

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 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. **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 CY 2020)
- 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 to measures 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 TPCC measure.
- 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/no response.

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 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.

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 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. 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 extent feasible.

New MVP Development Criteria:

- Use measures and improvement activities across all 4 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.
- 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 be 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.

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.

