# The 2022 CMS PFS and QPP Final Rule: A Warning Shot to Provider Holdouts of Value-Based APMs

written by Dave Halpert | November 10, 2021

CMS has released the 2022 Physician Fee Schedule and Quality Payment Program (QPP) Final Rule, and the message of these 2,414 pages is clear: CMS wants to push providers into value-based care arrangements.

That intent was foreshadowed by the Proposed Rule released over the summer, which confirmed our predictions of trends under the Biden administration. Specifically, we saw a push to move providers into value-based care arrangements with an emphasis on closing the health equity gap, and a shift toward measuring progress through enhanced quality reporting requirements within a value-based care arrangement.

To that end, in the Final Rule CMS doubles down on its commitment to push providers out of "Traditional MIPS" and into APMs or MVPs. Here are their four key strategies:

# 1. Move MVPs from Theory to Practice

CMS has acknowledged that flexibility within Traditional MIPS creates an environment in which the four components under measurement (Quality, Improvement Activities, Promoting Interoperability, and Cost) can be fulfilled independently. The result is the same fragmentation they had sought to avoid when consolidating legacy programs like PQRS, Meaningful Use, and the Value-Based Payment Modifier. Their solution, MIPS Value Pathways (MVPs), is intended to weave these four components into a comprehensive quality initiative.

CMS has been pushing the concept of MVPs for several years, but the logistics were undefined—until now. This rule outlines the nuts and bolts of how MVPs will be developed and reported, starting with seven MVPs available in 2023:

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

To successfully complete the MVP reporting requirements, participants must submit data on the same three MIPS components as they do today: Quality, Improvement Activities (IA), and Promoting Interoperability (PI). The difference is that, in an MVP, the Quality, IA, and Cost components are identified in advance, ensuring that the MVP topic is the driver of measurement.

For Quality, participants report on a set of four pre-determined quality measures, and at least one of those must be a relevant outcome measure—and each provider in the MVP must have a clinically appropriate outcome measure within the set. The Improvement Activities category is fulfilled by attesting two medium-weighted or one high-weighted IA that is relevant to the MVP topic. Promoting Interoperability is specialty-agnostic; while it must be completed, the MVP topic is unrelated to PI measures. Likewise, a required Population Health measure (either Hospital-Wide, 30-day, All-Cause Unplanned Readmission Rate, or Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions), calculated by CMS, is required. This Population Health measure is separate from the Cost component, which is also calculated by CMS, and based on the cost measures associated with the MVP.

Beginning with 2024 performance, MVP results will be publicly posted. For groups for which an appropriate APM is not available, but that wish to demonstrate clinical excellence in a specific area, MVPs may be the most advantageous option, but only if you have the tools to measure and improve performance on an ongoing basis. Furthermore, since each MVP is required to have at least one outcome measure (plus three more that are relevant to the MVP), those who rely on their EHRs to report are limiting their measure selection in a manner that may make it more challenging to succeed—specifically, because the electronic measure library is substantially smaller than the library of MIPS measures. Fortunately, CMS has granted Third-Party Intermediaries (like Qualified Registries) the ability to support MVPs.

## 2. Put Increased Responsibility on Individual Clinicians through "Subgroup" Reporting

The biggest question surrounding MVPs was related to multi-specialty groups and how they would be expected to participate. In Traditional MIPS, these groups could pick from the entire library of measures, even if those measures applied to a small minority of the group's clinicians. To ensure that MVPs are reliable mechanisms for measurement, CMS has introduced the concept of "Subgroup Reporting." This means that groups must divide into smaller groups for reporting so that each clinician is reporting on a topic that is relevant to their field of practice. As each MVP is concentrated on a specific area, Subgroup reporting is CMS's way of ensuring that clinicians are not able to succeed in an MVP without demonstrating that they played a role.

MVP reporting will be substantially more formalized than the existing group reporting process. Group Reporting in Traditional MIPS automatically applies to clinicians who bill under that group's Tax ID Number (TIN), which further obscures an individual clinician's contribution to the overall score. This will not be the case with MVPs. To ensure that CMS knows which clinicians are being scored under which MVP, CMS has established a registration process for MVP participants, which is defined in this rule.

The registration process bears a striking resemblance to that of an Alternate Payment Model, and most importantly, requires participating providers to be identified at the individual NPI level, whether reporting as a group, APM entity, or a subgroup. The informal "everyone billing under our TIN" method will be off limits; organizations will need to effectively communicate with their clinicians to ensure an understanding of how each individual will be evaluated. There may be multiple MVP subgroups, Traditional MIPS participants, and APM Qualified Participants.

The registration period occurs between April 1 and November 30 of the performance year. Once it closes, *no changes may be made* to the MVP selection, the measures within the MVP, or

the participant list. Subgroups will be identified by a unique ID, similar to an APM site.

An organization without dynamic tools to organize participants and programs is putting itself at risk, as those clinicians who slip through the cracks will be subject to financial penalties.

## 3. Enhance the Challenges of Traditional MIPS

From the above summary, it's clear that implementing an MVP and demonstrating superior performance will require organizations to overcome challenges on administrative, IT, and clinical fronts. Since MVPs are not mandatory, the natural temptation for Traditional MIPS participants is to maintain the status quo.

But if you're nodding in agreement, beware! The Rule outlines several changes to Traditional MIPS, and these will make it challenging to avoid financial penalties in 2022 and beyond.

By statute, 2022 is the first year that Quality and Cost will carry the same weight toward your total MIPS score—each component is worth 30 percent. To understand why that's so important, consider the history of MIPS. At the outset, Quality was worth a whopping 60 percent of the MIPS score, while Cost was for informational purposes only, having no bearing on the total. The Promoting Interoperability category (then called Advancing Care Information) was focused on reporting, rather than performance. Since then, the Promoting Interoperability category has become more performance-oriented and requires 2015 EHR Certification. Although many MIPS participants felt the sting from Promoting Interoperability, they were able to make up for suboptimal PI scores with excellent Quality scores. Now, however, with Quality and PI weighted at 30 percent and 25 percent, respectively, organizations must recognize that excellent quality reporting cannot effectively correct for poor PI performance.

The other side of this story is Cost, which has gone from an FYI to nearly a third of MIPS performance. The challenge here is that CMS did not release any Cost feedback in 2020. In response to the pandemic, CMS reweighted the Cost component for the 2020 performance year, and since the category carried no weight towards the total MIPS score, providers and organizations received no information. That means, going into 2022, the soonest anyone will learn where their baseline performance resides (their 2021 score) on the 18 existing episodes and two global measures will be in the late summer/early fall of 2022.

*In other words, the year will be more than half over before anyone knows where they stand, with less than half a year to make the improvements needed to separate themselves from the pack (or catch up with it!).* Furthermore, the five cost measures that were proposed (Asthma/COPD, Colon and Rectal Resection, Diabetes, Melanoma Resection, Sepsis) have all

been finalized. With so much more of the total score at stake, the Cost component puts Traditional MIPS participants in a tenuous position, at best.

Additional changes compound the challenges for Traditional MIPS participants. Even if the category weights remained unchanged, it would still be harder to succeed in 2022 using the same strategy employed in 2021. The minimum performance threshold—the break-even point between bonuses and penalties—is being raised by 15 points, from 60 to 75. Given the category weighting updates, this creates a very real possibility that participants could submit full sets of data for all categories, yet still incur a financial penalty for failing to meet the minimum threshold.

Smaller changes to quality measure scoring add insult to injury. Beginning in 2022, there will no longer be bonus points awarded for reporting additional outcome or high priority measures. The End-To-End bonus points for reporting on fully electronic measures without manual intervention is also on the chopping block. Many have counted on these bonuses to recoup ground that was lost to performance on outcome measures, or measures that could not earn full marks due to topped-out status, low volume, or lack of an established performance benchmark. CMS provides some relief by putting a floor on the points that may be earned by new measures, but this is tempered by their removal of the 3-point floor for established measures. In 2023, the 3-point floor will also be removed for established measures without benchmarks and for measures with low volume—for those who are not in small practices (15 or fewer clinicians), these will no longer be worth any points.

With penalties remaining high (up to a 9 percent penalty), those who have “gotten by” in prior years are making a risky bet that the same strategy will clear the newly-raised bar. In 2023, it will be even harder.

## 4. Reward Existing APM Participants with Lenient Transition Timelines

In recent years, we’ve seen a common theme in CMS rules: substantial changes are proposed for ACOs, but walked back to varying degrees in the Final Rule. Eventually, the change takes effect, but on a longer timeline than proposed. This year is no different.

In 2020 CMS proposed retiring the Web Interface as a reporting option for everyone, including ACOs, at the end of that year. The 2021 Final Rule, released in the fall of 2020, granted a one-year reprieve, allowing ACOs one more year to report on a sample of patients through the Web Interface, rather than on all patients through the Alternate Payment Model Performance Pathway (APP).

The 2022 Proposed Rule indicated that ACOs would be able to report via the Web Interface for one more year, but would have to report at least one all-patient eCQM or MIPS CQM in 2023. The 2022 Final Rule gives ACOs the ability to continue reporting via the Web Interface through the 2024 performance year, with no requirement for an all-payer measure in the interim. The 2025 deadline coincides with CMS's deadline for converting to Digital Quality Measures (dQMs).

Despite the delay, it will be more challenging for APMs to demonstrate quality care in the very near future; CMS has postponed its requirement for reporting measures on all patients via the APP, but has not axed the proposal. Taken in the context of CMS's desire to improve equity across its programs, the concept of reporting quality metrics on all patients has a deeper meaning than a CMS desire to sunset their Web Interface, and all-patient reporting cannot be credibly delayed much longer.

Coinciding with the delayed retirement of the CMS Web Interface, CMS has adjusted the timeline for ACOs to meet enhanced quality performance standards, but with a subtle push for ACOs to move to the APP.

Consider this: For 2022 and 2023, in order to meet performance standards, ACOs must earn a quality performance score that meets or exceeds the 30th percentile across MIPS performance category scores if reporting via the Web Interface. On the other hand, if the ACO reports three eCQMs/MIPS CQMs via the APP and achieves a score equivalent to the 10th percentile of the performance benchmark for at least one of the four outcome measures in the APP set and meets the 30th percentile on at least one of the five other measures, the ACO would meet quality performance standards. In short, those who do report via the APP do not need to perform as well.

For these reasons, along with others we've previously described, forward-thinking ACOs should consider a tandem approach and simultaneously report through both the APP and the Web Interface. As we've outlined, this is the safest, long-term way to fulfill performance standards and offers one other incentive: CMS will assign the highest of the two scores to the ACO.

In order to succeed, be it in APMs, MVPs, or Traditional MIPS, providers and groups must establish a strategy now that gives them insights into their care and costs—with the ability to see the big picture, and the flexibility to trace the effects of their overall strategy down to the individual patient level.

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