Quality Payment Program—Year 5
2021 Proposed Rule Overview

On August 3, 2020, CMS released the 2021 Medicare Physician Fee Schedule (MPFS) proposed rule, which includes the Quality Payment Program (QPP) Year 5, beginning January 1, 2021, and impacting 2023 payments. The QPP includes both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

This guide provides an overview of the proposed changes to the Quality Payment Program Year 5. In-depth guides on each of the categories of MIPS and other elements of the program will be available once the final rule is issued.

Additional details on the QPP are available on the ASCRS ASOA MACRA Center website at ascrs.org/macracenter.

Key Proposed Changes to the QPP

In recognition of the 2020 Coronavirus (COVID-19) pandemic, CMS proposes limiting the number of significant changes to the Quality Payment Program in 2021, continuing a gradual implementation timeline for the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), and introducing the Alternative Payment Model (APM) Performance Pathway (APP).

The 2021 MPFS proposed rule maintains the following:

- **Continuing MIPS transition flexibility by setting the MIPS performance threshold at a level other than the mean or median of the previous year's scores.**
- **Maintaining the exceptional performance threshold:** CMS proposed keeping the exceptional performance threshold at 85 points; no change from the 2020 performance year.
- **Continuing to increase the weight of the Cost category gradually before reaching a final weight of 30% of the MIPS final score.**
- **Continuing to provide certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians.**

The 2021 MPFS proposed rule includes the following modifications to the QPP:

- Lowering the weight of the Quality Category performance score from 45% to 40% of the MIPS final score.
- For 2021, the MIPS performance threshold is set at 50 points, up from 45 points for 2020. MIPS participants must score at or above the 50-point performance threshold to avoid a penalty in 2023.
- The Cost Category weight would increase to 20% for the 2021 performance year and telehealth services would be added to previously established cost measures.
- New pathway only for MIPS APMs participants (ACOs) and complementary to MVPs with a fixed set of measures for each performance category.
- Use performance period, not historical, benchmarks to score quality measures for the 2021 performance period.
- Postponing 2021 MVP implementation and additions to the guiding principles and MVP candidate development and submission process.

2021 Performance Period for 2023 Payment (Proposed)

For full participation in the MIPS program in 2021, for 2023 payment, the performance period for the Quality and Cost categories is a full year, and any period of at least 90 days for the Promoting Interoperability and Improvement Activities categories.

For the Quality performance category, CMS proposes to:

Revise and expand their scoring flexibility policy that may be triggered due to updates to clinical guidelines or measures specifications, such as revisions to medication lists, codes and clinical actions. Therefore, based on the timing of the change and the availability of data, CMS may either:

- Truncate the performance period to 9 consecutive months, if there were no concerns with potential patient harm and 9 consecutive months of data were available; or
- Suppress the measure from scoring (0 achievement points and total measure achievement points reduced by 10 for each measure submitted that is impacted) if 9 consecutive months of data were not available.

MIPS Participation and Reporting (Proposed)

CMS is proposing that all MIPS eligible clinicians, including those in a MIPS APM, may choose to participate in MIPS as:

- An individual
- A group
- A virtual group
- An APM Entity

They are also proposing to end the APM Scoring Standard (reporting requirements and scoring approach for MIPS APM participants) beginning with the 2021 performance period and replace with the new APP Pathway.

APM Entities will be allowed to submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances, such as the public health emergency resulting from the COVID-19 pandemic. This policy would apply beginning with the 2020 performance period.

Final Score and 2021 Performance Threshold (Proposed)

CMS is continuing its transition flexibility by setting the 2021 performance threshold at a level other than the mean or median of the previous year's scores. **CMS proposes the 2021 MIPS final score threshold be set at 50 points, up from 45 points in 2020**. **To avoid the 9% penalty in 2023, physicians must earn at least 50 MIPS points in 2021.**

CMS proposes to maintain the 2021 exceptional performance threshold at 85 points. MIPS participants who score above the 85-point threshold are eligible for an additional bonus above and beyond the yearly available MIPS positive payment adjustment level. Congress set aside additional funds for exceptional performance in MACRA, which is not subject to the budget neutrality requirements of the MIPS payment adjustments.

CMS will continue providing certain reporting and scoring accommodations in MIPS for small practices of 15 or fewer Medicare-eligible clinicians. Specifically, these include:

- Continue the small practice hardship exemptions for the Promoting Interoperability category.
- Continue to receive full credit in the Improvement Activities category by submitting one high-weighted activity.
- Small practices will receive no fewer than 3 points for any quality measure submitted.
- The small practice bonus of 6 points will continue to be added to Quality category score.

Low-Volume Threshold and MIPS Opt-In

CMS maintained the low-volume threshold of $90,000 in allowed Part B charges or 200 patients, or 200 or fewer

covered professional services. If a physician falls below at least one of these criteria, he or she is considered low volume. Physicians falling below the low-volume threshold are exempt from MIPS and would not receive a 2023 payment adjustment.

CMS will continue to allow physicians who exceed at least one of the criteria of the low-volume threshold to opt into MIPS and be eligible for payment adjustments.

Complex Patient Bonus Points (Proposed)

CMS proposes no change to the complex patient bonus for the 2021 performance period. However, they are proposing the following updates to the 2020 performance period:

- **Double the complex patient bonus for the 2020 performance period only.** Clinicians, groups, virtual groups and APM Entities would be able to earn up to 10 bonus points (instead of 5 bonus points) to account for the additional complexity of treating their patient population due to COVID-19. CMS believes the existing complexity indicators, HCC risk score, and dual Medicare and Medicaid eligibility serve as a proxy for capturing the increased complexity due to the pandemic.

MIPS Performance Categories (Proposed)

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Promoting Interoperability (EHR), and Improvement Activities.

Quality: 40% of Total Score in Year 5 (2021)

CMS proposes to:

- Use performance period, not historical, benchmarks to score quality measures for the 2021 performance period since the national public health emergency for COVID-19 (which impacted data submission in 2020) could skew benchmarking results.
- Update the scoring policy for topped-out measures so that the 7 measure achievement point cap will be applied only if the measure is identified as topped out based on the established benchmarks for both the 2020 and 2021 performance periods, given that they are proposing to use performance period, not historical, benchmarks for the 2021 performance period.
- Maintain the previous reporting requirements of a minimum of six measures, with at least one outcome measure, if available. If no outcome measure is available, the clinician or group must report on "high priority measure."

Cost: 20% of Total Score in Year 5 (2021)

CMS proposes to:

- Increase the Cost performance category to be weighted at 20% (5% proposed increase from PY 2020)
- Update existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the TPCC measure.
- **Unfortunately, CMS has not indicated it will make any changes regarding the inclusion of pass-through drugs in the cataract surgery cost measure. We will continue to advocate that pass-through drugs be excluded from calculations of the cataract episode measure.**

Promoting Interoperability (PI): 25% of Total Score in Year 5 (2021)

CMS proposes to:

- Maintain the Electronic Prescribing objective's Query of PDMP measure as optional but increasing the bonus points from **five to 10 points.**
- Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing "incorporating" with "reconciling".

- Add a new Health Information Exchange (HIE) Bi-Directional Exchange measure to the HIE objective as an optional alternative to the two existing measures. Physicians either may report the two existing measures and associated exclusions OR may choose to report the new bi-directional exchange measure. The HIE Bi-Directional Exchange measure would be worth 40 points. The HIE Bi-Directional Exchange measure would be reported by attestation and would require a yes/no response.

Improvement Activities: 15% of Total Score in Year 5 (2021)

CMS proposes to:

- **Changes to the Annual Call for Activities**: An exception to the nomination period timeframe such that during a PHE, stakeholders can nominate improvement activities outside of the established Annual Call for Activities timeframe. Instead of only accepting nominations and modifications submitted February 1st through June 30th each year, CMS would accept nominations for the duration of the PHE as long as the IA is still relevant.
- **Establish a new criterion for nominating new IAs**, "Activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible."
- **Consider HHS-nominated improvement activities all year long** in order to address HHS initiatives in an expedited manner.
- **Modify two existing IAs**:
    - Engagement of patient through implementation of improvements in patient portal, and
    - Comprehensive Eye Exams.
    - To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following:
        - providing literature,
        - facilitating a conversation about this topic using resources such as the "Think About Your Eyes" campaign,
        - referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology's EyeCare America and the American Optometric Association's VISION USA, or
        - promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment.
        - **This activity is intended for:**
            - Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist;
            - Ophthalmologists/optometrists caring for underserved patients at no cost; or
            - Any clinician providing literature and/or resources on this topic.

This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.

Proposed Changes to Ophthalmology Measures

CMS proposes to:

- **Add one new measure for the Ophthalmology set:** Use of High-Risk Medications in the Elderly: Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted.
  (1) Percentage of patients who were ordered at least one high-risk medication.
  (2) Percentage of patients who were ordered at least two of the same high-risk medications.

CMS is also proposing changes to several individual measures, which are outlined below:

- **#12 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation**. Removing from the claims and registry collection types because they have reached the end of the topped-out lifecycle but keeping EHR submission. Removing telehealth encounters, as telehealth is not an appropriate setting for this measure, as well as to align with the other collection types.

- **#14 Age-Related Macular Degeneration (AMD): Dilated Macular Examination**. Revised: Severity of Macular Degeneration – Early, intermediate, and advanced; or active choroidal neovascularization, inactive choroidal neovascularization, or with inactive scar to align with current ICD-10 coding.
- **#19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.** Updated logic for collection (remove the "sender" and "recipient" attributes from the numerator logic and the value set/coding of the eCQM Specifications collection type and revert to the numerator logic from performance year 2019). Removed telehealth encounters from the denominator of the eCQM Specifications collection type as telehealth is not an appropriate setting for this measure, as well as to align with the other collection types.
- **#117 Diabetes Eye Exam: Added coding to identify patients with advanced illness and frailty.** Updated numerator options for claims and registry measure. Propose denominator exclusion language and logic be updated to clarify that, for the measure, long-term care will be defined as patients staying 90 consecutive days at the long-term care facility versus any 90 days within the performance period.
- **#141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care:** Removing claims option as it shows very high-performance. However, the benchmarking data continues to show a gap for the MIPS CQMs (registry reporting) so that will be retained. ASCRS recognizes that this proposed update would eliminate the only outcome measure remaining in the ophthalmology set for claims reporting.

MIPS Value Pathways (MVPs) (Proposed)

CMS is proposing to delay the 2021 MVP implementation and plans to propose an initial set of MVPs and detailed policies for the 2022 performance period.

Future modifications to the MVP framework include:

- **Additions to the MVP guiding principles and MVP candidate development and submission process.**
    - CMS proposes that stakeholders consult patients and/or patient representatives as part of the MVP development process as a pre-requisite for CMS to consider the candidate MVP and must include the full set of Promoting Interoperability measures in their MVP.
    - Stakeholders would formally submit their MVP candidates using a standardized template on a rolling basis throughout the year. CMS and its contractors would then review, vet, and evaluate MVP candidates, reaching out to the stakeholders as needed to answer questions.
    - For MVP candidates that are deemed feasible, CMS proposes to schedule a feedback loop meeting with the stakeholders to discuss any recommended modifications to the MVP candidate. MVPs must then be established through rulemaking.
- **Proposed New MVP Development Criteria:**
    - Utilize measures and activities across all four performance categories, if feasible (Quality, Cost, Improvement Activities, and Promoting Interoperability)
        - Have a clearly defined intent of measurement
        - Align with the Meaningful Measure Framework
        - Have measure and activity linkages within the MVP
        - Be clinically appropriate
        - Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties
        - Be comprehensive and understandable by clinicians, groups, and patients
        - To the extent feasible, include electronically specified quality measures
        - Incorporates the patient voice
    - Ensures quality measures align with existing MIPS quality measure criteria, and considers whether the quality measures are applicable and available to the clinicians and groups.
    - Beginning with the 2022 performance period, may include QCDR measures that have been fully tested. Ensures that the cost measure is related to the other measures and activities included in the MVP, and if a

relevant cost measure for specific types of care are not available, includes a broadly applicable cost measure that is applicable to the clinician type, and considers what additional cost measures should be prioritized for future development and inclusion in the MVP.

- Includes improvement activities that can improve the quality of performance in clinical practice, that complement and/or supplement the quality action of the measures in the MVP and uses broadly applicable improvement activities when specialty or sub-specialty improvement activities are not available.
- Must include the entire set of Promoting Interoperability measures.
- Includes the administrative-claims based measure, Hospital Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups.

Incentives and Penalties (Proposed)

CMS estimates approximately 930,000 clinicians will be **MIPS eligible in 2021**: approximately 92.5 percent of eligible clinicians who submit data will receive a positive or neutral payment adjustment, the mean final score would be 76.75, the median would be 81.32, **the maximum positive payment adjustment would be 6.9 percent, and the maximum penalty would 9 percent (subject to variations from final calculations and COVID-19 impacts).**

Advanced Alternative Payment Models (APMs) (Proposed)

CMS proposes changes to the way the agency distributes APM incentive payments to qualified participants (QPs). Because there is a two-year lag between when a group participates in an Advanced APM and when the payment is made, the agency has identified several challenges distributing these payments.

CMS also proposes to update the methodology for calculating QP thresholds by excluding beneficiaries who are prospectively aligned to an APM Entity from the pool of attribution-eligible beneficiaries for other APM Entities in order to prevent diluting the QP threshold scores for participants in APMs that use retrospective attribution. CMS proposes to establish a targeted review period for correcting QP determination errors made by CMS.

In response to the COVID-19 public health emergency, CMS does not plan to amend the list of Advanced APMs in 2020 and would not revoke QP status in certain circumstances, such as when an APM terminates its participation early due to the pandemic.

QP Threshold Scores:

- CMS is proposing that in calculating Threshold Scores used in making Qualifying APM Participant (QP) determinations, beginning in the 2021 QP Performance Period, Medicare patients who have been prospectively attributed to an APM Entity during a QP Performance Period will not be included as attribution-eligible Medicare patients for any APM Entity that is participating in an Advanced APM that does not allow such prospectively attributed Medicare patients to be attributed again.
- Prospectively attributed Medicare patients would be removed from the denominators when calculating QP Threshold Scores for APM Entities or individual eligible clinicians in Advanced APMs that do not allow for attribution of Medicare patients that have already been prospectively attributed elsewhere, thereby preventing dilution of the QP Threshold Score for the APM Entity or individual eligible clinician in an Advanced APM that uses retrospective alignment.

Targeted Reviews:

- CMS is also proposing a targeted review process through which an eligible clinician or APM Entity may request review of a QP or Partial QP determination if they believe in good faith that, due to a CMS clerical error, an eligible clinician was omitted from a Participation List used for purposes of QP determinations.

There continue to be no ophthalmology specific Advanced APMs.

APM Performance Pathway (APP) (Proposed)

CMS has proposed a new APM Performance Pathway (APP) in 2021. This new Pathway would be complementary to MVPs. The APP would be available only to participants in MIPS APMs and may be reported by the individual eligible clinician, group (TIN), or APM Entity.

The APP, like an MVP, would be composed of a fixed set of measures for each performance category. In the APP, the Cost performance category would be weighted at 0%, as all MIPS APM participants already are responsible for cost containment under their respective APMs.

- The Improvement Activities performance category score would automatically be assigned based on the requirements of the MIPS APM in which the MIPS eligible clinician participates; in 2021, all APM participants reporting through the APP will earn a score of 100%.
- The Promoting Interoperability performance category would be reported and scored at the individual or group level, as is required for the rest of MIPS.
- The Quality performance category will be composed of six measures that are specifically focused on population health.
- Quality measures reported through the APP automatically will be used for purposes of Medicare Shared Savings Program quality scoring, thus satisfying reporting requirements for both programs.

MIPS APMs (Proposed)

For performance year 2021, CMS is proposing that Accountable Care Organizations (ACOs) participating in the **Medicare Shared Savings Program** would be required to report quality measure data for purposes of the Shared Savings Program via the new APP, instead of the CMS Web Interface.

ACOs would need to report one set of quality metrics that would meet requirements under both MIPS and the Medicare Shared Savings Program. The total number of measures in the ACO quality measure set would be reduced from 23 to 6 measures. The redesign also raises the quality performance standard for ACOs under the Shared Savings Program. ACOs would now be required to receive a Quality performance score equivalent to or above the 40th percentile across all MIPS Quality performance category scores in order to share in savings or avoid owing maximum losses.

For performance year 2020, all ACOs are deemed affected by the COVID-19 pandemic Public Health Emergency (PHE), and thus, the Shared Savings Program extreme and uncontrollable circumstances policy applies. In addition, for performance year 2020 only, CMS is proposing to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey. Consequently, ACOs would receive automatic full credit for the patient experience of care measures.

Additional Resources

For additional information, ASCRS ASOA members may contact Jennifer Gallihugh, ASOA Sr. Manager of Strategic Initiatives, at jgallihugh@asoa.org or 703-788-5741.