The 2022 CMS PFS and QPP Proposed Rule: 7 Things to Know

written by Dave Halpert | July 20, 2021

After the 2020 election, we predicted seven trends to expect in Value-Based Care. Our forecasts were right on track. Last week the Biden Administration released its first Physician Fee Schedule and Quality Payment Program Proposed Rule, a 1,747-page document that promotes restructured value-based care initiatives. As we predicted, it recognizes both a significant health equity gap and a lack of useful data available to healthcare consumers as major challenges to overcome.

We're highlighting the seven biggest takeaways from the newly proposed Rule. Here's the short version: The bar is higher, with substantial MIPS scoring changes ahead, and providers and organizations will have to prepare for a massive update to quality measurement and reimbursement in 2023, while at the same time keeping afloat in 2022 as cost score increases kick in.

Here's what you need to know:

1. ACOs have an extension on Quality Reporting for Medicare-only patients, but just long enough to implement the transition.

Although CMS's decision to sunset its Web Interface for ACO Quality reporting this year was finalized in the 2021 Rule, CMS bowed to pressure and postponed the timeframe to do so. ACOs maintained that reporting for the totality of the patient population (rather than a sample of Medicare patients) was not feasible.

They argued that, even if all practices did have Certified EHR Technology (CEHRT)—they do not, and are not required to—adding the results across practices would not produce accurate results, as the measures are intended to look at unique patients, rather than encounters. We've reviewed ACO data challenges and quality reporting over the past several months, and addressed hypothetical and real concerns for ACO data aggregation efforts. While some ACOs will need time to work with practices and manage implementation, all ACOs cannot continue with insufficient data long-term. Whether regulated or demanded by competition, ACOs will need to aggregate data to survive.

CMS has proposed an extra year of transition for ACOs. In 2022, they will have the choice of reporting all-payer clinical quality measures (CQMs) or continuing to report a sample of Medicare patients through the CMS Web Interface. In 2023, ACOs will still have the option to use the Web Interface, but they will be required to report one all-payer measure. This is significant, as even one all-payer measure requires the infrastructure to collect and aggregate data from disparate sources.

2. MVPs are delayed, but better defined.

CMS has filled in a lot of the blanks that surrounded MIPS Value Pathways (MVPs). While the concept was simple (a coordinated, rather than siloed quality effort), there was little definition beyond the five guiding principles. Nevertheless, there is more to be specified, and MVPs will be delayed until 2023. Upon rollout, CMS will start with seven possible MVPs:

Rheumatology
Stroke Care and Prevention
Heart Disease
Chronic Disease Management
Emergency Medicine
Lower Extremity Joint Repair
Anesthesia

For each MVP, groups will need to choose a population health measure (e.g. Hospital-Wide, 30-day, All-Cause Unplanned Readmission Rate), report on a set of pre-determined quality measures (one of which needs to be an outcome measure), and complete Improvement Activities and Promoting Interoperability measures. CMS will score cost based on the MVP's pre-determined cost measures.

One of the biggest questions was how MVPs could be applied to a multispecialty group. CMS addresses that with the concept of "subgroup" reporting. This will start as an option, but will become mandatory in 2025, and may lead to the sunsetting of "Traditional" (not part of a MIPS APM or MVP) MIPS after the 2027 performance year. Qualified Registries will be able to support MVPs.

With mandatory MVPs and MVP Subgroup reporting on the horizon, practices should begin preparing as early as possible in order to ascertain and address the inevitable operational and workflow challenges.

3. Traditional MIPS Quality reporting gets tough.

CMS has often stated their goal of getting providers out of "Traditional" MIPS and into MVPs or APMs, and this year's proposals will certainly drive some organizations that way. Proposed changes to Traditional MIPS—from the minimum performance threshold down to individual quality measure scoring—will make the program much more challenging.

By statute, the minimum performance threshold (the lowest score that can be achieved before penalties kick in) for the 2024 payment year (2022 performance year) must be either the mean or median of the final scores from the prior period. As MIPS performance has been historically high, this rule would lead to a jump from the prior thresholds. For the 2022 performance year, CMS has proposed using the mean from the 2017 performance year, which is interesting, given that this was the initial "transition" year of MIPS, but providers should breathe a sigh of relief, as this yields the lowest possible threshold. The mean for the 2017 performance year was 75, so providers and groups will need a score of at least 75 to avoid a penalty. The exceptional performance bonus will be 89, and 2022 will be the last year before it expires.

Unfortunately for MIPS participants, not only is the performance threshold increasing, but earning high marks in Quality will be more challenging. Several proposed scoring changes will make it harder to earn high scores, even if an entity is consistently performing as well as they have in prior years, and even if they are reporting on the same measures.

First, CMS has proposed that, if a measure either does not have a benchmark or the minimum

denominator (20 cases), the measure will not earn any points in 2022. In 2021, these measures were worth 3 points. This doesn't sound like much, but along with this, CMS is proposing significant changes to 84 existing measures, meaning that they will no longer have benchmarks. In other words, just because providers earned 10 points for each of their measures in 2021, there is no guarantee that the same performance across the same measures could earn a single point in 2022.

CMS has also proposed removing the 3-point floor for measures that have been benchmarked. Previously, even though measures are graded in terms of performance deciles, they were scored between 3 and 10 points. In 2022 and beyond, CMS is proposing that these measures could begin earning from 1 to 10 points. Once again, it doesn't sound like much, but with topped-out measures and measures with benchmarks in transition, small cuts add up.

The exception will be new measures, as they cannot be benchmarked. These will have a 5-point floor for the measure's first two years in the program. If the measure can be benchmarked after the first year, it will be worth between 5 and 10 points. If it cannot be benchmarked, it will be worth 5 for one more year.

Finally, and as if you didn't need another reason for concern, CMS is also getting rid of bonus points for end-to-end reporting and for reporting additional high-priority measures.

The payment adjustment range remains the same: a maximum penalty of 9 percent, with a sliding scale for incentive payments based on the size of the penalty pool (the program must remain budget-neutral). With the increased complexity and decrease in available point-earning measures, organizations will need a trusted and knowledgeable partner to avoid falling into a MIPS Quality Reporting trap.

4. Cost will be subject to increased focus.

By law, 2022 is the year that Quality and Cost must shoulder an equal portion of the total MIPS score. Therefore, in 2022, each will be weighted at 30 percent of the MIPS final score; so, just as much effort should be directed to Cost as to Quality.

In addition to the two global measures (the 12-month Total Per Capita Cost measure and the episode-based Medicare Spending Per Beneficiary measure), CMS is retaining its 18 existing specific episode measures, and adding five additional episodes:

Melanoma Resection (procedural)
Colon and Rectal Resection (procedural)

Sepsis (acute condition)
Diabetes (chronic condition)
Asthma/COPD (chronic condition)

The chronic condition measures would be attributed according to a new methodology, beginning with two claims billed in a short timeframe by clinicians in the same group, where that condition is diagnosed. The first visit must be an evaluation and management (E/M) visit and the second must be either an E/M for primary care services or a procedure code related to the management of the specific condition. To get to the provider level, CMS looks at the volume of qualifying services billed by each clinician in the practice. CMS confirms that the clinician is still active and practicing by looking for recent E/M visits with condition-focused service and whether the clinician wrote condition-related prescriptions for multiple patients.

The challenge for 2022 performance is that, since CMS re-weighted the cost component in 2020, they will not be releasing detailed cost information with the 2020 feedback reports at the beginning of August. That means that practices will not have any meaningful information from CMS about their costs until the 2021 Cost scores are released in late summer 2022. In short, Cost will be more important in 2022 than any prior year, and physician groups will be flying blind unless they significantly invest in cost data analysis and episodes of care. In order to succeed in this setting, organizations will need to understand how they compare to others, identify pain points, and take steps to improve.

5. CMS will push for improved data exchange and patient-reported outcomes using Digital Quality Measures.

The 2022 Proposed Rule upholds CMS's desire to enhance quality measurement through the development and deployment of Digital Quality Measures. This Proposal includes an RFI for transitioning to quality measurement using Fast Healthcare Interoperability Resources (FHIR) by 2025. What makes this interesting is that a Digital Quality Measure (dQM) is NOT the same as an Electronic Clinical Quality Measure (eCQM).

Given the emphasis on eCQMs in the legacy Meaningful Use program, the gradual abandonment of eCQMs may be surprising. However, this move is in keeping with CMS's stated objective of bringing more patient-reported outcomes and patient-generated health data (like wearables) into the quality measurement fold. For organizations who have gotten used to saying "my EHR takes care of the quality reporting," take note—that process is on its way out. The focus on data exchange will be through Application Programming Interfaces, or "APIs," meaning that patients, clinicians, and other entities can share data more easily, but while

preserving privacy. The goal, using these APIs, is to collect data from a variety of sources, including patients, payers, providers, and registries, and to produce results.

6. The effects of the pandemic will be felt in program rules for years to come.

COVID-19 turned the health care delivery system (and everything else) on its head. With patients sheltering in place, the demand for telehealth exploded. As clinics continue to expand personal visits, the question of continued reimbursement for telehealth services has been left open. For the time being, CMS is allowing dozens of telehealth services to remain "in play" through the end of 2023. It is anticipated that many will no longer be covered at that point, but there is still uncertainty, and this solution at least offers an opportunity for a smoother transition.

Of particular note is the focus on improved access for mental health services through telehealth. This proposal allows for reimbursement even if the visit is audio-only. Furthermore, several geographic restrictions for telehealth mental health services have been lifted, which should remove a serious barrier to care.

We also see updates to individual components within quality programs that come directly from the effects of the pandemic. For example, CMS proposes that the Promoting Interoperability component of MIPS requires immunization registry reporting and electronic case reporting (where groups report certain diagnoses in order to track outbreaks), and Improvement Activities and Quality measures related to COVID-19 immunizations.

7. CMS needs your help to define health equity strategies.

As we have described, a gap in health equity leads to a vast discrepancy in healthcare outcomes. We noted that hospitalizations and deaths related to COVID-19 highlighted this, but only represent a fraction of the problem.

The theme of health equity runs through the Proposed Rule. It can be seen in the desire to push ACOs to demonstrate quality care for all patients, and in the request for comment on ways to encourage providers who treat vulnerable populations to participate in Alternate Payment Models.

With these concerns in mind, CMS has issued a Request for Information (RFI) on how to close the health equity gap. The RFI is centered around stratification of quality measures by race and

ethnicity, and the improvement of patient demographic data collection, with evidence showing that outcomes are worse for those who live near or below the poverty level, those who belong to a racial or ethnic minority, are part of the LGBTQ+ community, or who live in rural areas.

To comment on this RFI, or any other portion of the Proposed Rule, you can do so prior to September 13, 2021 at 5:00 p.m. Eastern time by visiting http://www.regulations.gov and following the "Submit a Comment" instructions, referring to file code CMS-1751-P.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Suzanne D. Williams