2021 Quality Payment Program Proposed Rule Overview Fact Sheet

Future Direction of the Quality Payment Program

As clinicians across the country continue to respond to the 2019 Coronavirus (COVID-19) pandemic, we recognize that the most important priority right now is ensuring patients are getting the care they need. We want to support this focus by limiting the number of significant changes to the Quality Payment Program in 2021, continuing a gradual implementation timeline for the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), and introducing the Alternative Payment Model (APM) Performance Pathway (APP).

We had previously finalized that participation through MIPS Value Pathways would begin with the 2021 performance period. However, we recognize stakeholder concerns about this timeline, even more so now that clinicians are working hard to address the spread of COVID-19 within their practices and communities. Therefore, we will not be introducing any MVPs into the program for the 2021 performance period. Instead we are proposing additions to the 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.

Additionally, as we continue to make strides towards facilitating transition of clinicians from MIPS to APMs, we are proposing a new APM Performance Pathway (APP) reporting option in 2021 to align with the MVP framework. As part of the APP introduction, we will also be sunsetting the CMS Web Interface as a collection type beginning in the 2021 performance period. This change will significantly reduce the number of measures required to be reported by Accountable Care Organizations **(**ACOs) participating in the Medicare Shared Savings Program as well as groups and virtual groups that report through the CMS Web Interface as they transition to other collection types that offer greater choice. We believe working towards a future state of the program that is more aligned through these participation pathways will achieve our goal of moving away from siloed performance category activities and measures and moving towards sets of measurement options that are more relevant to a clinician's scope of practice and that are meaningful to patient care.

Quality Payment Program Proposals CY 2021 Overview

In light of the national public health emergency triggered by the COVID-19 pandemic, we limited our policy proposals to focus on the highest priorities for the program. In order to help us progress further towards the future state of MIPS, we have made some additional strides in furthering the MVP framework by proposing updates to the MVP guiding principles and additional guidance and structure that stakeholders should consider when collaborating with us on MVP creation. In addition, for the 2021 performance period, we have proposed some needed updates to both the MIPS and Advanced APM tracks to continue reducing burden, respond to feedback that we have heard from clinicians and stakeholders, and align with statutory requirements.

(*Note*: This section provides a highlight of our proposals on the topics below. For more details, refer to the comparison table beginning on page 12.)

Participation Pathways

MIPS Value Pathways (MVPs)

In the CY 2020 PFS Final Rule, we had finalized a set of guiding principles to help us define what MVPs would look like as we implement them in future years. A majority of stakeholders have supported the implementation of a set of guiding principles but provided comments on ways we could further refine the principles. Based on stakeholder comments provided through the RFI, we have proposed updates to further refine the guiding principles of MVPs to include the patient voice, subgroup reporting, and a fifth principle related to promoting digital performance measure data submission. In addition, we have also heard from stakeholders the need for criteria for stakeholders to follow as they work to develop MVP candidates. Therefore, we have also proposed a set of criteria to be considered when creating MVP candidates. We refer readers to the table below for additional details.

APM Performance Pathway (APP)

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

The APP, like an MVP, would be composed of a fixed set of measures for each performance category. In the APP, the Cost performance category would be weighted at 0%, as all MIPS APM participants already are responsible for cost containment under their respective APMs. The Improvement Activities performance category score would automatically be assigned based on the requirements of the MIPS APM in which the MIPS eligible clinician participates; in 2021, all APM participants reporting through the APP will earn a score of 100%. The Promoting Interoperability performance category would be reported and scored at the individual or group level, as is required for the rest of MIPS.

The Quality performance category will be composed of six measures that are specifically focused on population health and that we believe to be widely available to all MIPS APM participants. Therefore, participants in various MIPS APMs should be able to work together to easily report on a single set of quality measures each year that represent a true cross-section of their participants' performance.

One useful note about the APP is that quality measures reported through the APP automatically will be used for purposes of Medicare Shared Savings Program quality scoring, thus satisfying reporting requirements for both programs. We believe this approach would reduce burden and enhance further alignment across APMs. (Please refer to the Appendix for a list of the core Quality measures in the APP.)

MIPS Program Updates

Participation Options

We are continuing to allow MIPS eligible clinicians to participate in MIPS as individuals or as part of a group or virtual group, and we are expanding the use of the APM Entity submitter type to allow the use of all MIPS submission mechanisms.

In past years, MIPS eligible clinicians participating in MIPS APMs were required to participate in MIPS through their APM Entity for scoring under the APM Scoring Standard. We are proposing to end the APM Scoring Standard beginning with the 2021 performance period. Additionally, we are proposing to add the APM Entity as a submitter type which may report to MIPS on behalf of associated MIPS eligible clinicians. The APM Entity would be defined by the Participation List or Affiliated Practitioner list of the applicable MIPS APM. The APM Entity would be able to report on the Quality and Improvement Activities performance categories. Quality measures could be selected and reported in the same manner and using the same options that are available to all other MIPS eligible clinicians, or could be reported through the APP.

We note that the Cost category would also be scored for APM Entities that do not report through the APP. When an APM Entity chooses to report to MIPS, we would generally calculate a Promoting Interoperability performance category score for the APM Entity group.

Performance Threshold and Performance Category Weights

We propose to continue to incrementally adjust the performance threshold and performance category weights to meet the requirements established by the statute. Beginning with the sixth year of the program (2022 performance period), the performance threshold needs to be set at the mean or median of the final scores for all MIPS eligible clinicians for a prior period, and the Quality and Cost performance categories must be equally weighted at 30% each.

We are proposing the following **performance threshold and category weights** for the 2021 performance period (which equates to the 2023 payment year):

- The performance threshold to be 50 points
- The Quality performance category to be weighted at 40% (5% decrease from PY 2020)
- The Cost performance category to be weighted at 20% (5% increase from PY 2020)
- The Promoting Interoperability performance category to be weighted at 25% (no change from PY 2020)
- The Improvement Activities performance category to be weighted at 15% (no change from PY 2020)

In the CY 2020 PFS Final Rule, we had finalized a performance threshold of 60 points for the 2021 performance period but are proposing and soliciting comment on a lower performance threshold of 50 points.

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period.

Performance Category Proposals

For the **Quality performance category,** we are proposing to:

- Use performance period, not historical, benchmarks to score quality measures for the 2021 performance period. We are concerned we may not have a representative sample of historic data for CY 2019 because of the national public health emergency for COVID-19 (which impacted data submission in 2020), which could skew benchmarking results.
- Update the scoring policy for topped-out measures, so that the 7 measure achievement point cap will be applied only if the measure is identified as topped out based on the established benchmarks for both the 2020 and 2021 performance periods, given that we are proposing to use performance period, not historical, benchmarks for the 2021 performance period;
- Address substantive changes to 112 existing MIPS quality measures, removing 14 quality measures from the MIPS program, and proposing a total of 206 quality measures starting in the 2021 performance year, including two new administrative claims-based measures, one of which has a 3-year measurement period;
- Revise scoring flexibility for measures with specification or coding changes during the performance year; and
- End the CMS Web Interface as a quality reporting option for ACOs and registered groups, virtual groups, or other APM Entities beginning with the 2021 performance period.

We recognize that our proposal to end the CMS Web Interface would be a big change for groups and virtual groups using the CMS Web Interface measures, especially those that have reported through this collection type for the first 3 years of the program and through a similar reporting mechanism in our legacy programs. However, we believe that the transition to using an alternative collection type for the 2021 performance period would reduce reporting requirements for these groups and virtual groups. Groups and virtual groups would be able to:

- Select their own quality measures instead of reporting on a pre-determined set of measures established under the CMS Web Interface.
    - The ability to select measures more meaningful to their scope of practice, including specialty specific measures, would better prepare them for implementation of MVPs.

- Report fewer measures (6 as opposed to 10) with the ability to report on all-payer data.
- Have the option to report the eCQM or MIPS CQM version of the same primary care measures previously reported through the CMS Web Interface.
    - There are 10 eCQMs and 9 MIPS CQMs that are the same as the previously reported CMS Web Interface measures.

There is a separate proposal that would require ACOs participating in the Shared Savings Program to report their quality measures through the APM Performance Pathway (APP). The quality measures reported through the APP would also count for the MIPS Quality performance category for the MIPS eligible clinicians participating in these ACOs.

For the **Cost performance category,** we are proposing to:

- Update existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the TPCC measure.

For the **Improvement Activities performance category**, we are proposing to:

- Make minimal updates to the Improvement Activities Inventory;
- Establish policies in relation to the Annual Call for Activities including an exception to the nomination period timeframe during a public health emergency (PHE) and a new criterion for nominating new improvement activities; and
- Establish a process for agency-nominated improvement activities.

For the **Promoting Interoperability performance category**, we are proposing to:

- Retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and propose to make it worth 10 bonus points;
- Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling”; and

- Add an optional Health Information Exchange (HIE) bi-directional exchange measure.

We are also focused on improving partnerships with third party intermediaries to help reduce clinician reporting burden and improve the services clinicians receive.

For **third party intermediaries**, such as Qualified Clinical Data Registries (QCDRs) and Qualified Registries, we are:

- Proposing to allow QCDRs, Qualified Registries, and Health IT vendors to support:
    - MVPs beginning with the 2022 performance period
    - The APM Performance Pathway (APP) beginning with the 2021 performance period
- Proposing to establish specific data validation requirements for QCDRs and Qualified Registries, and seeking comment on whether Health IT Vendors and CAHPS survey vendors should perform similar data validation.
- Proposing that the following additional factors will be considered when determining whether to approve a third party intermediary for future participation in the MIPS program:
    - The entity's compliance with the requirements of this section for any prior MIPS performance period for which it was approved as a third party intermediary.
    - Whether the entity provided inaccurate information to the clinicians regarding Quality Payment Program requirements.
- Updating the standards for QCDR measures (details in the table below):
    - Modifications to the QCDR measure testing requirement
    - QCDR measures must be fully tested at the clinician level in order to be considered for inclusion in an MVP.
    - Modifications to the QCDR measure data collection requirement

Lastly, we are proposing to require additional information be submitted to CMS as part of the corrective action plans under the remedial action and termination policies applicable to all third party intermediaries.

Scoring Proposals (COVID-19 Flexibilities for PY 2020)

We are proposing to change the maximum number of points available for the complex patient bonus to account for the additional complexity of treating patients during the COVID-19 Public Health Emergency. As proposed, clinicians, groups,

virtual groups, and APM Entities could now earn up to 10 bonus points towards their final score for the 2020 performance year. We are proposing this increase for the 2020 performance period only.

We are also proposing to 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 performance period.

Physician Compare

Finally, to more completely and accurately reference the website for which CMS will post information available for public reporting we propose to define Physician Compare to mean the Physician Compare Internet Web site of the Centers for Medicare & Medicaid Services (or a successor Web site).

Advanced APMs

We are proposing that in calculating QP Threshold Scores used in making Qualifying APM Participant (QP) determinations, beginning in the 2021 QP Performance Period, Medicare patients who have been prospectively attributed to an APM Entity during a QP Performance Period will not be included as attribution-eligible Medicare patients for any APM Entity that is participating in an Advanced APM that does not allow for attribution of Medicare patients that have already been prospective attributed to other APM Entities.

The effect of this proposed policy would be to remove such prospectively attributed Medicare patients 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.

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

Medicare Shared Savings Program

For performance year 2021, we are proposing that Accountable Care Organizations **(**ACOs) participating in the Shared Savings Program would be required to report quality measure data for purposes of the Shared Savings Program via the APP, instead of the CMS Web Interface. Under this new approach, ACOs would only 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, and the number on which ACOs are required to actively report would be reduced from 10 to 3. In addition, we are considering adding a "Days at Home" measure that is currently under development, to the APP core measure set in future years. (Please refer to the Appendix for a list of the core Quality measures in the APP.)

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. Currently, ACOs have to completely and accurately report all measures and achieve at or above the 30th percentile on one measure in each domain to be eligible to share in savings. Under the proposed redesign, if the quality performance standard is met, the ACO would receive the maximum sharing rate. If the quality performance standard is not met, the ACO would not be eligible to share in any earned savings. For ACOs that owe shared losses, the losses would be scaled using the MIPS Quality performance category score under Track 2 and the ENHANCED track; and under the BASIC track and the Track 1+ ACO Model, we would continue to apply a fixed 30% loss sharing rate.

In conjunction with our proposed changes to the quality performance standard, we are proposing to strengthen our Shared Savings Program policies regarding compliance with the quality performance standard by broadening the conditions under which CMS may terminate an ACO's participation agreement when an ACO demonstrates a pattern of failure to meet the quality performance standard.

For performance year 2020, all ACOs are considered to be affected by the Public Health Emergency (PHE) for the COVID-19 pandemic, and the Shared Savings Program extreme and uncontrollable circumstances policy applies. In addition, for performance year 2020 only, we are proposing to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey. Consequently, ACOs would receive automatic full credit for the patient experience of care measures. We are also seeking comment on an alternative scoring methodology approach under the extreme and uncontrollable circumstances policy.

We Want to Hear from You

We welcome your feedback on the proposed policies for the 2021 performance period of the Quality Payment Program. Please note that the official method for commenting is outlined below.

How Do I Comment on the CY 2021 Proposed Rule?

The proposed rule includes directions for submitting comments. Comments must be received within the 60-day comment period, which closes on October 1, 2020. When commenting refer to file code: CMS-1734-P

FAX transmissions won't be accepted. Use one of the following ways to officially submit your comments:

- Electronically through Regulations.gov
- Regular mail
- Express or overnight mail

The proposed rule can be accessed through the "Regulatory Resources" section of the QPP Resource Library.

Contact Us

We will continue to provide support to clinicians who need assistance. While our support offerings will reflect our efforts to streamline and simplify the Quality Payment Program, we understand that clinicians will still need assistance in order to help them successfully participate. We will continue offering direct, customized technical assistance to clinicians in small practices through our Small, Underserved, and Rural Support initiative.

We also encourage clinicians to contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time or by email at QPP@cms.hhs.gov. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Changes to QPP Policies Proposed in the CY 2021 NPRM

Quality Payment Program CY 2021 NPRM: MIPS Overview

Policy Area	CY 2020 Policy	CY 2021 Proposed
Participation Pathways		
MIPS Value Pathways (MVPs)	**MVP Implementation Timeline:** MVPs will be a participation framework beginning with the 2021 performance period. **MVP Guiding Principles:** 1. MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden, related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data. 2. 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; 3. MVPs should include measures to encourage performance improvements in high priority areas.	**MVP Implementation Timeline:** MVPs must be established through rulemaking and we are not proposing any MVP candidates for comment in this NPRM. As a result, MVPs will not be available for MIPS reporting until the 2022 performance period, or later. **Proposed Revisions to MVP Guiding Principles** *(Italics will indicate updates):* 1. 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. *2.* 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.* *3.* MVPs should include measures *selected using the Meaningful Measures approach and, wherever possible, the patient voice*

Policy Area	CY 2020 Policy	CY 2021 Proposed
	4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.	*must be included,* to encourage performance improvements in high priority areas. 4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement. (No change) 5. *MVPs should support the transition to digital quality measures*. **Proposed New MVP Development Criteria:** • Utilize measures and activities across all four performance categories, if feasible (Quality, Cost, Improvement Activities, and Promoting Interoperability) • Have a clearly defined intent of measurement • Align with the Meaningful Measure Framework • Have measure and activity linkages within the MVP • Be clinically appropriate • Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties • Be comprehensive and understandable by clinicians, groups, and patients • To the extent feasible, include electronically specified quality measures • Incorporates the patient voice • Ensures quality measures align with existing MIPS quality measure criteria, and considers the following: Whether the quality measures are applicable and available to the clinicians and groups, collection types measures are available through • Beginning with the 2022 performance period, may include QCDR measures that have been fully tested

Policy Area	CY 2020 Policy	CY 2021 Proposed
		• Ensures that the cost measure is related to the other measures and activities included in the MVP, and if a relevant cost measure for specific types of care are not available, includes a broadly applicable cost measure that is applicable to the clinician type, and considers what additional cost measures should be prioritized for future development and inclusion in the MVP • Includes improvement activities that can improve the quality of performance in clinical practice, that complement and/or supplement the quality action of the measures in the MVP, and uses broadly applicable improvement activities when specialty or sub-specialty improvement activities are not available • Must include the entire set of Promoting Interoperability measures • Includes the administrative-claims based measure, Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups **<u>Proposed Process for Candidate MVP collaboration, solicitation, and evaluation:</u>** • We would hold a public facing MVP development webinar to review MVP development criteria, timelines, and process in which to submit a candidate MVP • Stakeholders would formally submit their MVP candidates using a standardized template (to be published in the QPP Resource Library)

Policy Area	CY 2020 Policy	CY 2021 Proposed
		• We would review and evaluate MVP candidates as they are received (asking follow up questions as needed), against the aforementioned described criteria. • We would also vet the quality, QCDR, and cost measures from a technical perspective to validate the coding and inclusion of clinician types intended to be measured. • When an MVP candidate is identified as feasible for the upcoming performance periods, we would schedule meetings with the stakeholder collaborators to discuss our feedback and next steps. • Because MVPs must be established through rulemaking, CMS will not communicate to the stakeholder whether an MVP candidate has been approved, disapproved, or is being considered for a future year, prior to the publication of the proposed rule.
APM Performance Pathway		• This new Pathway is a complementary Pathway to the MVPs. • The APP would be available only to participants in MIPS APMs and would be required for Medicare Shared Savings Program quality determinations for ACOs. It may be reported by the individual eligible clinician, group TIN, or APM Entity. • The APP, like an MVP, would be comprised of a fixed set of measures for each performance category. • In the APP, the Cost performance category would be weighted at 0%, as all MIPS APM participants are already responsible for cost containment under their APMs. • The Improvement Activity performance category score would automatically be assigned based on the Improvement Activity requirements of the MIPS APM in which the MIPS eligible

Policy Area	CY 2020 Policy	CY 2021 Proposed
		clinician participates. All APM participants reporting the APP would earn a score of 100% for the 2021 performance period. • The Promoting Interoperability performance category would be reported and scored as required for the rest of MIPS. • The Quality performance category would be comprised of 6 measures designed specifically focused on population health and believed to be widely available to all MIPS APM participants. Therefore, participants in various MIPS APMs should be able to work together to easily report on a single set of quality measures each year that represent a true cross-section of their participants' performance. • Quality measures reported through the APP would automatically be used for purposes of quality performance scoring under the Shared Savings Program.
MIPS Participation Options		
MIPS Participation and Reporting	MIPS eligible clinicians may participate in MIPS as: • An individual clinician • A group • A virtual group **Exception:** Eligible clinicians in a MIPS APM are required to participate in MIPS through their APM Entity under the APM Scoring Standard.	We are proposing that all MIPS eligible clinicians, including those in a MIPS APM, may choose to participate in MIPS as: • An individual • A group • A virtual group • An APM Entity We are also proposing to end the APM Scoring Standard (reporting requirements and scoring approach for APM participants) beginning with the 2021 performance period.

Policy Area	CY 2020 Policy	CY 2021 Proposed
MIPS Performance Categories		
Performance Category Weights	**No change from CY 2019:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	We are proposing the following performance category weights for the 2021 performance period: • Quality: **40%** • Cost: **20%** • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change) Note that these weights do not apply to the APM Performance Pathway.
Quality Performance Category Collection Types	**Available Collection Types for Groups and Virtual Groups** • CMS Web Interface Measures • Electronic Clinical Quality Measures (eCQMs) • Medicare Part B Claims Measures • MIPS Clinical Quality Measures (MIPS CQMs) • QCDR Measures	**Available Collection Types for Groups and Virtual Groups** • Electronic Clinical Quality Measures (eCQMs) • Medicare Part B Claims Measures • MIPS Clinical Quality Measures (MIPS CQMs) • QCDR Measures We are proposing to remove the CMS Web Interface as a collection type and submission type for groups and virtual groups beginning with the 2021 performance period.
Quality Measures		We are proposing a total of 206 quality measures for the 2021 performance period which reflect proposals on: • Substantive changes to 112 existing MIPS quality measures; • Changes to specialty sets; • Removal of measures from specific specialty sets; • Removal of 14 quality measures; and • 2 new administrative claims outcome quality measures.

Policy Area	CY 2020 Policy	CY 2021 Proposed
		The 2 proposed administrative claims measures are: 1. **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups** a. 200 case minimum b. 1-year measurement period c. Only applies to groups and virtual groups with 16 or more clinicians and that meet the case minimum 2. **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) Eligible Clinicians** a. 25 case minimum b. 3-year measurement period c. Applies to individual clinicians, groups and virtual groups that meet the case minimum
Quality Measure Benchmarks	Whenever possible, we use historical data (from 2 years prior) to establish quality measure benchmarks. A historical benchmark is created when at least 20 clinicians, groups or virtual groups reported the measure in the baseline period and met the criteria for contributing to the benchmark. When a historical benchmark cannot be created, we will attempt to create a benchmark using data submitted for the performance period.	**Proposed Quality Measure Benchmarks:** We intend to use performance period benchmarks for the CY 2021 MIPS performance period, using the data submitted during the CY 2021 performance period rather than baseline period historic data. We are concerned we may not have a representative sample of historic data for CY 2019 because of the national public health emergency for COVID-19 (which impacted data submission in 2020), which could skew benchmarking results.

Policy Area	CY 2020 Policy	CY 2021 Proposed
Topped Out Measures	When the published historical benchmarks identify a measure as topped out for 2 or more consecutive years, the measure can earn a maximum of 7 achievement points beginning in the second consecutive year the measure is identified as topped out.	Tied to our proposal above, we propose to apply a cap of 7 achievement points, for the 2021 performance period and beyond, to measures that are identified as topped out for 2 or more consecutive years including the 2021 MIPS performance period benchmarks.
Scoring Flexibilities	We established scoring flexibility for quality measures with significant changes during the performance period. • For measures with significant ICD-10 coding changes, we truncated the performance period to the first 9 months of the calendar year. (ICD-10 changes are effective 10/1 each year.) • For measures with significant changes to clinical practice guidelines, we suppressed the measure from scoring (0 achievement points and total measure achievement points reduced by 10).	We are proposing to increase our previously established scoring flexibility by: • Expanding the list of reasons that a quality measure may be impacted during the performance period, and • Revising when we would allow scoring of the measure with a performance period truncation (to 9 months) or the complete suppression of the measure if 9 months of data are not available. Potential changes that may impact quality measures during the performance period include updates to clinical guidelines or measure specifications, such as revisions to medication lists, codes and clinical actions. Based on the timing of the change and the availability of data, we would • Truncate the performance period to 9 consecutive months if there were no concerns with potential patient harm and 9 consecutive months of data were available; **or** • Suppress the measure from scoring (0 achievement points and total measure achievement points reduced by 10 for each measure submitted that is impacted) if 9 consecutive months of data were not available.

Policy Area	CY 2020 Policy	CY 2021 Proposed
		Our intent is to establish an approach that allows us to score a quality measure even when there has been a change to the measure outside of the clinician's control during the performance period.
Third Party Intermediaries	**Data Submission** • For the 2020 performance period, QCDRs, Qualified Registries, and Health IT vendors may support data submission for the Quality, Improvement Activities, and Promoting Interoperability performance categories. • For the 2021 performance period, QCDRs and Qualified Registries must support data submission for the Quality, Improvement Activities, and Promoting Interoperability performance categories. Health IT vendors must be able to submit data for at least one of the aforementioned performance categories. **Data Validation** • QCDRs and qualified registries conduct data validation audits on an annual basis; • QCDRs and qualified registries would conduct a detailed audit if errors are identified during the randomized audit.	**Data Submission Proposals** • No proposals to change the performance category data submission requirements finalized in the CY 2020 PFS Final Rule. • For the 2021 performance period, QCDRs, Qualified Registries, and Health IT Vendors may support data submission for the APM Performance Pathway (APP). • For the 2022 performance period, QCDRs, Qualified Registries, and Health IT vendors may support data submission for MVPs. **Data Validation Proposals** • We are proposing that QCDRs and qualified registries would conduct data validation audits, with specific obligations, on an annual basis. • We are proposing that QCDRs and qualified registries would also conduct a targeted audit if errors are identified during the data validation audit.

Policy Area	CY 2020 Policy	CY 2021 Proposed
	Third Party Intermediary Approval Criteria • A third party intermediary's principle place of business and retention of any data must be based in the U.S. • If the data is derived from CEHRT, a QCDR, qualified registry, or health IT vendor must be able to indicate its data source. • All data must be submitted in the form and manner specified by CMS. • If the clinician chooses to opt-in in accordance with §414.1310, the third party intermediary must be able to transmit that decision to CMS. • The third party intermediary must provide services throughout the entire performance period and applicable data submission period. • Prior to discontinuing services to any MIPS eligible clinician, group, or virtual group during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, or virtual group to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected,	• We are seeking comment on whether we should require Health IT Vendors and CAHPS vendors to perform similar data validation. **Third Party Intermediary Approval Criteria Proposal** • We are proposing the following additional factors for consideration when determining whether to approve a third party intermediary for future participation in the MIPS program: ○ The entity's compliance with the requirements of this section for any prior MIPS performance period for which it was approved as a third party intermediary ○ Whether the entity provided inaccurate information to the clinicians regarding Quality Payment Program requirements

Policy Area	CY 2020 Policy	CY 2021 Proposed

	collection type according to a CMS approved a transition plan.
	
	<u>Third Party Intermediary Remedial Action and Termination</u>
	
	• If CMS determines that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, has submitted a false certification under paragraph (a)(5) of this section, or has submitted data that are inaccurate, unusable, or otherwise compromised, CMS may take one or more of the following remedial actions after providing written notice to the third party intermediary:
	• Require the third party intermediary to submit a corrective action plan (CAP) to CMS to address the identified deficiencies or data issue, including the actions it will take to prevent the deficiencies or data issues from recurring. The CAP must be submitted to CMS by a date specified by CMS.
	• Publicly disclose the entity's data error rate on the CMS website until the data error rate falls below 3%.
	• CMS may immediately or with advance notice terminate the ability of a third party intermediary to submit MIPS data on behalf of a MIPS eligible clinician, group, or virtual group for one or more of
		<u>Third Party Intermediary Remedial Action and Termination Proposal</u>
		Proposing additional policy on what information would be required in a corrective action plan (CAP):
		• The CAP must detail the issues that contributed to the non-compliance.
		• The CAP must detail the impact to individual clinicians, groups, or virtual groups, regardless of whether they are participating in the program because they are MIPS eligible, voluntary participating, or opting in to participating in the MIPS program.
		  ○ The CAP must detail the corrective actions implemented by the third party intermediary to ensure that the non-compliance issues have been resolved and will not reoccur in the future.
		  ○ The CAP must include a detailed timeline for achieving compliance with the applicable requirements.

Policy Area	CY 2020 Policy	CY 2021 Proposed
	the following reasons: CMS has grounds to impose remedial action; • CMS has not received a CAP within the specified time period or the CAP is not accepted by CMS; or • The third party intermediary fails to correct the deficiencies or data errors by the date specified by CMS	
	QCDR Measure Requirements: *Beginning with the 2020 performance period:* • In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. Duplicative QCDR measures will not be approved if QCDRs do not elect to harmonize identified measures as requested by CMS within the allotted timeframe. *Beginning with the 2021 performance period*: • QCDRs must identify a linkage between their QCDR measures to the following, at the time of self-nomination: (a) cost measure; (b) Improvement Activity; or (c) CMS developed MVPs as feasible. • QCDR Measures must be fully developed with completed testing results at the clinician level and	**QCDR Measure Requirements:** *Beginning with the 2022 performance period:* • QCDR measures must be **fully tested** at the clinician level in order to be considered for inclusion in an **MVP**. We also finalized policies in the Medicare and Medicaid Interim Final Rule with Comment (IFC) published 5/8/2020 (CMS-5531 IFC) which delayed QCDR measure requirements: • **Delaying** the QCDR measure testing requirement until the 2022 performance period in light of the pandemic and modifying the QCDR measure testing requirement to be two-step process that first requires face validity testing and eventually full measure testing (beta testing). • **Delaying** the QCDR measure data collection requirement until the 2022 performance period in light of the pandemic. QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

Policy Area	CY 2020 Policy	CY 2021 Proposed
	must be ready for implementation at the time of self-nomination. • QCDRs must collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. • CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. • A QCDR measure that does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance may not continue to be approved in the future. • At CMS discretion, QCDR measures may be approved for two years, contingent on additional factors. • Additional QCDR measures considerations include: (a) conducting an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and (b) utilized the CMS Quality Measure Development	

Policy Area	CY 2020 Policy	CY 2021 Proposed
	Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development.	
Improvement Activities Performance Category	**Improvement Activities Inventory:** • Addition of 2 new Improvement Activities. • Modification of 7 existing Improvement Activities. • Removal of 15 existing Improvement Activities.	**Improvement Activities Inventory:** • Modification of 2 existing Improvement Activities.
	Criteria for nominating a new improvement activity: • Relevance to an existing improvement activities subcategory (or a proposed new subcategory); • Importance of an activity toward achieving improved beneficiary health outcomes; • Importance of an activity that could lead to improvement in practice to reduce health care disparities; • Aligned with patient-centered medical homes; • Focus on meaningful actions from the person and family's point of view; • Support the patient's family or personal caregiver; • Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care); • Feasible to implement, recognizing importance in minimizing burden, especially for small practices,	**Criteria for nominating a new improvement activity:** We are proposing to establish 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.

Policy Area	CY 2020 Policy	CY 2021 Proposed
	practices in rural areas, or in areas designated as geographic HPSAs by HRSA; • Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; • Include a public health emergency as determined by the Secretary; or • CMS is able to validate the activity.	
	Pathway for nominating a new improvement activity: A stakeholder may nominate a new activity or request a modification to an existing improvement activity by submitting a nomination form available at www.qpp.cms.gov during the Annual Call for Activities.	**Pathways for nominating a new improvement activity:** We are proposing to allow nomination of Improvement Activities in addition to the Annual Call for Activities in two circumstances: 1. An exception to the nomination period timeframe during a public health emergency (PHE); and 2. A process for agency-nominated improvement activities.
Promoting Interoperability Performance Category	**Objectives and Measures:** *Beginning with the 2019 performance period:* • The **optional** Query of **PDMP measure** will require a **yes/no response** instead of a numerator/denominator. • We will redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Electronic Access to Their Health Information measure if an exclusion is claimed. *Beginning with the 2020 performance period:* • We will remove the Verify Opioid Treatment Agreement Measure.	**Objectives and Measures:** We are proposing to: • Retain the Query of PDMP measure as an optional measure and propose to make it worth **10 bonus points** • Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling” • Add an optional Health Information Exchange (HIE) bi-directional exchange measure

Policy Area	CY 2020 Policy	CY 2021 Proposed
		Reweighting: We are proposing to continue our automatic reweighting policies related to the following clinician types for 2021: • Nurse Practitioners (NPs); • Physician Assistants (PAs); • Certified Registered Nurse Anesthesiologists (CRNAs); • Clinical Nurse Specialists (CNSs); • Physical Therapists; • Occupational Therapists; • Qualified Speech-language Pathologist; • Qualified Audiologists; • Clinical Psychologists; and • Registered Dieticians or Nutrition Professionals.
Cost Performance Category	**Measures:** • TPCC measure (**Revised**) • MSPB-C (MSPB Clinician) measure (**Name and specification Revised**) • 8 existing episode-based measures • **10 new episode-based measures:** 1. Acute Kidney Injury Requiring New Inpatient Dialysis 2. Elective Primary Hip Arthroplasty 3. Femoral or Inguinal Hernia Repair 4. Hemodialysis Access Creation 5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	**Measures (previously established):** • TPCC measure • MSPB Clinician measure (no change from CY2020) • 18 existing episode-based cost measures **Updates to measures:** • Adding telehealth services directly applicable to existing episode-based cost measures and TPCC measure. • Updated specifications available for review on the MACRA feedback page (https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback)

Policy Area	CY 2020 Policy	CY 2021 Proposed
	6. Lower Gastrointestinal Hemorrhage (applies to groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels 8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment No changes to case minimums	
Complex Patient Bonus	Existing policy: Clinicians, groups, virtual groups and APM Entities are able to earn up to 5 bonus points to account for the complexity of their patient population	For the **2020 performance period only**: We are proposing to double the complex patient bonus for the 2020 performance period only. Clinicians, groups, virtual groups and APM Entities would be able **to earn up to 10 bonus points** (instead of 5 bonus points) to account for the additional complexity of treating their patient population due to COVID-19.
Extreme and Uncontrollable Circumstances Reweighting Application	Individual clinicians, groups and virtual groups can submit an application to reweight 1 or more MIPS performance categories due to extreme and uncontrollable circumstances, outside the clinician's control; for example, circumstances that: • Prevent them collecting data for a sustained period of time, or • Could impact performance on cost measures Data submission would override approved reweighting on a category-by-category basis.	No change to policy for individual clinicians, groups and virtual groups. Beginning with the 2020 performance period: • We are proposing to allow APM Entities to submit an application to request reweighting of all MIPS performance categories. • If the application were approved, the APM Entity group would receive a score equal to the performance threshold even if data is submitted (note this is different than our policy for individuals, groups and virtual groups).

Policy Area	CY 2020 Policy	CY 2021 Proposed
Performance Threshold / Additional Performance Threshold / Payment Adjustment	*For the 2020 performance period (2022 payment year):* • Performance Threshold is set at **45 points**. • Additional performance threshold is set at **85 points** for exceptional performance. • As required by statute, the maximum negative payment adjustment is **-9%**. • Positive payment adjustments can be up to 9% (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9%. *For the 2021 performance period:* • Performance Threshold is set at **60 points**. • Additional performance threshold is set at **85 points** for exceptional performance.	*For the 2021 performance period (2023 payment year):* • We proposed to set the Performance Threshold at **50 points**. *We did not propose any changes to the additional performance threshold of **85 points** for exceptional performance.*
Application of Final Score to Payment Adjustment	When a clinician has multiple final scores associated with a single TIN/NPI combination, we will use the following hierarchy to assign the final score that will be used to determine the 2022 MIPS payment adjustment applicable to that TIN/NPI combination: • APM Entity final score (highest of these if more than one) • Virtual group final score • Group or individual score (whichever is higher)	We are proposing to change this hierarchy beginning with the 2021 performance period/2023 payment year: • Virtual group final score • Highest available final score from APM Entity, APP, group, and/or individual participation

Quality Payment Program CY 2021 NPRM: Advanced APM Overview

Policy Area	CY 2020 Policy	CY 2021 Proposed
Advanced APMs: QP Threshold Scores	Threshold Scores used for QP determinations calculated using the patient count method are calculated as a ratio of attributed Medicare patients to whom the APM Entity or eligible clinician furnishes Medicare Part B covered professional services and attribution-eligible Medicare patients to whom the APM Entity or eligible clinician furnishes Medicare Part B covered professional services during the QP Performance Period. Similarly, Threshold Scores used for QP determinations calculated using the payment amount method are calculated as a ratio of the aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity or eligible clinician to attributed beneficiaries during the QP Performance Period and the aggregate of payments for Medicare Part B Part B covered professional services furnished by the APM Entity or eligible clinician to attribution-eligible beneficiaries.	We are proposing that in calculating Threshold Scores used in making Qualifying APM Participant (QP) determinations, beginning in the 2021 QP Performance Period, Medicare patients who have been prospectively attributed to an APM Entity during a QP Performance Period will not be included as attribution-eligible Medicare patients for any APM Entity that is participating in an Advanced APM that does not allow such prospectively attributed Medicare patients to be attributed again.
Advanced APMs: Targeted Review of QP Determinations	There currently is no targeted review process for QP determinations.	Beginning with the 2021 QP Performance Period, we 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) was not included on a Participation List of an APM Entity participating in an Advanced APM for purposes of QP or Partial QP determinations.

Quality Payment Program CY 2021 NPRM: Public Reporting via Physician Compare Overview

Policy Area	CY 2020 Policy	CY 2021 Proposed
Public Reporting Under Physician Compare	**Release of Aggregate Performance Data:** Aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores, will be available on Physician Compare beginning with Year 2 (CY 2018 data, available starting in late CY2020), as technically feasible.	No change
	Facility-based Clinician Indicator: Publicly report an indicator if a MIPS eligible clinician is scored using facility-based measurement, as technically feasible and appropriate. Link from Physician Compare to Hospital Compare where facility-based measure information that applies to the clinician or group would be available, beginning with Year 3 (2019 performance information available for public reporting in late 2020).	No change
	Definitions & Proposed Regulation Text Changes: None	**Definitions & Proposed Regulation Text Changes:** We propose to define Physician Compare to mean the Physician Compare Internet Web site of the Centers for Medicare & Medicaid Services (or a successor Web site).

Appendix: APP Core Quality Measure Set

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID # 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Quality ID # 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID # 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID # 236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Measure # TBD	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions