ASRA PAIN MEDICINE

American Society of Regional Anesthesia and Pain Medicine

A GUIDE TO PARTICIPATION IN PERFORMANCE YEAR 2022

Prepared by Hart Health Strategies Inc.

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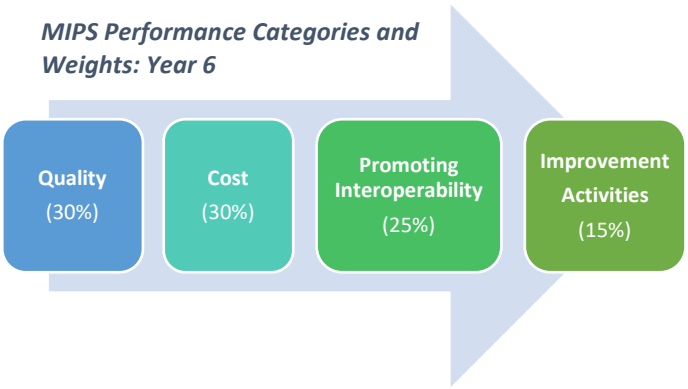
The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law April 2015, repealing the flawed sustainable growth rate (SGR) and establishing a two-track Quality Payment Program (QPP) that emphasizes Medicare's transition to value-based payment and delivery. Under the QPP, eligible pain medicine practitioners are required to participate in the Merit-based Incentive Payment System (MIPS) or are considered a qualifying participant (QP) in an Advanced Alternative Payment Model (APM) and are exempt from MIPS reporting. With the QPP moving into its sixth year – the 2022 performance period – pain medicine practitioners should note important changes that impact participation.

Merit-Based Incentive Payment System

Performance Categories, Weights and Thresholds

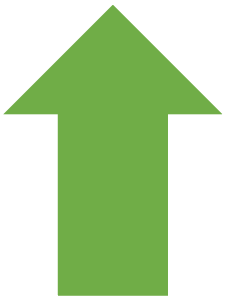
MIPS incorporates four weighted performance categories – Quality, Cost, Promoting Interoperability, and Improvement Activities – that contribute to an annual MIPS final score of between 0 and 100 points. The final score is compared to a performance threshold to determine Medicare payment adjustments. Final scores above the threshold will receive a positive payment adjustment, those below the threshold will receive a negative payment adjustment, and those equal to the threshold will receive no adjustment. The performance threshold for the 2022 performance period is 75 points, and the exceptional performance threshold is 89 points.

MIPS Performance Categories and Weights: Year 6



Final scores at or above the performance threshold will yield a neutral or positive payment adjustment

Final scores below the performance threshold will yield a negative payment adjustment



Payment Adjustments

MIPS is a budget neutral program (i.e., negative payment adjustments create the funding pool for positive payment adjustments) and payment adjustments are made on a sliding scale (i.e., in general, the lower a clinician scores below the performance threshold, the higher the penalty). The MIPS payment adjustments are applied to the Medicare paid amount for covered professional services two years after the performance period (i.e., final scores for the 2022 performance period will determine 2024 payment adjustments). For 2022 performance, the maximum downward payment adjustment in 2024 is -9 percent.

Those with exceptional performance may earn "bonus" incentives from a special pool of funding, in addition to their positive MIPS payment adjustment (up to an additional 10 percent). However, this funding is only available through the 2022 performance year/2024 payment year.

To date, positive payment adjustments – including exceptional performance bonuses – have been low due to a relatively small number of clinicians qualifying for penalties; for example, the maximum positive payment adjustment in 2020 was 1.68 percent, and it was 1.79 percent in 2021.

MIPS Payment Adjustments by Payment Year

Clinicians can participate in MIPS as individuals, at the group practice level, or at the APM Entity level, if eligible. Note that it is possible to participate in MIPS in multiple ways. If a clinician (identified by a single unique Tax Identification Number/National Provider

Identifier or TIN/NPI combination) has more than one MIPS final score associated with a practice, they will receive a payment adjustment based on the highest available score. For example, if your practice opts to participate at the group (TIN) level, each MIPS eligible clinician in that group practice will receive a payment adjustment based on the group's final score, unless that clinician has a higher final score through individual or APM Entity level participation. Also note that if a MIPS eligible clinician billed Medicare under multiple TINs during the performance year, the clinician will receive a separate MIPS final score and payment adjustment for each unique TIN/NPI combination. MIPS payment adjustments are applied on a claim-by-claim basis two years after the performance year to payments made for covered professional services furnished by a MIPS eligible clinician. Note that the adjustment is applied to the Medicare paid amount and not the "allowed amount".

MIPS Eligibility & Facility-Based Determinations

The clinician types to the right are eligible for and required to participate in MIPS, as long as they also meet certain other requirements as outlined by CMS.

CMS will evaluate each TIN/NPI combination for MIPS eligibility; it will use TINs to evaluate group practices for eligibility. A single clinician (NPI) that bills Medicare under multiple TINs will receive an eligibility determination under each unique TIN/NPI combination and may be required to satisfy the requirements of MIPS under each unique practice.

CMS reviews past and current Medicare Part B Claims and Provider Enrollment, Chain, and Ownership System (PECOS) data for clinicians and practices during two determination periods for each performance year. From those data, CMS will determine MIPS eligibility, including whether a clinician or group exceeds the low-volume threshold.

CMS will also use these data to assign special statuses to clinicians and groups (e.g., hospital-based, small practice, etc.). Those with a special status must still participate in MIPS, but qualify for reduced reporting requirements in certain performance categories.

In addition, CMS will identify practices and clinicians who are facility-based and eligible for facility-based scoring. In general, practices and clinicians identified as facility-based are attributed to a facility with a Hospital Value-Based Purchasing (HVBP) Program score. CMS will automatically use the VBP Program score in lieu of a MIPS score for the Quality and Cost performance categories if the HVBP-based score is more favorable than the clinician's combined Quality and Cost score under MIPS. In the future, this could result in a reduced reporting burden for these types of clinicians.

MIPS Eligible Clinician Types: Year 6

MIPS eligible clinicians are defined as:

- ✓ 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
- ✓ Clinical social workers
- ✓ Certified nurse midwives

Excluded from MIPS are those who are:

- ✗ **Newly enrolled in Medicare** (*Enrolled in Medicare for the first time during the performance period*)
- ✗ **Below the Low-Volume Threshold** (*Medicare Part B allowed charges less than or equal to $90,000 a year; see 200 or fewer Medicare Part B patients a year; or provide 200 or fewer covered professional services to Medicare Part B patients*)
- ✗ **Qualifying APM Participants** ("QPs")

Of note, physicians who have opted out of Medicare and do not accept payments from Medicare are not required to participate in MIPS as they would fall below the low-volume threshold and will therefore not be affected by MIPS payment adjustments.

Clinicians should check their MIPS eligibility and Qualifying APM Participant (QP) status using the QPP Participation Status Tool. The tool is searchable by NPI and will show eligibility for each unique group practice that the NPI is affiliated with. As a reminder, clinicians with QP status are not required to participate in MIPS.

Participation Options

As noted above, clinicians may participate in MIPS as individuals, at the group practice level, or at the APM Entity level, if eligible. In general, clinicians that report as an individual (i.e., a single NPI tied to a single TIN) will have their payments adjusted based only on their own performance, and clinicians that report as part of a group (i.e., defined as a set of clinicians, identified by their NPI, who share a common TIN no matter the specialty or practice site) will have their payments adjusted based on the group's performance across all four MIPS categories. However, if both an individual and group score applies for a given TIN/NPI combination, CMS will apply the higher score to determine the payment adjustment for that TIN/NPI combination. Similarly, clinicians that report at the APM Entity level will be assessed and scored at that level unless they receive a higher final score through individual or group practice participation. Note that certain APMs are called MIPS APMs, and their participants may be eligible for certain scoring benefits under MIPS.

Clinicians may also participate as a "virtual group," which is a combination of two or more TINs made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually (regardless of specialty or location) to participate in MIPS for a performance period of a year. Learn more about this option by reviewing CMS' Virtual Groups Toolkit.

Reporting Mechanisms

Clinicians may also choose to collect and report data via multiple mechanisms, including claims (limited to physicians in small practices), registry, certified EHR, and web-based attestation (via the QPP Portal). Although most clinicians stick with a single reporting mechanism, clinicians may use different mechanisms across performance categories (e.g., report quality measures via claims and improvement activities via registry) and within performance categories (e.g., report quality measure A through claims and quality measure B through a registry). For members seeking to collect data via a registry, a list of Qualified Registries (QRs) and Qualified Clinical Data Registries (QCDR) approved for 2022 is posted to CMS' QPP Resource Library. Clinicians can find out if their EHR is certified by searching the Certified Health IT Product List, but are encouraged to also contact the vendor directly to confirm MIPS reporting capabilities.

Quality Performance Category

For 2022, clinicians and groups must report at least six measures, including one outcome or high-priority measure, for at least 70 percent of *all* patients eligible for the measure (i.e., not just Medicare, except in the case of claims-based reporting) to meet CMS' data completeness requirement. Clinicians and groups who report a quality measure, but fail to satisfy the data completeness requirement will receive 0 points on that measure (except for small practices, who will receive 3 points). For groups of 16 or more, CMS will also automatically calculate performance on certain administrative claims measures, including (as applicable) a hospital-wide, 30-day, all-cause unplanned readmission rate measure; a measure assessing the risk-standardized complicate rate following elective primary total hip arthroplasty and/or total knee arthroplasty; and a new risk-standardized hospital admission rate measure for patients with multiple chronic conditions.

For the 2022 performance period, CMS removed 13 measures that it deemed low-priority, low-bar and/or did not meet certain reporting volumes. CMS will continue to evaluate measures for removal using these and other factors as part of its Meaningful Measures initiative. CMS also made substantive changes to 87 quality measures and added 4 new measures for 2022.

Each measure is generally worth up to 10 points (note that certain "topped out" measures with historically high performance are subject to a 7-point cap, and new measures will receive a 7-point scoring floor in the first performance year and a 5-point scoring floor in the second performance year starting in 2022). CMS awards a clinician or group points for each measure based on their performance achievement compared to national benchmarks for each measure (which should also be available for download through the CMS QPP Resource Library[1]).

Clinicians can also earn improvement points of up to 10 additional percent for the Quality performance category based on their improvement in the category relative to the previous year. Small practices are also eligible for a bonus of 6 points added to the numerator of their Quality performance category score.

CMS has organized available MIPS quality measures into specialty measure sets to assist clinicians with selecting relevant measures. For 2022, there is a specialty measure set available for Anesthesiology, but not for Pain Medicine. Note that these sets are offered for

[1] Benchmark data for 2022 was not available as of the development of this guide.

guidance only-- clinicians are not required to rely on these sets or to report all of the measures in a set so long as they satisfy the 6-measure reporting requirement. See Appendix A and Appendix B for a list of suggested measures for use by pain medicine practitioners. A list of all available measures is available for download from CMS' QPP website. The specifications for all claims and registry measures available for the 2022 performance period are also available on CMS' QPP website.

Cost Performance Category

CMS calculates cost performance using claims data; no reporting is required under this category. If attributed a sufficient number of beneficiaries, clinicians may be assessed on a Total per Capita Cost (TPCC) measure, a Medicare Spending per Beneficiary (MSPB) measure, and where applicable, more focused episode-based measures. For the 2022 performance period, there are 23 episode-based cost measures that focus on specific conditions and procedures. Learn more about cost measures on CMS' QPP website.

Promoting Interoperability (PI) Performance Category

Clinicians must submit data for certain measures across four objectives that align with the capabilities of 2015 Edition CEHRT and for a period of 90 continuous days or more during the 2022 performance period. Reporting the optional measure Query of Prescription Drug Monitoring Program (PDMP) will earn 10 bonus points for this category. Optional reporting of certain registry and surveillance data under the Public Health and Clinical Data Exchange objective may also qualify for some bonus points. Review the full list of PI measures on CMS' QPP website.

Clinicians must also attest "yes" to the following attestation statements:

- ✓ The Prevention of Information Blocking Attestation;
- ✓ The ONC Direct Review Attestation;
- ✓ The security risk analysis measure; and
- ✓ A new Safety Assurance Factors for EHR Resilience (SAFER) Guides measure.

Hardship exceptions are available in this category for clinicians and groups who use decertified EHR technology, have insufficient internet connectivity, face extreme and uncontrollable circumstances, or lack of control over the availability of CEHRT. Clinicians with a specified special status (e.g., hospital-based) will have their PI performance category score automatically reweighted to the Quality performance category and will not need to submit a hardship exception application. New for 2022, this automatic reweighting policy will also apply to small practices.

Improvement Activities Performance Category

Generally, clinicians and groups must attest to two high-weighted (20 points each), four medium-weighted (10 points each) activities, or a combination of both to achieve a total of 40 points in this category. In general, an activity must be performed for at least 90 consecutive days during the performance period to receive credit.

For small practices (15 or fewer eligible clinicians), as well as practices in rural areas or health professional shortage areas (HPSAs), CMS only requires submission of one high-weighted activity or two medium-weighted activities.

Of note, for the 2020 performance period and future years, CMS increased the participation threshold for group reporting. Groups may only earn credit for an improvement activity if at least 50% of the clinicians in the TIN fulfill the activity during *any* continuous 90-day period within the performance year.

For 2022, CMS added 7 new improvement activities, modified 15 improvement activities, and removed 6 previously adopted improvement activities. Many of the additions and modifications focused on efforts to address health equity.

A full list of improvement activities can be downloaded from CMS' QPP Resource Library. [2]

[2] The full list of improvement activities for 2022 was not posted to the QPP website as of the development of this guide.

Alternative Payment Models

Alternative Payment Models (APMs) are a payment approach that gives added payment incentives to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs that meet specific requirements, such as taking on financial risk for the value of patients' care. Clinicians participating sufficiently in an Advanced APM in 2022 (i.e., a minimum number of payments or patients affiliated with the APM) will be determined to be Qualifying APM Participants, or QPs, will be exempt from MIPS for 2022, and will earn a 5% Medicare incentive payment in 2024.

The number of clinicians in this track will remain relatively small compared to those in the MIPS track, particularly among specialists for which few Advanced APMs are currently available. For a list of Advanced APMs approved for 2022, please visit the QPP Resource Library. Physicians can use the QPP Participation Status Look-up Tool to determine whether they qualify as a QP in 2022. CMS will post initial predictive QP determinations for 2022 starting in the spring of 2022.

MIPS APMs

Clinicians who participate in what is known as a "MIPS APM," but do not meet the criteria to be considered a QP, must still participate in MIPS. However, they have multiple options for participation, including participation through the APM Performance Pathway (APP) under MIPS at the individual, group, or APM entity level. The APP was first introduced in performance year 2021. This optional pathway provides special scoring accommodations to participants, in recognition of the work completed under the MIPS APM to improve quality and control costs. More information about the APP is available here.

MIPS Value Pathways (MVP) for 2023

Starting in performance year 2023, clinicians can participate in MIPS Value Pathways, or "MVPs," which are defined as "subsets of MIPS measures and activities established through rulemaking." This new framework aims to allow clinicians to fully participate in MIPS based on reporting a subset of measures and activities that are relevant to a clinician's scope of practice and integrated across each of the MIPS performance categories. More information can be found in this downloadable file that includes a resource on MVPs for 2023.

Appendix A: Key Measures for Pain Management Specialists (Chronic Pain) and Available Collection Types

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
076^	Prevention of Central Venous Catheter-Related Bloodstream Infections	✓	✓		
128	Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan	✓	✓	✓	
130	Documentation of Current Medications in the Medical Record	✓	✓	✓	
134*	Preventive Care & Screening: Screening for Clinical Depression & Follow-Up Plan	✓	✓	✓	✓
145	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	✓	✓		
155	Falls: Plan of Care	✓	✓		
182*	Functional Outcome Assessment		✓		
220	Functional Status Change for Patients with Low Back Impairments		✓		

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #					CMS Web Interface
226*	Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	✓	✓	✓	✓
238*	Use of High-Risk Medications in Older Adults		✓	✓	
318*	Falls: Screening for Future Fall Risk			✓	✓
357	Surgical Site Infection (SSI)		✓		
374*	Closing the Referral Loop: Receipt of Specialist Report		✓	✓	
375*	Functional Status Assessment for Total Knee Replacement			✓	
376*	Functional Status Assessment for Total Hip Replacement			✓	
404^	Anesthesiology Smoking Abstinence		✓		
424^	Perioperative Temperature Management		✓		
430^	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy		✓		
463^	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)		✓		
477^	Multimodal Pain Management		✓		
478*	Functional Status Change for Patients with Neck Impairments		✓		

KEY: *Red text indicates a high-priority measure; * indicates a change in measure specifications; ^ indicates measure is part of the Anesthesiology specialty measure set. Review claims and registry specifications for the 2022 performance period on CMS' QPP website.*

Appendix B: Key Measures for Pain Management Specialists (Regional Anesthesia and Acute Pain) and Available Collection Types

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
076^	Prevention of Central Venous Catheter-Related Bloodstream Infections	✓	✓		
130	Documentation of Current Medications in the Medical Record	✓	✓	✓	
317*	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	✓	✓	✓	

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title		Registry	CEHRT	CMS Web Interface
322	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients		✓		
324	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients		✓		
351	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation		✓		
357	Surgical Site Infection (SSI)		✓		
375*	Functional Status Assessment for Total Knee Replacement			✓	
376*	Functional Status Assessment for Total Hip Replacement			✓	
404^	Anesthesiology Smoking Abstinence		✓		
424^	Perioperative Temperature Management		✓		
430^	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy		✓		
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		✓		
463^	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)		✓		
477^	Multimodal Pain Management		✓		
478*	Functional Status Change for Patients with Neck Impairments		✓		

KEY: *Red text indicates a high-priority measure; * indicates a change in measure specifications; ^ indicates measure is part of the Anesthesiology specialty measure set. Review claims and registry specifications for the 2022 performance period on CMS' QPP website.*

Note that the following measures have been removed from the MIPS program for performance year 2022 onward:

- 021: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- 023: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- 044: Coronary Artery Bypass Graft (CABG): Preoperative Beta Blocker in Patients with Isolated CABG Surgery
- 154: Falls: Risk Assessment
- 342: Pain Brought Under Control within 48 Hours
- 444: Medication Management for People with Asthma