Quality Payment PROGRAM

2021 Quality Payment Program Final Rule Comparison Table

Changes to QPP Policies Finalized for CY 2021

Quality Payment Program CY 2021 Final Rule: MIPS Overview

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
Reporting Pathways		
MIPS Value Pathways (MVPs)	**MVPs Implementation Timeline:** MVPs will be a reporting framework beginning with the 2021 performance period. **MVPs 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,	**MVPs Implementation Timeline:** MVPs must be established through rulemaking and we didn't propose any MVPs candidates for comment. As a result, MVPs won't be available for MIPS reporting until the **2022 performance period**, or later. **MVPs Guiding Principles** 1. MVPs should consist of limited, **connected, complementary sets of measures and activities** that are meaningful to

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	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. 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.	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 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**, to the extent feasible. **MVPs 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.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy

		• 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.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		• 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. **Process for Candidate MVP Collaboration, Solicitation, and Evaluation:** • We'll hold a public-facing MVP Solicitation Kick-Off webinar to review MVP development criteria, timelines, and process in which to submit a candidate MVP. • Stakeholders will formally submit their MVP candidates using a standardized template (to be published in the QPP Resource Library). • We'll review and evaluate MVP candidates as they're received (asking follow up questions as needed), against the aforementioned described criteria. • We'll 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'll 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.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy

APM Performance Pathway (APP)	**N/A**	• The APP is only available to MIPS eligible clinicians participating in MIPS APMs.
		• The APP is required for Medicare Shared Savings Program ACOs.
		• The APP may be reported by the individual eligible clinician, group, or APM Entity.
		• The APP is comprised of a fixed set of measures for each performance category, just as MVPs will be.
		• In the APP, the Cost performance category will be weighted at 0%, as all MIPS APM participants are already responsible for cost containment under their APMs.
		• The Improvement Activity performance category score will automatically be assigned (up to 100%) based on the improvement activity requirements of the MIPS APM in which the MIPS eligible clinician participates.
		  ○ For the 2021 performance period, all APM participants reporting the APP will be eligible to earn an Improvement Activities performance category score of 100%
		• The Promoting Interoperability performance category will be reported and scored as required for the rest of MIPS.
		• 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

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		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 easily report on a single set of quality measures each year that represent a true cross-section of their participants' performance.
MIPS Participation Options		
MIPS Eligibility and Participation	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. Clinicians in a MIPS APM are only evaluated for MIPS eligibility at the Entity level.	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; we'll 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.
MIPS Performance Categories		
Performance Category Weights	**No change from CY 2019:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	Performance category weights **for individuals, groups, and virtual groups** reporting traditional MIPS for the 2021 performance period: • Quality: **40%** • Cost: **20%** • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change)

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		Note that these weights don't apply to the APP. Performance category weights for **APM Entities** reporting traditional MIPS for the 2021 performance period: • Quality: 50% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 20%
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	**No change in policy from CY 2020.** We're extending the **CMS Web Interface** as a collection type and submission type for groups and virtual groups **through the 2021 performance period.** The CMS Web Interface will sunset as a collection/submission type beginning with the 2022 performance period.
Quality Measures		There are a total of 209 quality measures for the 2021 performance period that reflect: • Substantive changes to 113 existing MIPS quality measures (7 of which had substantive changes that don't allow comparison with historical data). • Changes to specialty sets. • Addition and/or removal of measures from specific specialty sets. • Removal of 11 quality measures from the MIPS program (including the All-Cause Hospital Readmission measure). • Addition of 2 new administrative claims quality measures.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		The 2 administrative claims measures are: **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, and APM Entities with 16 or more clinicians and that meet the case minimum **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 can't be created, we'll attempt to create a benchmark using data submitted for the performance period.	**No change in policy from CY 2020.** We have determined that sufficient data were submitted for the 2019 performance period to allow us to calculate historical benchmarks for the 2021 performance period.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
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.	**No change in policy from CY 2020.**
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 extended our previously established scoring flexibility by: • Expanding the list of reasons that a quality measure may be impacted during the performance period, and • Revising 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 performance period. If such data is not available or may result in patient harm or misleading results, the measure is suppressed. 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. Significant changes are changes to a measure that are outside of the control of the clinicians 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.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		Based on the timing of the change and the availability of data, we'll: • Truncate the performance period to 9 consecutive months if 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 weren't available or may result in patient harm or misleading results.

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 Submission
		QCDRs, Qualified Registries, and health IT vendors must be able to submit data for all of the following MIPS performance categories:
		• Quality, except:
		  ○ The CAHPS for MIPS Survey; and
		  ○ For Qualified Registries and health IT vendors, QCDR measures;
		• Improvement activities; and
		• Promoting Interoperability; however, a third-party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups are eligible for reweighting
		Health IT vendors that do not support MVPs must be able to submit data for at least one of the MIPS performance categories described above.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	Data Validation Policies established through preamble within the CY 2017 Quality Payment Program Final Rule: • 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.	• 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** Policies codified into regulation: QCDRs and Qualified Registries will conduct data validation audits, with specific obligations, on an annual basis, including: • Beginning with the 2021 performance period, QCDRs and Qualified Registries must conduct annual data validation audits in accordance with §414.1400 (b)(2)(iv) and §414.1400(c)(2)(iii). • QCDRs and Qualified Registries must conduct data validation for the performance period prior to submitting any data for that performance period to CMS for purposes of the MIPS program. • QCDRs and Qualified Registries must conduct data validation on data for each performance category for which it will submit data, including if applicable the Quality, Improvement Activities, and Promoting Interoperability performance categories. • QCDRs and Qualified Registries must conduct data validation on data for each submitter type for which it will submit data, including if applicable MIPS eligible clinicians, groups, virtual groups, voluntary participants, and opt-in participants. • QCDRs and Qualified Registries must use clinical documentation (provided by the clinicians they are submitting

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy

		data for) to validate that the action or outcome measured actually occurred or was performed.
		• QCDRs and Qualified Registries shall conduct each data validation audit using a sampling methodology that meets the following requirements:
		  ○ Uses a sample size of at least 3 percent of the TIN/NPIs for which QCDRs and Qualified Registries will submit data to CMS, except that if a 3 percent sample size would result in fewer than 10 TIN/NPIs, QCDRs and Qualified Registries must use a sample size of at least 10 TIN/NPIs, and if a 3 percent sample size would result in more than 50 TIN/NPIs, the QCDR may use a sample size of 50 TIN/NPIs.
		  ○ Uses a sample that includes at least 25 percent of the patients of each TIN/NPI in the sample, except that the sample for each TIN/NPI must include a minimum of 5 patients and does not need to include more than 50 patients.
		• Each QCDR and qualified registry data validation audit must include the following:
		  ○ Verification of the eligibility status of each eligible clinician, group, virtual group, opt-in participant, and voluntary participant.
		  ○ Verification of the accuracy of TINs and NPIs.
		  ○ Calculation of reporting and performance rates.
		  ○ Verification that only the MIPS quality measures and QCDR measures, as applicable, that are relevant to the performance period will be used for MIPS submission.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
		• In a form and manner and by a deadline specified by CMS, QCDRs and Qualified Registries must report the results of each data validation audit, including the overall data deficiencies or data error rate, the types of deficiencies or data errors discovered, the percentage of clinicians impacted by any deficiency or error, and, how and when each deficiency or data error type was corrected. • QCDRs and Qualified Registries must conduct targeted audits in accordance with §414.1400 (b)(2)(v) and §414.1400(c)(2)(iv) respectively. • If a data validation audit under § 414.1400(b)(2)(iv) or §414.1400(c)(2)(iii) identifies one or more deficiency or data error, QCDRs and Qualified Registries must conduct a targeted audit into the impact and root cause of each such deficiency or data error for that MIPS performance period. • QCDRs and Qualified Registries must conduct any required targeted audits for the MIPS performance period and correct any deficiencies or data errors identified through such audit PRIOR to the submission of data for that MIPS performance period. • QCDRs and Qualified Registries must conduct the targeted audit using the sampling methodology described. The sample for the targeted audit must not include data from the sample used for the data validation audit in which the deficiency or data error was identified. • In a form and manner and by a deadline specified by CMS, QCDRs and Qualified Registries must report the results of each targeted audit, including the overall deficiency or data error rate, the types of deficiencies or data errors discovered, the

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy

	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 certified EHR technology (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,
		percentage of clinicians impacted by each deficiency or data error, and how and when each deficiency or data error type was corrected.
		
		Third-Party Intermediary Approval Criteria
		• Additional factors for consideration when determining whether to approve a third-party intermediary for future participation in the MIPS program:
		  ○ Whether the entity failed to comply with the third-party intermediary requirements for any prior MIPS performance period for which it was approved as a third-party intermediary.
		  ○ Whether the entity provided inaccurate information to any eligible clinicians regarding Quality Payment Program requirements.
		• All third-party intermediaries must attend and complete training and support sessions in the form and manner, and at the times, specified by CMS.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	collection type according to a CMS-approved 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%.	**<u>Third-Party Intermediary Remedial Action and Termination</u>** • Establishes that unless different or additional information is specified by CMS, requested a corrective action plan (CAP) must address the following issues: ○ The issues that contributed to the non-compliance. ○ The impact to individual clinicians, groups, or virtual groups, regardless of whether they are participating in the program because they are MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program. ○ The corrective actions to be implemented by the third-party intermediary to ensure that the non-compliance issues have been resolved and will not reoccur in the future. ○ A detailed timeline for achieving compliance with the applicable requirements.
	QCDR Measure Requirements: <u>Beginning with the 2020 performance period:</u> • In instances in which multiple, similar QCDR measures exist that warrant approval, we may provisionally approve the individual QCDR	**QCDR Measure Requirements:** We are finalizing policies from the Medicare and Medicaid Interim Final Rule with Comment (IFC) published 5/8/2020 (CMS-5531 IFC, 85 FR 27550) which delayed QCDR measure requirements:

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	measures for one 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 don't elect to harmonize identified measures as requested by CMS within the allotted timeframe. <u>Beginning with the 2021 performance period**:**</u> • 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 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 isn't available to MIPS eligible clinicians, groups, and virtual groups	• **Delaying** the QCDR measure testing requirement until the 2022 performance period in light of the pandemic • **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. <u>Beginning with the 2022 performance period:</u> • QCDR measures must be **fully tested** at the clinician level in order to be considered for inclusion in an **MVP**. • We are modifying the QCDR measure testing requirement to be a two-step process that first requires face validity testing and eventually full measure testing (beta testing). • For existing QCDR measures that were previously approved for the CY 2020 MIPS performance period, are required to, at a minimum, be face valid prior to being self-nominated for the CY 2022 MIPS performance period. QCDR measures that were approved for the 2022 performance period with face validity, are required to be fully tested prior to being self-nominated for any subsequent performance periods (that is, CY 2023 MIPS performance period and beyond) in order to be considered for inclusion in the MIPS program. • For a new QCDR measure to be approved for the CY 2022 MIPS performance period, a QCDR measure must be face valid; QCDR measures that were approved for the 2022 performance period with face validity, are required to be fully tested prior to being self-nominated for any subsequent performance periods

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	reporting through other QCDRs, CMS may not approve the measure. • A QCDR measure that doesn't 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 2 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) used the CMS Quality Measure Development Plan Annual Report and the Blueprint for the CMS Measures Management System to identify measurement gaps prior to measure development.	(that is, CY 2023 MIPS performance period and beyond) in order to be considered for inclusion in the MIPS program. • Individual QCDR measures may be provisionally approved for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures or MIPS quality measures in order to be considered for the program in subsequent years. If such areas of duplication are not addressed, CMS may reject the duplicative QCDR measure. • QCDR measures may be approved for 2 years, at CMS discretion by attaining approval status by meeting QCDR measure considerations and requirements. Upon annual review, CMS may revoke a QCDR measure's second year approval, if the QCDR measure is found to be: Topped out; duplicative of a more robust measure; reflects an outdated clinical guideline; or if the QCDR self-nominating the QCDR measure is no longer in good standing.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
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. • Continuation of the COVID-19 clinical data reporting improvement activity with modification as outlined in the September Interim Final Rule with Comment (IFC) • Removal of 1 improvement activity that is obsolete: ○ CC_5 CMS Partner in Patients Hospital Engagement Network
	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 patient health outcomes. • Importance of an activity that could lead to improvement in practice to reduce healthcare 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, practices in rural areas, or in areas designated as geographic health professional shortage areas	**Criteria for nominating a new improvement activity:** 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.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	(HPSAs) by the Health Resources & Services Administration (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 improvement 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:** 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. Separately, 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.
Promoting Interoperability Performance Category	**Objectives and Measures:** Beginning with the 2019 performance period: • The **optional** Query of **PDMP measure** requires a **yes/no response** instead of a numerator/denominator. • We'll redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients	**Objectives and Measures:** Beginning with the 2021 performance period: • The Query of Prescription Drug Monitoring Program (PDMP) measure will remain as an optional measure worth **10 bonus points.** • The name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information will be changed to Support

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	Electronic Access to Their Health Information measure if an exclusion is claimed. <u>Beginning with the 2020 performance period:</u> • We removed the Verify Opioid Treatment Agreement Measure.	Electronic Referral Loops by Receiving **and Reconciling** Health Information. • A **new optional Health Information Exchange (HIE) bi-directional exchange measure** is added as an alternative reporting option to the 2 existing measures under the HIE objective. **Reweighting:** Our automatic reweighting policies related to the following clinician types will continue for 2021: • Nurse Practitioners (NPs) • Physician Assistants (PAs) • Certified Registered Nurse Anesthesiologists (CRNAs) • Clinical Nurse Specialists (CNSs) • Physical Therapists • Occupational Therapists • Qualified Speech-language Pathologists • Qualified Audiologists • Clinical Psychologists • Registered Dieticians or Nutrition Professionals

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
	CEHRT Requirements: MIPS eligible clinicians must use technology certified to the 2015 Edition certification criteria to collect and report their Promoting Interoperability data and eCQMs for the Quality performance category	**CEHRT Requirements for Performance Periods in CY 2020, 2021 and 2022:** 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
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 6. Lower Gastrointestinal Hemorrhage (applies to groups only) 7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	**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 Finalized Policy
	8. Lumpectomy Partial Mastectomy, Simple Mastectomy 9. Non-Emergent Coronary Artery Bypass Graft (CABG) 10. Renal or Ureteral Stone Surgical Treatment There currently are no changes to case minimums.	
Complex Patient Bonus	<u>Existing policy:</u> 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.	<u>For the **2020 performance period only**:</u> • The complex patient bonus will be doubled for the 2020 performance period only. • Clinicians, groups, virtual groups and APM Entities will 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 one or more MIPS performance categories due to extreme and uncontrollable circumstances, outside the clinician's control; for example, circumstances that: • Prevent them from 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. <u>Beginning with the 2020 performance period:</u> • APM Entities can submit an application to request reweighting of all MIPS performance categories. • If the application is approved, the APM Entity group will receive a score equal to the performance threshold even if data are submitted. • Note that our policies for APM Entities differ from our policy for individuals, groups, and virtual groups.

Policy Area	CY 2020 Policy	CY 2021 Finalized Policy
Performance Threshold / Additional Performance Threshold / Payment Adjustment	<u>For the 2020 performance period (2022 payment year):</u> • 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%. <u>For the 2021 performance period:</u> • Performance Threshold is set at **60 points**. • Additional performance threshold is set at **85 points** for exceptional performance.	<u>For the 2021 performance period (2023 payment year):</u> • The performance threshold is set at **60 points** (no change from previously finalized threshold for 2021). • The additional performance threshold for exceptional performance remains at **85 points**. ○ We note that the 2022 performance period/2024 payment year will be the final year of the additional positive adjustment for exceptional performance.
Application of Final Score to Payment Adjustment	When a clinician has multiple final scores associated with a single Taxpayer Identification Number/National Provider Identifier (TIN/NPI) combination, we'll 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)	When a clinician has multiple final scores associated with a single TIN/NPI combination, we'll use the following hierarchy 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 (based on the APP or traditional MIPS reporting) from APM Entity, group, or individual participation

Quality Payment Program CY 2021 Final Rule: Advanced APM Overview

Policy Area	CY 2020 Policy	CY 2021 Policy
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 Medicare patients during the QP Performance Period **and** the aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity or eligible clinician to attribution-eligible Medicare patients.	We have 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.
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'll 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.

Quality Payment Program CY 2021 Final Rule: Public Reporting Overview

Policy Area	CY 2020 Policy	CY 2021 Policy
Public Reporting	**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 Doctors and Clinicians to Hospitals on Care Compare (formerly Physician Compare and Hospital Compare) where facility-based measure information that applies to the clinician or group would be available, beginning with the 2019 performance (available for public reporting in late 2020).	No change
	Definitions & Proposed Regulation Text Changes: None	**Definitions & Finalized Regulation Text Changes:** We finalized to define Physician Compare to mean CMS's Physician Compare website (or a successor website).

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 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 a.m. - 8 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.

Version History

Date	Change Description
12/1/2020	Original version

Appendix: APP Core Quality Measure Set

Table 1. This table identifies the core quality measure set for reporting the APP.[1]

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#: 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 480	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	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/CMS Web Interface*	APM Entity/Third-Party Intermediary	Treatment of Mental Health
Quality ID#: 236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third-Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third-Party Intermediary	Prevention and Treatment of Opioid

[1] We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) do not have benchmarks and are therefore not scored; they are, however, required to be reported in order to complete the Web Interface dataset.

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
				and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third-Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third-Party Intermediary	Treatment of Mental Health

* ACOs will have the option to report via the CMS Web Interface for the 2021 MIPS performance year only.