additional circumstances which may limit our ability to reliably calculate cost measure scores that adequately capture and reflect performance (such as those due to external factors beyond the control of MIPS clinicians and groups), and which may inform our decision to reweight the cost performance category to provide scoring flexibility in the future.

For the **improvement activities performance category**, we're updating the improvement activities inventory for the 2022 performance year by adding new improvement activities about health equity and standardizing language related to equity across the improvement activities 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.
    - These modifications allow the activities to focus more explicitly on addressing health equity and, in some cases, specifically add requirements to address racial equity.
- We're also removing 6 previously adopted improvement activities.

For the **Promoting Interoperability performance category**, we're:

- Applying automatic reweighting to clinical social workers and small practices.
- Revising reporting requirements in the following ways:
    - Revise reporting requirements for the Public Health and Clinical Data Exchange objective to support public health agencies (PHAs) during future health threats and the long-term COVID-19 recovery process.
    - Add a 4th exclusion for the Electronic Case Reporting measure, available for the 2022 performance period only.
    - Require MIPS eligible clinicians to attest to conducting an annual assessment of the High-Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides), beginning with the CY 2022 performance period.
    - Modify the Prevention of Information Blocking attestation statements to distinguish this from separate information blocking policies under the Office of the National Coordinator for Health Information Technology (ONC) requirements established in the 21st Century Cures Act Final Rule. In addition, we're updating the attestation name to the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation.

We didn't finalize our proposal to add a requirement in the Provide Patients Electronic Access to Their Health Information measure that patients have access to their health information indefinitely, for encounters on or after January 1, 2016.

Care Compare (Public Reporting)

We're adding affiliations with the following facility types on Care Compare individual clinician profile pages:

- Long-Term Care Hospitals
- Inpatient Rehabilitation Facilities

- Inpatient Psychiatric Facilities
- Skilled Nursing Facilities
- Home Health Agencies
- Hospice
- End-Stage Renal Disease (ESRD) Facilities

Advanced APM Policies

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.

Medicare Shared Savings Program Policies

In response to Accountable Care Organizations' (ACOs') concerns regarding the transition to reporting on eCQMs/MIPS CQMs, which require the submission of all-payer quality data, we're finalizing a longer transition for Shared Savings Program ACOs by extending the CMS Web Interface as a reporting option for 3 years through performance year 2024. ACOs will be required to report the 3 eCQMs/MIPS CQMs beginning in performance year 2025. Also, we're finalizing an additional one-year delay in the phase-in of the increase in the Shared Savings Program ACO quality performance standard that ACOs must meet to share in savings and avoid maximum losses (if applicable) and an additional incentive to encourage ACOs to report all-payer measures. These finalized policies, in addition to existing policies, provide 4 years for ACOs to transition to reporting the 3 eCQMs/MIPS CQMs under the APP and to meet the increased Shared Savings Program quality performance standard.

APP Reporting Options

For the 2022 to 2024 performance years:

- ACOs will be required to either report the 10 CMS Web Interface measures **or** the 3 eCQMs/MIPS CQMs.

- Under the APP, all ACOs are required to administer the CAHPS for MIPS Survey and be scored on 2 administrative claims-based measures (calculated by CMS).
- Based on the ACO's chosen reporting option (CMS Web Interface or the eCQMs/MIPS CQMs), either 6 (3 eCQM/MIPS CQMs, 1 CAHPS for MIPS Survey measure, and 2 administrative claims-based measures) or 10 measures (7 CMS Web Interface measures, 1 CAHPS for MIPS Survey measure, and 2 administrative claims-based measures) will be included in the calculation of the ACO's quality performance score.
- If an ACO chooses to report both the 10 CMS Web Interface measures and the 3 eCQMs/MIPS CQMs, it will receive the higher of the 2 quality scores for purposes of the MIPS quality performance category.
- For more information on the APP measure set that will be reported by Shared Savings Program ACOs for the 2022 and subsequent performance years, please refer to Table 25 in section III.J.c.(4) in the 2022 PFS Final Rule.

For the 2025 performance year and subsequent years:

- ACOs will be required to report the 3 eCQMs/MIPS CQMs and administer the CAHPS for MIPS Survey.
- CMS will calculate 2 measures using administrative claims data.
- All 6 measures will be included in the calculation of the ACO's quality performance score.

Calculating the Quality Performance Score

- Each ACO's MIPS quality performance category score will be calculated using the ACO's performance on the measures under the APP, any applicable MIPS bonus points, and quality improvement points.
- We'll use the MIPS quality performance category scores calculated under the APP for purposes of the Shared Savings Program, in determining shared savings and shared losses, thus satisfying the reporting requirements for both programs.
- ACOs that don't meet the quality performance standard aren't eligible to share in savings and will owe maximum losses, if applicable.

Quality Performance Standard

We're also delaying for an additional year the increase in the quality performance standard ACOs must meet in order to share in savings. We're maintaining the 30th percentile MIPS quality performance category score for the 2023 performance year, as well as providing an incentive for ACOs to report eCQMs/MIPS CQMs in the 2022 and 2023 performance years.

For the 2022 and 2023 performance years:

- An ACO **will** meet the quality performance standard used to determine shared savings and losses if the ACO:
    - 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 remaining 5 measures in the APP measure set. Consequently, the ACO would be required to meet the performance benchmark on either 2 outcome measures (one measure at the 10th percentile and the other at the 30th percentile) **or** 1 outcome measure at the 10th percentile and any other measure in the APP measure set at the 30th percentile.
- An ACO **won't** meet the quality performance standard if the ACO doesn't (1) report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey.

For the 2024 performance year and subsequent performance years:

- An ACO **will** meet the quality performance standard used to determine shared savings and losses if the ACO:
    - Achieves a quality performance score equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring.
- An ACO **won't** meet the quality performance standard if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey.

Contact Us

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

We encourage clinicians to contact the QPP at 1-866-288-8292, Monday through Friday, 8 a.m. - 8 p.m. ET, or by email at QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- 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

Appendix A: MVP Reporting Requirements

The table below provides an overview of the MVP reporting requirements.

Quality Performance Category*	Improvement Activities Performance Category*	Cost Performance Category
A MVP Participant selects 4 quality measures. • One must be an outcome measure (or a high-priority measure if an outcome measure isn't available or applicable). **Note:** As applicable, an outcome-based administrative claims measure may be selected at the time of MVP registration to meet the outcome measure requirement.	A MVP Participant selects: 2 medium weighted improvement activities **OR** 1 high-weighted improvement activity **OR** IA_PCMH (participation in a PCMH), if the activity is available in the MVP.	MVP Participants will be scored on the cost measures included in the MVP.
Foundational Layer (MVP Agnostic)		
Population Health Measures* A MVP Participant selects one population health measure, at the time of MVP registration, on which to be scored. The results are added to the quality performance category score. **Promoting Interoperability Performance Category** A MVP Participant is required to meet the Promoting Interoperability performance category requirements at § 414.1375(b).		

*Indicates a MVP Participant may select measures and/or improvement activities.

Appendix B: MVP Participant Registration Timeline

The table below provides an overview of the registration process and timeline for MVP and subgroup registration, beginning with the 2023 MIPS performance year.

April 1st of the applicable performance year	MVP Participants may begin to register for MVP reporting.
June 30th of the applicable performance year (or a later date as specified by CMS)	Groups, subgroups, and APM Entities who intend to report the CAHPS for MIPS Survey Measure through a MVP, must: • Submit their MVP selection and population health measure selection. • As applicable, select an outcomes-based administrative claims measure that's associated with a MVP. • As applicable, each subgroup must submit a list of each TIN/NPI associated with the subgroup. • As applicable, each subgroup must submit a plain language name for the subgroup. • Separately register through the MIPS registration system by June 30th to participate in the CAHPS for MIPS Survey.
November 30th of the applicable performance year	The registration period closes. New registrations or changes to registration won't be accepted after November 30th. MVP Participants can't make any changes to their registration of: • MVP selection. • Population health measure selection. • As applicable, the selection of an outcomes-based administrative claims measure associated with the MVP. • As applicable, the list of each TIN/NPI associated with the subgroup. • As applicable, subgroup participation (including the subgroup's plan language name).

Appendix C: Information Required at the Time of MVP Registration and Reporting Expectations for MVP Participants

The table below provides a crosswalk of the various clinician types, the information expected at the time of MVP registration, and a reminder of the MVP reporting requirements.

Who Reports	Information Required at the time of MVP Registration	MVP Reporting Requirements
Years 1-2 (2023 and 2024)		
Individual Clinicians	MVP selection, Population Health Measure selection, and (as applicable) outcomes-based administrative claims measure selection, as finalized at § 414.1365(b)(2).	Requirements in Appendix A.
Groups	MVP selection, Population Health Measure selection, and (as applicable) administrative claims-based measure selection, as finalized at § 414.1365(b)(2).	Requirements in Appendix A. Members of the group will be required to report on the same measures and activities within a MVP.
Subgroups	MVP selection, Population Health Measure selection, (as applicable) the outcomes-based administrative claims measure selection, and the subgroup participant information described at § 414.1365(b)(2). **Note:** Subgroups will also receive a subgroup identifier from CMS at the time of registration.	Requirements in Appendix A. Members of the subgroup will be required to report on the same measures and activities within a MVP.
APM Entities	MVP selection, Population Health Measure selection, and (as applicable) outcomes-based administrative claims measure selection, as finalized at § 414.1365(b)(2).	Requirements in Appendix A.
Year 3 and Future Years (2025 and beyond)		
Individual Clinicians	MVP selection, Population Health Measure selection, and (as applicable) outcomes-based administrative claims measure selection, as finalized at § 414.1365(b)(2).	Requirements in Appendix A.
Single Specialty Groups[+]	MVP selection, Population Health Measure selection, and (as applicable) outcomes-based	Requirements in Appendix A.

	administrative claims measure selection, as finalized at § 414.1365(b)(2).	Members of the group will be required to report on the same measures and activities within a MVP.
Subgroups	MVP selection, Population Health Measure selection, (as applicable) outcomes-based administrative claims measure selection, and the subgroup participant information described at § 414.1365(b)(2). Subgroups will also receive a subgroup identifier from CMS at the time of registration.	Requirements in Appendix A. Members of the subgroup would be required to report on the same measures and activities within a MVP.
APM Entities	MVP selection, Population Health Measure selection, and (as applicable) outcomes-based administrative claims measure selection, as finalized at § 414.1365(b)(2).	Requirements in Appendix A.

[+]Multispecialty Groups will be required to form subgroups to report a MVP. We refer readers to § 414.1305 for the definitions of a MVP Participant, single specialty group, multispecialty group, and subgroup.