Quality Payment Program
2021 Final Rule Guide

A Comprehensive Guide to the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act (MACRA).

This booklet contains information for ophthalmic practices participating in the Quality Payment Program (QPP) in 2021 and includes the following guides:

- **2021 Key MIPS Changes**
- **QPP Final Rule Overview**
- **Guides on each of the Four Categories of the Merit-Based Incentive Payment System (MIPS):**
  - **Quality**
  - **Promoting Interoperability**
  - **Improvement Activities**
  - **Cost**

Coming Soon

- **2021 Cataract Episode-Based Cost Measure**
- **MIPS APM Guide for APM Performance Pathway (APP)**

Updated and additional information can be found on the ASCRS•ASOA MACRA Center webpage at:

ascrs.org/macracenter

2021 MIPS: Key Changes for Ophthalmology Practices

2021 is the fifth performance year of the Merit-Based Incentive Payment System (MIPS). While many of the requirements for 2021 are the same as they were for previous years, there are a few key changes that ophthalmology practices should be aware of to be successful in the program. This guide outlines key changes for 2021. For other resources, including in-depth guides to each of the categories of MIPS, visit the ASCRS ASOA MACRA Center web page at ascrs.org/macracenter.

Key 2021 MIPS Changes

MIPS Performance Threshold

- **The 2021 MIPS performance threshold will increase from 45 points in 2020 to 60 points.** Physicians and practices must score at least 60 total points to avoid a maximum 9% penalty in 2023. This will be subject to variations from final calculations and COVID-19 impacts.
- **Maintaining the exceptional performance threshold:** CMS finalized keeping the exceptional performance threshold at 85 points; no change from the 2020 performance year.
- CMS estimates approximately 92.5 percent of eligible clinicians who submit MIPS data will receive a positive or neutral payment adjustment and between 196,000 and 252,000 eligible clinicians will be Qualifying APM Participants (QPs), excluded from MIPS, and receive a five percent incentive payment in 2023.

Cost Category

- **Cost will count for 20% of a physician's final MIPS score in 2021 – increased from 15% in 2020.**
- Existing measure specifications updated to include telehealth services that are directly applicable to existing episode-based cost measures and the TPCC measure.
- Weigh the Cost performance category at 0% for APM Entities reporting traditional MIPS.

Quality Reporting

- **Lowering the weight of the Quality Category performance score from 45% to 40% of the MIPS final score.**
- Historical benchmarks will be used to score quality measures for the 2021 performance period.
- Revised scoring flexibility for measures with specification or coding changes during the performance year.
- Sunset the CMS Web Interface as a collection and submission type; extending the availability of the CMS Web interface as a collection and submission type for one year for the 2021 performance period.

Improvement Activities

- Added 1 new criterion to the criteria for nominating new improvement activities beginning with the CY 2021 performance period and future years:
    - Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible.
    - Pathways for nominating a new improvement activity:
        - A stakeholder may nominate improvement activities during the Annual Call for Activities; or, as an exception to the Annual Call for Activities nomination period timeframe, during a public health emergency.

- The agency may nominate improvement activities and would consider HHS-nominated improvement activities all year long in order to address HHS initiatives in an expedited manner. Any HHS-nominated improvement activities would then be proposed through rulemaking.

Modify two existing IAs:

- **Engagement of patient through implementation of improvements in patient portal.**
  - To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.
- **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.

Promoting Interoperability Performance Category

- Maintaining the Electronic Prescribing objective's Query of PDMP measure remains as optional but increased the bonus points from **five to 10 points**.
- Changing the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing "incorporating" with "reconciling"; and
- Adding an optional Health Information Exchange (HIE) bi-directional exchange measure.

MIPS Value Pathways (MVPs)

- No MVPs will be introduced into the program for the 2021 performance period. Implementation of MVPs will begin in 2022.
- Additions and revisions to the MVP framework's guiding principles and development criteria to support

stakeholder engagement in co-developing MVPs and establishing a clear path for MVP candidates to be recommended through future rulemaking.

APM Performance Pathway (APP)

- New pathway only for MIPS APMs participants (ACOs) and complementary to MVPs with a fixed set of measures for each performance category
  - **Quality**: Composed of 6 measures specifically focused on population health, available to all MIPS APM participants; Quality measures reported through the APP would automatically be used for purposes of quality performance scoring under the Shared Savings Program
  - **Cost**: Weighted to 0% to align with current MIPS APMs responsibilities
  - **Improvement Activities**: Score automatically assigned based on MIPS APMs respective requirements; in 2021, all APM participants reporting via the APP will receive a score of 100%
  - **Promoting Interoperability**: Reported and scored at the individual or group level as required in MIPS
- Medicare Shared Savings Program ACOs will be required to report through the APP. Individual physicians participating in an ACO have the option of reporting outside the APP, through traditional MIPS.

MIPS Participation Options

- All MIPS eligible clinicians, including those in a MIPS APM, may choose toparticipate in MIPS as:
  - An individual
  - A group
  - A virtual group
  - An APM Entity
- The APM Scoring Standard (reporting requirements and scoring approach for APM participants) will end beginning with the 2021 performance period. MIPS eligible clinicians in a MIPS APM will be able to participate as an individual, as part of group, virtual group, or through their APMEntity.

COVID-19 Flexibilities

- Double the Complex Patient Bonus to 10 bonus points to account for additional difficulty in treating patients during the COVID-19 PHE **(for the 2020 performance period only).**
- Allow APM Entities 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 performanceperiod.
- Continuing to offer the application-based **Extreme and Uncontrollable Circumstances (EUC) Policy.**
- **The EUC Exception application for calendar year 2020 deadline is extended until February 1,2021**

Quality Payment Program – Year 5
2021 Final Rule Overview

On December 1, 2020, CMS released the 2021 Medicare Physician Fee Schedule (MPFS) final 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 summarizes the Quality Payment Program Year 5. Full details on the QPP are available on the ASCRS ASOA MACRA Center website at ascrs.org/macracenter.

Key Changes to the QPP

In recognition of the 2020 Coronavirus (COVID-19) pandemic, CMS limited 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 final 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 finalized 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.**
- In consideration of the COVID-19 public health emergency (PHE), CMS will continue to offer the application-based **Extreme and Uncontrollable Circumstances (EUC) Policy.**
    - **APM Entities may submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances.**
    - **The EUC Exception application deadline for 2020 is extended until February 1, 2021**

The 2021 MPFS final 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 60 points**, up from 45 points for 2020. MIPS participants must score at or above the 60-point performance threshold to avoid a penalty in 2023.
- The **Cost Category weight will increase to 20%** for the 2021 performance year and telehealth services were 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.
- **Postponing 2021 MVP implementation – with implementation in 2022 -** and additions to the guiding principles and MVP candidate development and submission process.

2021 Performance Period for 2023 Payment

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 finalized modifications to the scoring flexibility policy to provide that for each measure that is submitted, if applicable, and impacted by significant changes, performance is based on data for 9 consecutive months of the applicable CY performance period. If such data are not available or may result in patient harm or misleading results, the measure is excluded from a MIPS eligible clinician's total measure achievement points and total available measure achievement points.

- "Significant changes" means changes to a measure that are outside the control of the clinician and its agents and that CMS determines may result in patient harm or misleading results. Significant changes include, but are not limited to, changes to codes (such as ICD-10, CPT, or HCPCS codes), clinical guidelines, or measure specifications.

MIPS Participation and Reporting

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

Clinicians in a MIPS APM will be evaluated for MIPS eligibility at the individual and group levels; CMS will no longer evaluate entities for the low-volume threshold.

The APM Scoring Standard (reporting requirements and scoring approach for APM participants) will not be used beginning with the 2021 performance period.

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 (PHE) resulting from the COVID-19 pandemic. This policy will apply beginning with the 2020 performance period. If the application is approved, the APM Entity group will receive a score equal to the performance threshold, even if data are submitted.

Final Score and 2021 Performance Threshold

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 finalized that the 2021 MIPS final score threshold be set at 60 points, up from 45 points in 2020**. **To avoid the 9% penalty in 2023, physicians must earn at least 60 MIPS points in 2021.**

CMS maintains 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. **We note that the 2022 performance period/2024 payment year will be the final year of the additional positive adjustment for exceptional performance.**

CMS finalized changes to the hierarchy when assigning a final score such that when a clinician has multiple final scores associated with a single TIN/NPI combination, the following hierarchy will be used to assign the final score that will be used to determine the 2023 payment year MIPS payment adjustment applicable to that TIN/NPI combination:

- Virtual group final score
- Highest available final score from APM Entity, APP, group, or individual

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 Interoperabilitycategory.
- 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. **APM Entities are no longer evaluated for the low-volume threshold.**

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

CMS made no change to the complex patient bonus for the 2021 performance period. However, they finalized for the 2020 performance year only:

- **The complex patient bonus will be doubled 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.

MIPS Performance Categories

MIPS assesses the performance of clinicians based on four categories: Quality, Cost, Promoting Interoperability (EHR), and Improvement Activities. Performance category weights for individuals, groups, and virtual groups reporting traditional MIPS for the 2021 performance period are:

- Quality: 40% (down from 45% for CY2020)

- Cost: 20% (up from 15% for CY 2020)
- Promoting Interoperability: 25% (no change)
- Improvement Activities: 15% (no change)

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

CMS finalized the following:

- Historical benchmarks will be used to score quality measures for the 2021 performance period.
- Revised scoring flexibility for measures with specification or coding changes during the performance year.
- Continuing implementation of the Meaningful Measures framework by adding 2 new administrative claims measures, removal of 11 measures and updates tomeasures and specialty sets.
- Sunset the CMS Web Interface as a collection and submission type but will extend the availability of the CMS Web interface as a collection and submission type for one year for the 2021 performance period.

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

CMS finalized the following:

- Increase the Cost performance category to be weighted at 20% (5% increase from PY 2020)
- Update existing measure specifications to include telehealth services that are directly applicable to existing episode- based cost measures and the TPCCmeasure.
- Weigh the Cost performance category at 0% for APM Entities reporting traditional MIPS.

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

CMS finalized the following:

- Maintain the Electronic Prescribing objective's Query of PDMP measure as optional but increased the bonus points from **five to 10 points.**
- The name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information will be changed to Support Electronic Referral Loops by Receiving **and Reconciling** Health Information.
- Added 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 will be worth 40 points. The HIE Bi-Directional Exchange measure would be reported by attestation and would require a yes/noresponse.

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

CMS finalized the following:

- Added 1 new criterion to the criteria for nominating new improvement activities beginning with the CY 2021 performance period and futureyears:
    - Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible.
- Pathways for nominating a new improvement activity:

- A stakeholder may nominate improvement activities during the Annual Call for Activities; or, as an exception to the Annual Call for Activities nomination period timeframe, during a public health emergency.
- The agency may nominate improvement activities and would consider HHS-nominated improvement activities all year long in order to address HHS initiatives in an expedited manner. Any HHS-nominated improvement activities would then be proposed through rulemaking.

- Modify two existing IAs:
  - Engagement of patient through implementation of improvements in patient portal.
    - To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.
  - 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 thefollowing:
      - 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 visionimpairment.
    - **This activity is intendedfor:**
      - 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.

Changes to Ophthalmology Measures

CMS finalized the following:

- **Added one new measure for the Ophthalmology set: #238 Use of High-Risk Medications in Older Adults: Percentage of patients 65 years of age and older who were ordered at least two of the same high-risk medications.**

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

- **#12 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation**. Removed from the claims and registry collection types because they have reached the end of the topped-out lifecycle but keeping EHR

submission. Removed 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 reverted 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 othercollection types.
- **#117 Diabetes Eye Exam: Added coding to identify patients with advanced illness and frailty.** Updated numerator options for registry measure. Denominator exclusion language and logic 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.

MIPS Value Pathways (MVPs)

MVPs won't be available for MIPS reporting until the 2022 performance period, or later. CMS finalized the MVP guiding principles, MVP development criteria, and a process for candidate submission. Modifications to the MVP framework include:

MVP Guiding Principles:

- MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.
- MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care; MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.
- MVPs should include measures selected using the **Meaningful Measures approach and, wherever possible, the patient voice must be included**, to encourage performance improvements in high-priority areas.
- MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.
- MVPs should **support the transition to digital quality measures**, to the extentfeasible.

New MVP Development Criteria:

- Use measures and improvement activities across all 4 performance categories, iffeasible (Quality, Cost, Improvement Activities, and Promoting Interoperability).
- Have a clearly define 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.
- Incorporate the patient voice.
- Ensure quality measures align with existing MIPS quality measure criteria, and consider the following:
    - Whether the quality measures are applicable and available to the clinicians and groups, and
    - The available collection types for the measures
- 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 isn't 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.
- Include 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 aren't available.
- Must include the entire set of Promoting Interoperability measures.
- Include the administrative-claims based measure, Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups.

Incentives and Penalties

Based on the MACRA statute, MIPS participants will receive a positive, negative, or neutral payment adjustment based on their final score. The negative adjustment will be capped at 9% in 2023.

CMS estimates approximately 891,000 clinicians will be **MIPS eligible in 2021.** The maximum MIPS penalties and incentive payments is 9 percent in 2023, which is tied to the 2021 performance year. CMS estimates 93 percent of eligible clinicians who submit data will be eligible for a neutral payment adjustment or incentive payment, and 53 percent will be eligible for an additional bonus for exceptional performance. CMS notes these estimates are based on 2019 data and do not account for disruptions due to the COVID-19 PHE.

CMS estimates approximately 92.5 percent of eligible clinicians who submit MIPS data will receive a positive or neutral payment adjustment and between 196,000 and 252,000 eligible clinicians will be Qualifying APM Participants (QPs), excluded from MIPS, and receive a five percent incentive payment in 2023.

Advanced Alternative Payment Models (APMs)

CMS finalized a policy related to calculating Qualifying APM Participant (QP) Threshold Scores used in making QP determinations, beginning in the 2021 QP performance period. Medicare patients who have been attributed to an APM Entity during a QP performance period will not be included as attribution-eligible Medicare patients for any APM Entity where the Medicare patient could not actually be attributed to the APM Entity.

Such attributed Medicare patients will be removed from the denominator of the QP Threshold Score calculations for APM Entities or individual eligible clinicians in APMs that do not allow for attribution of Medicare patients who have already been prospectively attributed to another APM Entity.

CMS also finalized 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.

QP Threshold Scores:

CMS finalized 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 attributed to an APM Entity during a QP Performance Period won't be included as attribution-eligible Medicare patients for any APM Entity that is participating in an APM that doesn't allow such attributed Medicare patients to be attributed to another APM Entity.
- 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:

Beginning with the 2021 QP Performance Period, CMS will accept Targeted Review requests under limited circumstances where:

- An eligible clinician or APM Entity believes, in good faith, CMS has made a clerical error such that an eligible clinician(s) wasn't included on a Participation List of an APM Entity participating in an Advanced APM for purposes of QP or Partial QP determinations.

There continue to be no ophthalmology specific Advanced APMs.

APM Performance Pathway (APP)

CMS finalized a new reporting framework, the APM Performance Pathway (APP), to begin in 2021. This new Pathway is complementary to MVPs. The APP is available only to participants in MIPS APMs and can reported by the individual eligible clinician, group, or APM Entity. Quality scores for ACOs that have been reported through the APP will also be used for purposes of the Shared Savings Program, thus satisfying reporting requirements for both programs.

The APP will:

- Have a defined set of 6 quality measures, designed to be broadly accessible to APM participants. The Quality performance category will be weighted at 50% of the MIPS Final Score.
- The CMS Web Interface will be an optional, alternative collection type for a sub-set of quality measures in the APP for the 2021 performance period only.
- Have a Cost performance category weight of 0%

- Have a Promoting Interoperability performance category weight of 30%.
- Automatically apply an Improvement Activities performance category score up to 100% based on the Improvement Activities performance category requirements of the MIPS APMs. This category will be weighted at 20% of the MIPS Final Score.
- For the 2021 performance period, all APM participants reporting the APP will earn an Improvement Activities performance category score of 100%.

Additionally:

- The APP will have a quality measure set that consists of 3 eCQM/MIPS CQM/Medicare Part B Claims measures, a CAHPS for MIPS Survey measure, and 2 measures that will be calculated by CMS using administrative claims data.
- For the 2021 performance period only, participants in ACOs can report the 10 CMS Web Interface measures in place of the 3 eCQM/MIPS CQM/Medicare Part B claims measures in the APP.
- Therefore, participants in various MIPS APMs should be able to work together to report on a single set of quality measures each year that represent a true cross-section of their participants' performance.
- The APP is required for Medicare Shared Savings Program ACOs.

MIPS APMs

For performance year 2021, CMS finalized its proposal to require Accountable Care Organizations participating in the Shared Savings program and MIPS APM participants to report quality measure data via the APM Performance Pathway (APP), instead of the CMS Web Interface or quality measures that were specific to individual APM programs. **However, due to the COVID-19 pandemic, reporting the APP measures will be optional in 2021, and ACOs will still have the option to report quality through the Web Interface in 2021. Starting in 2022, the Web Interface will sunset, and ACOs will be required to report quality via the APP measure set.**

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 the 2021 performance year, ACOs will be required to report quality data via the APP and can choose to actively report either the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures. In addition, ACOs will be required to field the CAHPS for MIPS Survey, and CMS will calculate 2 measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures will be included in the calculation of the ACO's MIPS Quality performance category score.

MIPS Program: 2021 Quality Performance Category

Quality Category Weight – 40%

For 2021, CMS will weight a provider's Quality performance score at 40% of the overall MIPS final score.

Prior to passage of technical corrections to the MACRA statute in early 2018, CMS was required to increase the Cost category weight to 30% in 2019, to impact 2021 payments. The Quality category weight was scheduled to decrease to 30% in 2019. However, CMS has the authority to keep the Cost category weight below 30% for three additional years and set it at 20% for 2021. The Quality category will be 40% (down from 45% in 2020). If a physician or group does not have any cost measures attributed, the weight of the Cost category is transferred to Quality.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

Quality Category Performance Period

In 2021, physicians and groups must submit quality measure data for the full calendar year to be considered full participants in the MIPS program.

Quality Reporting Requirements

Practices of 15 or fewer providers must report 6 measures, each worth up to 10 total possible points, while practices of 16 or more providers will also be scored on 2 new administrative claims-based measures in addition to the 6 reported measures., Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of Medicare Part B patients if reporting via claims.

CMS will automatically calculate and score individuals, groups, and virtual groups on the 2 new administrative claims measures when the individual, group or virtual group meets the case minimum and clinician requirement for the measure.

- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Groups (This measure is replacing the All-Cause Hospital Readmission (ACR) measure, Quality ID 458). This measure must have 200 attributed cases.**
- **Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS). This measure must have 25 attributed cases.**

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one "high priority" measure. High priority measures are certain CMS designated measures that include all outcome measures.

****Following a policy implemented in 2019, only practices of 15 or fewer Medicare eligible clinicians may submit quality measures through claims.**

Each measure reported must have a minimum of 20 cases to be included in the Quality category score.

If a group, virtual group, or APM Entity participating in traditional MIPS registers for the CMS Web Interface, they must report on all 10 required quality measures for the full year (January 1 - December 31, 2021).

The CMS Web Interface will no longer be an available collection and submission type beginning with the 2022 performance period. The 2021 performance period will be the final year to report through the CMS Web Interface.

In 2021, CMS will continue to measure a physician's improvement on quality measures prior to the previous year. Physicians have the opportunity to earn up to 10 additional points, not to exceed the 60 or 70 total available points in the category, from year-to-year improvement in the Quality category.

Topped-Out Measures

After determining that several ophthalmology measures—predominantly those reported via claims—have been "topped out" for multiple years, meaning that overall performance is consistently high, **CMS began capping the total possible points for these measures at seven points in 2019, instead of the usual ten possible points per measure.** Therefore, if a physician or group reports only capped measures, that physician or group cannot earn the full available points for the category. This impacts nearly all ophthalmology measures, as well as many for other specialties, reported via claims and some reported via registry and EHR.

ASCRS and the medical community have consistently opposed the topped-out measure methodology and argued that physicians should continue to receive full credit for maintaining high quality. We will continue to work with the medical community to address this issue.

Multiple Submission Methods

In 2019, CMS instituted an option that allows physicians to submit measures through multiple submission types. Physicians and groups may select any six measures and submit them through a variety of options. For example, a physician may report four measures through claims, but meet the full required six by submitting two more through registry. In addition, for measures that have multiple submission options, the physician or group may submit through both mechanisms, and CMS will include whichever one has the highest score in the final category score. **If physicians or groups use a submission type that has fewer than six measures they can report, they are not required to identify other measures in an additional submission mechanism to make up the full six measures.**

Transition Period Scoring Consideration

Small practices of 15 or fewer eligible clinicians will receive 3 points on quality measures that don't meet data completeness, while non-small practices of 16 or more eligible clinicians will receive 0 points.
Small practices would still receive a 6 point bonus added to the Quality performance score, as long as one quality measure is submitted.

Quality Achievement Score

Under MIPS, **providers must demonstrate achievement on a quality measure, relative to a benchmark performance. For the 2021 performance year, CMS will set a baseline performance benchmark for each measure based on historical performance data. A physician's benchmark score on each measure is known as the "achievement" score. The achievement score will be added to any improvement or bonus points to**

determine the category score.

For 2021, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or 10-point, scale. For each submission method, CMS has assigned different levels of performance to each decile. Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile. If a physician or group has submitted a measure through multiple submission mechanisms, CMS will use whichever score is highest toward the achievement score.

The total possible achievement score in the Quality category depends on the size of the practice:

- Providers in groups of 15 or fewer eligible clinicians are subject to 6 measures and are eligible to receive up to **60 points** in the Quality performance category.
- Providers in groups of 16 or more are subject to 8 measures (6 to be reported, and 2 new administrative claims-base measures).
- As a reminder, for 2021, CMS has replaced the administrative claims All-Cause Hospital Readmission measure with the Hospital-Wide 30-day All Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups measure. This measure will only apply to practices with 16 or more eligible clinicians and must have 200 attributed cases.
- CMS also finalized an additional new administrative claims measure: Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS). This measure must have 25 attributed cases.
- If the individual, group, or virtual group does not meet the case minimum and clinician requirement for the new measures, they will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

Quality Improvement Score

For 2021 performance, CMS will also calculate a physician's or group's quality improvement score. Because physicians have the option of choosing which quality measures to report and are not required to report the same measures from year to year, CMS is evaluating improvement on a category basis.

CMS will compare a physician's total 2020 achievement score, which is determined based on the physician's performance relative to the benchmarks and excludes any bonus points and compare it to the 2021 achievement score. CMS will award between 1 and 10 percentage points, up to the total 60 or 70 available for the category, depending on how much a physician's or group's achievement score improved above the prior year.

The improvement score is derived by:

- **The increase in quality achievement percent score from prior performance period to current performance period**
- **Divided by prior performance period quality achievement percent score**
- **Multiplied by 10%**

Improvement scores cannot be less than zero points, and thus a physician who earns a lower achievement

score in the current performance period than the prior one will not be penalized.

CMS will only calculate improvement scores in 2021 for physicians and groups who participated fully in the Quality category in 2020 and earned at least 30% of available points in the Quality category.

Bonus Points

To incentivize providers to report on additional "high priority" measures, CMS will continue to award bonus points to providers who report these measures. Specifically, CMS will award:

- Two bonus points for each additional outcome measure reported beyond the required one;
- One bonus point for each additional high priority measure which need to meet data completeness, case minimum, and have performance greater than0;
- One bonus point for using certified EHR technology (CEHRT) to collect measure data and meeting end-to-end electronic reporting.

Bonus points for reporting additional high priority and outcome measures are capped at 10% of the denominator of the total Quality performance category. For example, if a provider is in a small practice and can score up to 60 points, the total number of bonus points that can be awarded is 6.

Quality measures reported through "end-to-end" electronic submissions will earn the provider bonus points. Providers may earn up to 10% of the total available points in the Quality performance category if they submit measures through EHR or a QCDR that meet the definition of "end-to-end" electronic reporting. To be considered "end-to-end" electronic reporting, an automated process must be used to aggregate the measure data, calculate the measure, perform any filtering of measurement data, and submit the data electronically to CMS. Systems that require manual abstraction and re-entry of data are not considered end-to-end and, therefore, not eligible for a bonus.

Each measure submitted electronically through EHR or QCDR will receive one bonus point. For example, if a provider is scored on 60 possible points in the Quality performance category, he or she can earn up to 6 bonus points for electronic submission toward the Quality category score. **Electronic bonus points are awarded in addition to bonus points for additional high priority and outcome measures.**

If a physician or group reports the same measure through multiple submission types and would be awarded bonus points for that measure through one of the submission mechanisms, the bonus points would still be added to the score even if the measure's highest achievement score is for a mechanism that does not include a bonus. For example, a physician may submit a measure through the EHR, which would result in a one-point bonus for end-to-end reporting. However, if he or she submitted the same measure through claims and, based on the benchmarks, would score more achievement points, CMS would take the claims measure's achievement points and still add the electronic end-to-end bonus.

Small Practice Bonus

In 2019, CMS moved the small practice bonus—which had previously been added to the MIPS final score—to the Quality category and will continue this policy for 2021. For 2021, 6 bonus points will be added to the Quality category score of any small practice, as long as one quality measure is submitted.

Similar to the other bonuses discussed above, small practice bonus points will only be awarded up to the total 60 points available for the category.

Quality Performance Score

A physician's or group's Quality performance category score will be the sum of the achievement, improvement, and bonus points divided by the total available points, depending on practice size. The Quality category score will then be weighted to count for 40% of the total MIPS score.

2021 Sample Quality Performance Score Calculation for a Physician Practicing in a Group of 15 or Fewer				
Measure	Achievement Score	Bonus Points (high priority/outcome)	Bonus Points (electronic reporting)	Total
Measure A submitted via claims	8			8
Measure A submitted via EHR	4 (not included in category score since claims submission was higher)		1 (bonus still counts even though claims score was higher)	1
Measure B submitted via EHR	6		1	7
Measure C (first outcome) submitted via EHR	5		1	6
Measure D (additional outcome) submitted via	6	2	1	9
Measure E (high priority) submitted via EHR	8	1	1	10
Measure F submitted via EHR	7		1	8
2021 Achievement Score (2020 Achievement Score of 30)	40			
Small Practice Bonus			6	6
Total Quality Achievement and Bonus Points (of a				55 (or 91.67%)
Improvement Score				1.0%
Quality Score				92.67% (will be weighted

Global and Population Measures

For 2021 CMS is replacing the administrative claims All-Cause Hospital Readmission measure with the Hospital-Wide 30-day All Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups measure. However, CMS maintains that the measure will only apply to

practices with 16 or more eligible clinicians and must have 200 attributed cases. This measure is a re-specification of measure Q458 currently within the MIPS program, which attributes outcomes solely to the primary care physician that provides the plurality of care during the measurement period. However, the primary care physician may not be the clinician with opportunity to impact readmissions. The intent of this measure is to improve upon the attribution of the current ACR measure and incentivize collaboration of care across inpatient and outpatient settings by considering shared attribution to up to three eligible clinician groups that provide care for patients inside and outside of the hospital and are therefore in position to influence patient risk of readmission. There are several exclusion criteria applied to the measure population ("starting cohort"), in order to identify the appropriate denominator patient population. Additionally, the measure is risk adjusted to account for differences in patient demographics and clinical characteristics across hospitals.

CMS also finalized an additional new administrative claims measure:
Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).
Physicians do not need to report on these measures; CMS will score them based on administrative claims.

Data Submission

Physicians and groups may report their quality performance data through claims, registry, EHR, or Web Interface (formerly known as GPRO—and only available for groups of 25 or more). In the 2021 rule, CMS finalized to sunset the CMS Web Interface as a collection and submission type but will extend the availability of the CMS Web interface as a collection and submission type for one year for the 2021 performance period.

Physicians or groups do not need to use the same submission mechanism for every category.

2021 MIPS Quality Category Measures for Ophthalmology

Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of all Medicare Part B patients if reporting via claims.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one **"high priority measure."** "High priority" measures are certain CMS-designated measures that include all outcome measures.

For 2021, CMS added one new measure for the Ophthalmology set: #238 Use of High-Risk Medications in Older Adults: Percentage of patients 65 years of age and older who were ordered at least two of the same high-risk medications.

CMS did remove two process measures previously included in the Ophthalmology set of measures for 2021. These measures remain in the MIPS program with changes.

- Measure 317: Preventative Care and Screening: Screening for High Blood Pressure and Follow-UpDocumented
- Measure 402: Tobacco Use and Help with Quitting Among Adolescents

NQF/Quality Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
0086/012	EHR	Process	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0087/014	Claims, Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
0089/019	Registry, EHR	Process	Communication and Care Coordination **(high priority)**	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0055/117	Registry, EHR	Process	Effective Clinical Care	Diabetes: Eye Exam
0419/130	Claims, Registry, EHR	Process	Patient Safety **(high priority)**	Documentation of Current Medications in the Medical Record
0563/141	Registry	Outcome	Communication and Care Coordination **(high priority)**	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documentation of a Plan of Care

0565/191	Registry, EHR	Outcome	Effective Clinical Care **(high priority)**	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
0028/226	Claims, Registry, EHR	Process	Community/Population Health **(high priority)**	Preventative Care and Screening: Tobacco Use: Screening and Cessation Information
0022/238	Registry, EHR	Process	Patient Safety **(high priority)**	Use of High-Risk Medications in Older Adults
N/A/303	Registry (not available in the IRIS registry)	Outcome	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
N/A/304	Registry (not available in the IRIS registry)	Outcome	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
N/A/374	EHR, Registry	Process	Communication and Care Coordination **(high priority)**	Closing the Referral Loop: Receipt of Specialist Report
N/A/384	Registry	Outcome	Effective Clinical Care (high priority)	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery
N/A/385	Registry	Outcome	Effective Clinical Care (high priority)	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
N/A/389	Registry	Outcome	Effective Clinical Care (high priority)	Cataract Surgery: Difference Between Planned and Final Refraction

Other Available Measures

CMS continues not to require that one of the quality measures be a cross-cutting measure. However, measures that are deemed cross-cutting are still available for physicians to report.

NQF/PQRS Number	Submission Method	Measure Type	Measure Domain	Measure Title
0018/236	Claims, Web Interface, Registry, EHR	Intermediate Outcome* **(high priority)**	Effective Clinical Care	Controlling: High Blood Pressure

*Intermediate outcome measures are considered outcome measures.

Ophthalmology Quality Measure Benchmarks

Each decile includes a range of performance rates. Deciles without benchmarks (denoted by a --) indicate that there are no scores available in that decile.

Measure Name	PQRS Number	Reporting Method	Seven Point	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	EHR	No	83.62 - 88.71	88.72 - 92.3	92.31 - 95.05	95.06 - 96.96	96.97 - 98.32	98.33 - 99.28	99.29 - 99.99	100
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Claims	Yes	--	--	--	--	--	--	--	100
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Registry	Yes	86.18 - 91.74	91.75 - 95.01	95.02 - 96.92	96.93 - 98.51	98.52 - 99.58	99.59 - 99.99	--	100

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	EHR	No	54.33 - 66.66	66.67 - 75.33	75.34 - 81.59	81.6 - 87.17	87.18 - 91.36	91.37 - 95.07	95.08 - 97.87	>= 97.88
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Registry	**Yes**	83.62 - 93.52	93.53 - 97.82	97.83 - 99.92	99.93 - 99.99	--	--	--	100
Diabetes: Eye Exam	117	EHR	No	12.0 - 20.54	20.55 - 30.68	30.69 -44.81	44.82 - 69.39	69.4 - 94.16	94.17 - 98.42	98.43 - 99.92	>= 99.93
Diabetes: Eye Exam	117	Registry	**Yes**	89.93 - 96.67	96.68 - 98.85	98.86 - 99.69	99.7- 99.99	--	--	--	100
Documentation of Current Medications in the Medical Record	130	EHR	**Yes**	83.73 - 91.27	91.28 - 94.9	94.91 - 96.99	97.0 - 98.3	98.31 - 99.17	99.18 - 99.69	99.7 - 99.94	>= 99.95
Documentation of Current Medications in the Medical Record	130	Claims	**Yes**	99.67 - 99.93	99.94 - 99.99	--	--	--	--	--	100
Documentation of Current Medications in the Medical Record	130	Registry	**Yes**	86.71 - 96.31	96.32 - 98.94	98.95 - 99.67	99.68 - 99.9	--	--	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Claims	No	--	--	--	--	--	--	--	100

Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Registry	No	32.62 - 60.31	60.32 - 82.13	82.14 - 93.47	93.48 - 98.54	98.55 - 99.99	--	--	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	EHR	No	88.04 - 93.45	93.46 - 95.7	95.71 - 97.12	97.13 - 98.22	98.23 - 98.85	98.86 - 99.49	99.5 - 99.99	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	Registry	No	94.17 - 96.29	96.3 - 97.43	97.44 - 98.44	98.45 - 99.44	99.45 - 99.99	--	--	100
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Claims	No	--	--	--	--	--	--	--	--
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	EHR	No	--	--	--	--	--	--	--	--
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Registry	No	--	--	--	--	--	--	--	--
Controlling High Blood Pressure	236	Claims	No	20 - 29.99	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
Controlling High Blood Pressure	236	Registry	No	20 - 29.99	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
Controlling High Blood Pressure	236	EHR	No	51.69 - 57.07	57.08 - 61.32	61.33 - 64.79	64.8 - 68.44	68.45 - 72.03	72.04 - 76.35	76.36 - 82.37	>= 82.38

Use of High-Risk Medications in Older Adults	238	Registry	No	--	--	--	--	--	--	--	--
Use of High-Risk Medications in Older Adults	238	EHR	No	--	--	--	--	--	--	--	--
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	303	Registry	No	--	--	--	--	--	--	--	--
Cataracts: Patient Satisfaction within 90 Days	304	Registry	No	--	--	--	--	--	--	--	--
Closing the Referral Loop: Receipt of Specialist Report	374	EHR	No	60.0 - 77.54	77.55 - 92.3	92.31 - 97.54	97.55 - 99.99	--	--	--	100
Closing the Referral Loop: Receipt of Specialist Report	374	Registry	No	9.72 - 16.97	16.98 - 25.5	25.51 - 34.92	34.93 - 46.42	46.43 - 59.99	60.0 - 74.59	74.6 - 89.65	>= 89.66
Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	384	Registry	No	96.0 - 99.99	--	--	--	--	--	--	100
Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	385	Registry	No	--	--	--	--	--	--	--	--
Cataract Surgery: Difference Between Planned and Final Refraction	389	Registry/QCDR	No	30.48 - 38.53	38.54 - 51.94	51.95 - 71.07	71.08 - 94.45	94.46 - 98.18	98.19 - 99.99	--	100

MIPS Program: 2021 Promoting Interoperability Category

2021 Updates Following 2019 Category Overhaul

Following a major overhaul of this category in the 2019 performance year, CMS did not finalize any major changes for the 2021 performance year. For 2021, CMS did make some minor changes, which are limited to:

- Maintaining the Electronic Prescribing objective's Query of PDMP measure as optional but increasing the bonuspoints from **five to 10 points,**
- Changing the name of Support Electronic Referral Loops by Receiving and Incorporating Health Information to Support Electronic Referral Loops by Receiving **and Reconciling** Health Information, and
- Adding 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 will be worth 40 points. The HIE Bi-Directional Exchange measure would be reported by attestation and would require a yes/noresponse.

As a reminder, the 2019 overhaul of the category was prompted by advocacy from ASCRS and the medical community that the previous scoring methodology was confusing, and the program retained several measures that relied on the actions of patients or other physicians. The 2019 updates simplified the scoring and removed or modified the measures that were not within the physician's direct control. ASCRS supported these modifications but continues to oppose the "all-or-nothing" scoring methodology and will continue to advocate that CMS make further changes to provide for partial credit in future years.

Small Practice Hardship Exemption

For 2021, CMS is continuing to offer a small practice hardship exemption for the PI category. **Practices of 15 or fewer eligible clinicians must submit a hardship application to have the 25% weight of the PI category re-weighted to the Quality category.**

Promoting Interoperability (PI) Category Weight

For 2021, the PI category score will continue to be weighted at 25% of the overall MIPS final score. If CMS determines that at least 75% of MIPS-eligible clinicians are "meaningful users" of EHR in future years, the scoring weight for PI could be lowered to no less than 15% of the overall score.

In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re- weight the individual provider's quality performance score to make up the difference. If a physician or small practice receives the small practice hardship exemption, the 25% weight of the category will be redistributed to Quality.

Promoting Interoperability Category Performance Period

For 2021, physicians must report PI for at least any 90-day period to be considered full participants. Physicians have the option to report more than 90 days, up to a full year.

Use of 2015 CEHRT

Implemented in 2019, all participants must continue to use 2015 certified electronic health technology (CEHRT) in 2021.

MIPS eligible clinicians may use:

- **Technology certified to the existing 2015 Edition certification criteria,**
- **Technology certified to the 2015 Edition Cures Update certification criteria, or**
- **A combination of both to collect and report their Promoting Interoperability data and eCQMs for the Quality performance category.**

Promoting Interoperability Category Score

A physician's or group's PI category score will be based on the cumulative performance on each of the required measures. The streamlined measure set includes four objectives, with five required measures and one bonus measure. **Physicians must report on all required measures or receive zero points for the entire category.**

Each measure will be scored based on the submission of a numerator and a denominator, except for the measures associated with the **Public Health and Clinical Data Exchange objective and, as of 2020, the optional Query of Prescription Drug Monitoring Program (PDMP)**, and as of 2021, the Health Information Exchange (HIE) Bi-Directional Exchange, both of which require "yes" or "no" submissions. **All measures must have at least 1 in the numerator or answer "yes" to receive credit for the measure.**

The measures will be scored by dividing the numerator by the denominator and multiplying by the designated weight of the measure. The measures are assigned points similarly to the previous methodology, where performance between 1% and 10% equals 1 point, 11% and 20% equals 2 points, etc. Each measure score is then multiplied by the individual measure's weight, which varies from measure to measure. For example, if a practice reports that 85 out of 100 possible patients were given electronic access to their health information, then the performance on the measure is 85%. Since this measure's weight is worth up to 40 points, the clinician's score would be a total of 34 points toward the total category score.

Bonus Points

In 2019, CMS added two new measures to the **e-Prescribe objective** that seek to curb opioid abuse. Since CMS was not able to predict whether all EHR systems would be able to offer the measures for 2019, they were both voluntary.

Following feedback from the vendor community on feasibility and other legislative action by Congress to address the nation's opioid crisis, CMS determined that it would remove one measure, Verify Opioid Treatment Agreement, and modify the remaining Query of PDMP measure to be a "yes" or "no" measure. **For 2021, this measure is still voluntary and clinicians can earn 10 bonus points for submitting a yes for the optional measure, Query of Prescription Drug Monitoring (PDMP).**

There are no longer any bonus points available for using 2015 CEHRT or reporting to additional registries.

Security Risk Analysis

The Security Risk Analysis is no longer a measure included in the PI category. However, since physicians and practices are required to review electronic security protocols under HIPAA, they will still have to attest that a security risk analysis was performed sometime during the performance year when reporting 2021 PI data for MIPS. **This attestation will not be included in the category score, but if the physicians or groups fail to attest to performing the security risk analysis, they will receive zero points for the category, regardless of whether they reported any other data.**

Public Health and Clinical Data Exchange Objective

For 2021, CMS will continue to include a **Public Health and Clinical Data Exchange objective**, which requires that participants report on at least two of the five types of registry reporting. There are exclusions available for each type of registry, so if physicians or groups do not have a total of two registries available to report to, they may claim an exclusion for one or both required registries. Alternatively, if physicians or groups have two of the same type of registry available to report to, they may attest to reporting to both registries of the same type to fulfill the requirement for the objective. Ophthalmologists who report to the IRIS Registry may attest to the **Clinical Data Registry measure**; however, they likely will not have another available registry of any type and will be required to take an exclusion for the second registry.

To receive credit for reporting to any of the data registries, a physician or group must answer "yes" when attesting or claim the exclusion. Answering yes or claiming exclusions for two registries will earn the physician or group the full 10 points for the objective.

Promoting Interoperability Objectives and Measure

2021 PI Objectives and Measures

Objective	Measure	Reporting Requirement	Exclusion	Maximum Points
Electronic Prescribing	**Electronic Prescribing**—At least one permissible prescription written by the provider is queried for a drug formulary and transmitted electronically using CEHRT.	Numerator/Denominator; must have at least 1 in the numerator	**Any MIPS-eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.**	**10 points**
	***Bonus:* Query of Prescription Drug Monitoring Program (PDMP)—** For at least one Schedule II opioid electronically prescribed using	Yes/No; must answer "yes"		**10 bonus points**

	CEHRT during the performance period, the MIPS-eligible clinician uses data from CEHRT to conduct a query of PDMP for prescription drug history, except where prohibited and in accordance with applicable law.			
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information—**For at least one transition of care or referral, the provider who transitions or refers his or her patient to another setting of care or healthcare provider (1) creates a summary of care record using CEHRT, and (2) electronically exchanges the summary of care record.	Numerator/Denominator; must have at least 1 in the numerator	**Any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.**	**20 points**
	Support Electronic Referral Loops by Receiving and Reconciling Health Information—For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS-eligible clinician was the receiving party of a	Numerator/Denominator; must have at least 1 in the numerator	**Any MIPS- eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patient never before encountered during the performance period.**	**20 points**

	transition of care or referral, or for patient encounters during the performance period in which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.			
	Health Information Exchange (HIE) Bi-Directional Exchange The MIPS eligible clinician or group must attest that they engage in bi-directional exchange with an HIE to support transitions of care.	Yes/No; must answer "yes"		**40 points**
Provider to Patient Access	**Provide Patients Electronic Access to Their Health Information**—For at least one unique patient seen by the provider, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information, and (2)	Numerator/Denominator; must have at least 1 in the numerator		**40 points**

	the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of his or her choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.			
Public Health and Clinical Data Exchange	Choose two of the following:	Yes/No; must answer "yes"		**10 points**
	Immunization Registry Reporting		**Any MIPS-eligible clinician meeting one or more of the following criteria: (1) does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period; (2) operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standard required to meet the CEHRT definition at**	

			the start of the performance period; (3) operates in a jurisdiction where no immunization registry or immunization information system had declared readiness to receive immunization data as of 6 months prior to the start of the performance period.	
	Electronic Case Reporting		**Any MIPS-eligible clinician meeting one or more of the following: (1) does not treat or diagnose any reportable diseases for which data is collected by his/her jurisdiction's reportable disease system during the performance period; (2) operates in a jurisdiction for which no public health registry is capable of receiving electronic case reporting data in the specific standard required to meet the CHERT definition at the start of the performance period; (3) operates in a jurisdiction where no public health agency has declared readiness to receive electronic care reporting data 6 months prior to the start of the performance period.**	
	Public Health Registry Reporting		**Any MIPS-eligible clinician meeting one**	

			or more of the following: (1) does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS- eligible clinician's jurisdiction during the performance period; (2) operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period; (3) operates in a jurisdiction where no public health registry for which the MIPS-eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.	
	Clinical Data Registry Reporting		**Any MIPS-eligible clinician meeting one or more of the following: (1) does not diagnose or directly treat any disease or condition associated with a clinical data registry in his/her jurisdiction during the performance period;**	

			(2) operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transaction in the specific standards required to meet the CEHRT definition at the start of the performance period; **(3) operates in a jurisdiction where no clinical data registry for which the MIPS-eligible clinician is eligible had declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.**	
	Syndromic Surveillance Reporting		**Any MIPS-eligible clinician meeting one or more of the following: (1) is not in a category of healthcare providers from which ambulatory syndromic surveillance data is collected by his/her jurisdiction's syndromic surveillance system; (2) operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the performance**	

			period; (3) operates in a jurisdiction where no public health agency had declared readiness to receive syndromic surveillance data from MIPS-eligible clinicians as of 6 months prior to the start of the performance period.	

MIPS Program:
2021 Improvement Activities Category

Improvement Activities Category Weight –15%

For 2021, the fourth performance year of MIPS, CMS will weight a clinician's or group's Improvement Activities score at 15% of the overall MIPS final score.

Improvement Activities Reporting Requirements

Physicians must achieve a total of 40 points from improvement activities during a 90-day reporting period. CMS will score individual improvement activities as either high- or medium-weighted. High-weighted activities are worth 20 points, while medium-weighted activities are worth 10 points. Providers are required to perform four medium-weighted or two high-weighted activities, or any combination of high- or medium-weighted activities.

Physicians in groups of 15 or fewer are only required to complete one high-weighted or two medium-weighted activities for full credit—40 points—for the category. For small practices, CMS will weigh the improvement activities at double the value for larger practices. Therefore, high-weighted activities are worth 40 points, while medium-weighted activities are worth 20 points. **Providers in groups of 15 or fewer can achieve half of the total category score by completing one medium-weighted improvement activity.**

Providers participating in a patient-centered certified medical home will automatically receive full credit for the Improvement Activities category of MIPS. For organizations with multiple practice sites, at least 50% of these locations must be recognized or certified patient-centered medical homes or comparable specialty practices to attest to this.

If you're a clinician in any Alternative Payment Model (APM) who is participating in traditional MIPS, you'll earn half credit (50%) automatically for the improvement activities performance category.

In 2021, all MIPS APM participants reporting via the new APM Performance Pathway (APP) will receive a score of 100%.

Group Reporting Participation Threshold

As of 2020, CMS is requiring that for groups reporting MIPS, at least 50% of the participants in the group must complete the improvement activity reported. However, participants completing the activity are not required to complete it within the same 90-day period. Previously, CMS only required that at least one person in the group completed the activity to receive credit for the entire group. This requirement is continuing in the 2021 performance year.

Improvement Activities Score

To determine a provider's Improvement Activities category score, CMS will divide the sum of the points earned by the provider by 40, the total available points for the category. The Improvement Activities category score would then be counted as 15% of the MIPS final score.

Ophthalmology Improvement Activity

In 2019, CMS added an ophthalmology specific improvement activity: Comprehensive Eye Exam, which is still available for 2021 but has been modified. For this medium-weighted activity, participants must promote the importance of a comprehensive eye exam, which may be accomplished by providing literature or facilitating conversation about the topic using materials created by the American Academy of Ophthalmology or the American Optometric Association.

For 2021, CMS modified the existing Improvement Activity for 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.

Improvement Activities

The final rule includes a list of all individual improvement activities. The activities are grouped in eight sub-categories corresponding to CMS' stated goals. Providers may choose any combination of improvement activities, regardless of category.

The categories and examples of activities included are listed below:

- **Expanded Practice Access:** Improvement activities include expanded practice hours, telehealth services, and participation in models designed to improve access to services.
- **Population Management:** Improvement activities include participation in chronic caremanagement programs, participation in rural and Indian Health Services programs, participation in community programs with other stakeholders to address population health, and use of a Qualified Clinical Data Registry (QCDR) to track population outcomes.
- **Care Coordination:** Improvement activities include use of a QCDR to share information, timely communication and follow up, participation in various CMS models designed to improve care coordination, implementation of care coordination training, implementation of plans to handle transitions of care, and active referral management.

- **Beneficiary Engagement:** Improvement activities include use of EHR to document patient-reported outcomes, providing enhanced patient portals, participation in a QCDR that promotes the use of patient engagement tools, and use of QCDR patient experience data to inform efforts to improve beneficiary engagement.
- **Patient Safety and Practice Assessment:** Improvement activities include use of QCDR data for ongoing practice assessments and patient safety improvements, as well as use of tools, such as the Surgical Risk Calculator.
- **Achieving Health Equity:** Improvement activities include seeing new and follow-up Medicaid patients in a timely manner and use of QCDR for demonstrating performance of processes for screening for social determinants.
- **Emergency Response and Preparedness:** Improvement activities include participation in disaster medical teams or participation in domestic or international humanitarian volunteer work.
- **Behavioral and Mental Health:** Improvement activities include tobacco interventionand smoking cessation efforts, and integration with mental healthservices.

For the full list of proposed improvement activities, please refer to the CMS website: https://qpp.cms.gov/mips/improvement-activities?py=2021

Data Submission

Providers can submit improvement activities data using the following mechanisms: qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. In 2021, all submission mechanisms must designate a “yes/no” response for submitting improvement activities.

MIPS Program: 2021 Cost Category

Cost Category Weight – 20% for 2021 Performance Year

CMS is increasing the Cost category weight to 20% of the final MIPS score in 2021—up from 15% in 2020.

In 2018, Congress enacted ASCRS-supported technical corrections to MACRA that allow CMS to extend the flexibility included in the first three years of MACRA and weight this category at less than 30% of the final MIPS score for three additional years. The Cost category must account for 30% of the final MIPS score beginning in the 2022 performance year.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference. If a physician or group does not have any cost measures attributed, the 20% weight in 2021 will be reassigned to the Quality category.

Cost Reporting Requirements

Physicians do not need to submit separate data for the Cost category. CMS will determine cost scores through administrative claims.

Cost Measures

For 2021, this category maintains several episode-based cost measures, including one for cataract surgery. In addition, CMS has retained population-health total per capita cost measure (TPCC) and the Medicare spending per beneficiary (MSPB) measure but has updated the attribution methodology. Following years of advocacy from ASCRS and the medical community, dating back to the Value-Based Payment Modifier when these measures were first used, as of 2020, CMS excludes ophthalmologists, optometrists, and other specialists who do not provide primary care from attribution to the TPCC measure.

For 2021, ophthalmologists will continue to only have the cataract surgery episode-based cost measure attributed in this category.

The episode-based measures, including cataract surgery, seek to measure the cost of care related to a specific procedure or condition and include the total costs of pre-operative testing, the surgery itself, facility fee, some drugs separately payable under Part B (including one administered during surgery), anesthesia costs, and additional post-operative care billed separately from the surgery, such as additional procedures as a result of a complication. The measure includes costs 60 days prior to the surgery and 90 days following it. Each year, the episode measures will be updated to include new Part B drugs on a case-by-case basis.

For 2021, the following Part B drugs are included in the cataract surgery episode measure in conjunction with certain diagnoses:

HCPCS Code	Description	Included Diagnoses
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	Included regardless of diagnosis
J0278	Injection, amikacin sulfate, 100 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J0713	Injection, ceftazidime, per 500 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J0197	Phenylephrine 10.16 Mg/Ml And Ketorolac 2.88 Mg/Ml Ophthalmic	Included regardless of diagnosis
J3370	Injection, vancomycin hcl, 500 mg	H25.11, H25.12, age-related nuclear cataract; H25.811, H25.812, combined forms of age-related cataract; H26.8, other specified cataract; H26.9, unspecified cataract; H44.021, H44.022, unspecified purulent endophthalmitis
J3465	Injection, voriconazole, 10 mg	H44.021, H44.022, unspecified purulent endophthalmitis; H44.011, H44.012, panophthalmitis (acute)

The cataract surgery episode measure is sub-grouped to compare the costs of cataract surgeries performed under similar conditions. Specifically, the measure divides cataract surgery between ASC and HOPDs and unilateral surgery versus bilateral surgery when the second eye is operated on within the first eye's global period. To calculate the measure, CMS will compare the costs of each sub-group of surgeries with the cost of other surgeries nationwide. For example, if a surgeon performs some surgeries in an ASC and others in an HOPD, the cost of the surgeries in the ASC will be compared to a national average of cataract surgeries in ASCs, and the surgeries performed in the HOPD will be compared to the national average cost of cataract surgeries in HOPDs.

To calculate the total measure score, CMS will evaluate each surgery, or episode, and compare it to the national average expected cost for its sub-group. This comparison is done by dividing the observed cost of the episode by its expected cost, which expresses the observed cost's deviation from the expected cost as a ratio. CMS will then add all the episodes' ratios together, across all sub-groups, and then divide that sum by the total number of episodes to determine the total average of the surgeon's episodes' deviations from the expected costs. That figure is then multiplied by a national average total cost to represent the surgeon's average deviation from expected costs as a dollar figure.

In addition, the measure is risk-adjusted to remove all patients with ocular co-morbidities. The list of excluded co- morbidities is identical to the list of exclusions for the MIPS quality measure 191, 20/40 or Better Visual

Acuity 90 Days following Cataract Surgery.
The complete measure specifications for the cataract episode measure are available on the ASCRS website.

CMS and its contractor Acumen developed the episode-based cost measures with physician input, including that of ASCRS. An ASCRS physician continues to serve on a technical expert panel advising CMS and Acumen on the development of the cataract and other episode measures.

Patient Attribution

For the cataract episode measure, an ophthalmologist will be attributed a patient that meets the following characteristics:

- **Medicare Part B patient;**
- **Performed uncomplicated cataract surgery and billed only 66984; and**
- **Did not have one of the exclusionary ocular co-morbidities.**

The attribution threshold is 10 patients for the cataract surgery episode measure. If physicians or groups bill at least 10 surgeries that meet the above specifications, they will be attributed this measure.

As mentioned above, the TPCC measure now excludes ophthalmologists and optometrists from attribution, and the MSPB measure is based on inpatient care and unlikely to be attributed to ophthalmologists or optometrists. However, if an ophthalmologist or optometrist practices in a large, multispecialty group, such as an academic practice, that reports MIPS as a group, these measures may be included in the final group score if other clinicians in the group, such as primary care or hospital-based specialists, are attributed.

Cost Category Score

To determine a provider's Cost category score, CMS will assign 1 to 10 points to each measure attributed to the physician or, if reporting as a group, the entire group based on performance relative to the established benchmark. The benchmark for each measure will be determined based on **cost data from the performance period.** CMS would award points for each measure depending on how a provider scored in relation to overall performance.

The total category points possible for a performance year depend on how many measures the physician or, if reporting as a group, the group is attributed. Each attributed measure has the same weight toward the category score. The Cost category score is determined by adding the points scored on each measure and dividing by the total possible points available. **However, since it is likely that most ophthalmologists will only have the cataract episode measure attributed, the entire category score will be based on the performance on this measure.**

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60%.

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.