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HFMA Executive Summary
2021 Proposed Physician Fee Schedule
Quality Payment Program Provisions

Key Quality Payment Program (QPP) Financial and Operational Impacts from the 2021 Proposed Physician Fee Schedule Rule

The 2021 performance year corresponds to the 2023 payment year. The Merit-Based Incentive Payment System (MIPS) payment adjustments will be ± 9% applied to 2023 payments to physicians. CMS estimates that approximately 930,000 clinicians will be MIPS-eligible clinicians during the 2021 performance period, while another 369,000 clinicians would be potentially MIPS-eligible but not required to participate. CMS further estimates that about 300,000 clinicians will be excluded from MIPS participation because they meet all three low-volume threshold criteria or for other reasons, including being newly-enrolled in Medicare or having reached qualified participant (QP) status.

Budget neutrality is required within the QPP by statute. CMS estimates that positive and negative payment adjustments distributed in payment year 2023 will each total $442 million. As in prior QPP years, an additional $500 million will be available for distribution for exceptional performance. CMS estimates that the maximum possible positive payment adjustment attainable for payment year 2023 will be 6.9%, combining the MIPS base adjustment with the adjustment for exceptional performance. Finally, CMS estimates that between 196,000 and 252,000 clinicians will meet thresholds to become QPs, resulting in total lump sum APM incentive payments of $700-900 million for the 2023 payment year. The APM bonus remains at 5% and will be calculated using the QP's covered Part B professional services furnished during 2022.

A detailed side-by-side comparison of current QPP requirements to those proposed, created by CMS, is available here.

1) **Proposed/Final Performance Category Weights for MIPS**: CMS proposes the following performance category weights for performance years 2021 (payment year 2023) and 2022 (payment year 2024).

MIPS Performance Category Weights (%)				
Performance Category	**Performance Year 2019 (Final)**	**Performance Year 2020 (Final)**	**Performance Year 2021 (Proposed)**	**Performance Year 2022 (Proposed)**
Quality	45	45	40	30
Cost	15	15	20	30
Improvement Activities	15	15	15	15
Promoting Interoperability	25	25	25	25

Performance Measure Category Reweighting: Similar to prior proposed rules, CMS lays out its policies for redistributing performance category weights if a provider or practice does not have data to report for a specific measure category. The proposed re-weightings for performance years 2021 and 2022 (payment years 2023 and 2024) are displayed in Exhibits 1 and 2 in the appendix.

2) **MIPS Performance Categories**: CMS proposes the changes discussed below to the quality, cost, improvement activities and promoting interoperability performance categories.

a. **Quality**: CMS proposes to reset the *Quality* performance category weight from 45% for performance year 2020 to 40% for performance year 2021 and 30% for performance year 2022. CMS notes that by statute the *Quality and Cost* category weights total 60%, so that changes to their weights move in tandem.

CMS Quality Web Interface Reporting: CMS proposes to retire the CMS web interface in concert with its proposal to revise the Shared Savings Program quality performance standard and transition those ACOs to reporting through an APM Performance Pathway (APP), discussed below, starting with performance year 2021.

Administrative Claims Measures Performance Periods: Currently, the MIPS *Quality* category performance period is one year – i.e., the full calendar year that is two years prior to the associated MIPS payment year. CMS proposes to create an exception for administrative claims-based quality measures to have an extended performance period. This exception, if finalized, would be applicable to the proposed measure, *Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS,* for which the performance period would be three years.

CAHPS for MIPS Survey: CMS notes the markedly increased use of telehealth and other communications technology-based services (CTBS) during the COVID-19 public health emergency (PHE) and proposes two Consumer Assessment of Healthcare Providers and Systems (CAHPS) changes to capture input from patients about their telehealth experiences during the performance year 2021 CAHPS survey administration:

- Add a survey-based measure to assess patient-reported usage of telehealth services
- Add a reference to care received by telehealth to the survey cover page to stimulate patient recall of their telehealth experiences as they begin to answer survey questions

CMS further proposes to use the same set of CPT and HCPCS telehealth/CTBS codes currently used to assign beneficiaries to Shared Savings Program ACOs for the purpose of assigning beneficiaries to groups for CAHPS for MIPS survey administration for performance year 2021 and subsequent years.

b. **Cost Category**: CMS proposes to increase the *Cost* weight to 20% for performance year 2021; then to 30% for 2022 and thereafter.

Adding Telehealth Services to Episode Cost Measures: CMS notes that clinicians are being assessed on 18-episode cost measures for performance year 2020 along with *Total per Capita*

Cost of Care and *Medicare Spending per Beneficiary*. Some telehealth service costs have already been assigned to specific episodes, but CMS proposes to assign codes that have been newly added to the Medicare telehealth list during the PHE and codes that were commonly being used at the time of episode construction.

c. Improvement Activities: No significant policy changes were proposed for performance year 2021. The *Improvement Activities* (IA) category remains weighted at 15% for performance years 2021 and 2022 in the proposed rule.

d. **Promoting Interoperability**: The *Promoting Interoperability* (PI) category remains weighted at 25% for performance years 2021 and 2022.

Future Reporting Periods: The PI performance period has been set annually for QPP Years 1-5. For payment year 2023 the period was finalized as a minimum of a continuous 90-day period within CY21, up to and including the full CY21. CMS proposes to continue this approach for payment year 2024 and thereafter, by setting the PI performance period as a minimum of a continuous 90-day period within the calendar year that occurs two years prior to the applicable MIPS payment year, up to and including the full calendar year. This proposal aligns with the proposed CY22 electronic health record (EHR) reporting period for eligible hospitals and critical access hospitals (CAHs) under their respective Medicare PI programs.

PI Measures Changes: CMS proposes one change under the *Electronic Prescribing* objective and two changes under the HIE objective.

- *Query of Prescription Drug Monitoring Programs (PDMP) Measure*: For the 2020 PI performance period, reporting of the *Query of PDMP* measure is optional and eligible for 5 bonus points. CMS proposes to continue the measure as optional for the 2021 performance period. CMS further proposes to increase the available bonus points for reporting the measure during that period from 5 points to 10 as an incentive to clinicians to perform PDMP queries as a routine part of patient care.

- *Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure*: CMS notes that "incorporating" health information received is not always required, but information received must always be "reconciled" into the Medication, Medication Allergy, and Current Problem List sections when using certified EHR technology (CEHRT). Therefore, CMS proposes to replace "incorporating" with "reconciling" in the name of this measure.

- *HIE Bidirectional Exchange Measure*: CMS proposes to add a new, optional, measure beginning with the 2021 performance period *Health Information Exchange Bidirectional Exchange.* Clinicians would be able to attest to this measure in lieu of reporting the two existing measures, *Support Electronic Referral Loops by Sending Health Information,* and

Support Electronic Referral Loops by Receiving and Incorporating Health Information. The new measure would be worth 40 points, the maximum allowed under the HIE objective of the PI category. The new measure would apply to all patient encounters and all patient records (i.e., no partial credit would be available).

PI Reweighting for Select Clinicians: CMS proposes to maintain the established policy of reweighting the PI category to zero for nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals for the 2021 performance period but scoring any clinician who submits PI data during that period.

PI Scoring: Exhibit 3 in the appendix provides the maximum number of points available for each of the promoting interoperability objectives.

3) **APM Scoring Standard and APM Entity Groups**: CMS proposes to eliminate the APM scoring standard effective January 1, 2021. CMS is proposing to add the APP as a new option for MIPS reporting and scoring applicable to MIPS APM clinicians beginning January 1, 2021.

APP: CMS proposes this new pathway in 2021. The pathway would be complementary to MIPS Value Pathways (MVPs) introduced in the CY20 PFS rule. The APP would be available only to participants in MIPS APMs and may be reported by the individual eligible clinician, group (taxpayer identification number), 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 IA 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 PI 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 CMS believes 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. The proposed APP Core Measure set is displayed in Exhibit 4.
APM Entity Groups: CMS states that termination of the APM scoring standard and its reliance on quality measure reporting to an APM markedly reduces the risk of MIPS final scores being inappropriately influenced by late-year clinician list changes, the risk that the full-TIN policy was designed to target. Therefore, concomitant with terminating the APM scoring standard, CMS proposes to:

- End the full-TIN policy (limiting December 31 QP determinations)
- Delete the defined term "full-TIN APM"
- Allow MIPS-eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any snapshot date (March 31, June 30, August 31 or December 31) to be considered participants in an APM Entity group, beginning in the 2021 MIPS performance period

APM Entity Groups: Scoring and Score Reweighting: The proposed revised policies, effective beginning January 1, 2021, are as follows:

- When performance category data are not reported by the APM Entity, CMS would use the highest available score for each clinician in the group.
- Available scores could be a group score reported by a TIN to which the clinician belongs or an individual score using data reported by the clinician.
- When a MIPS-eligible clinician in an APM Entity is excepted from otherwise applicable reporting requirements, CMS would use a null score for that clinician when calculating the entity's performance category score.
- When scoring is available from the preceding performance period, CMS would calculate an improvement score for each performance category having prior scores.

Extreme and Uncontrollable Reweighting: CMS also addresses performance category reweighting for APM Entity groups during extreme and uncontrollable circumstances through the proposals below, beginning with the 2020 performance year.

- An APM Entity group may apply for MIPS performance category reweighting due to extreme and uncontrollable circumstances. The request would apply for all four categories and all MIPS-eligible clinicians in the group and would be approved or denied in its entirety. In the application, the entity must demonstrate that over 75% of its participant MIPS-eligible clinicians would be eligible for PI reweighting (consistent with policies for PI reweighting for hospital-based and non-patient facing clinician groups).
- If CMS approves the request, the group's clinicians would be excepted from MIPS for the applicable performance period and the APM Entity's final score would be set equal to the applicable year's threshold. Any group data submitted during the applicable performance period would not trigger scoring of the group.

4) *MIPS Scoring Methodology and Payment Adjustments*: CMS states that proposals for performance year 2021 are limited to those necessary to maintain MIPS program stability and are confined to the *Quality* performance category. No scoring policy changes are being proposed for the Cost, IA, and PI categories. CMS proposes to continue several policies without change other than extending their applicability through performance year 2021:

- Assignment of achievement points, including maintaining a 3-point floor for all quality measures for which data are properly submitted, can reliably be scored against its benchmark, and meet the requirements for case minimums and data completeness
- Scoring of measures that fail case minimums or data completeness, or that lack a benchmark
- Awarding bonus points for reporting high priority measures and to cap those points at no greater than 10% of the total available measure achievement points
- During improvement scoring calculations, substitute a 30% *Quality* category achievement score for the preceding year (base year for comparison) for clinicians who earned a score equal to or less than 30%.

Topped Out Measures: CMS notes that the proposed use of performance period-based rather than historical baseline-based benchmarks for performance period 2021 would deviate from the established process for identifying topped-out measures. CMS proposes an exception for the 2021 performance period: a measure would be considered topped out were it to be identified as such in the historical baseline-based benchmarks for the 2020 MIPS performance period and in the performance period-based benchmarks proposed for use in the 2021 performance period. CMS chose not to propose eliminating the 7-point cap, expecting that cap retention will incent clinicians not to select topped-out measures. CMS also notes that measures found to be topped out for 2020 might not remain topped out in the 2021 period and thereby not be subject to the cap.

Case Minimums: CMS proposes to amend the existing policy to retain the default case minimum for MIPS quality measures at 20 but to set minimums for administrative claims-based measures individually for each measure. Minimums for claims-based measures would be communicated through the annual MIPS final list of quality measures.

Complex Patient Bonus: CMS believes that patient complexity likely will increase as a result of COVID-19 for performance year 2020 and proposes to increase the complex patient bonus and to raise the maximum available points to 10. The bonus would be calculated as usual for each clinician; then, would be doubled before being added to the clinician's final MIPS score.

Final Score Hierarchy: CMS proposes to update the final score hierarchy, given it terminated the APM scoring standard, modified APM Entity Group policies, and the added the APP effective beginning with the 2021 performance period. The combination of proposed policies, if finalized, results in a streamlined hierarchy that allows full consideration of virtual group scores for 2021 and subsequent years, shown in exhibit 5 in the appendix. CMS states an intention to revisit the hierarchy and the associated policies and make changes as appropriate as the MIPS Value Pathway inventory is populated.

Performance Thresholds: Due to COVID-19, CMS proposes that the performance threshold for QPP Year 5 be set at 50 points and makes no changes to the exceptional performance payment

threshold of 85 points. Exhibit 6 in the appendix shows the resultant progression of the performance threshold over time.

CMS reports using 2021 regulatory impact analysis data to model effects of varying the 50-point QPP Year 5 threshold. Reducing the threshold to 50 points from 60 would cause nearly 6% of clinicians to receive positive rather than negative MIPS adjustments applied to their 2023 payments. Small practices would benefit more than previously high performing clinicians.

5) **APM Incentive Payment Calculation***:* CMS clarifies that the APM bonus payment amount is calculated using paid amounts on claims submitted from January 1 through December 31 of the incentive base period, thereby excluding amounts that were allowed but not paid.

6) **Payment Recipient Identification***:* To improve the bonus disbursement process, CMS makes several proposals.

   - *Cutoff Date for Helpdesk Requests*: CMS proposes a cutoff date, after which CMS will no longer accept new helpdesk requests from QPs or their representatives who have not received their payments; the cutoff would occur on November 1 of each payment year or 60 days from the day on which CMS disburses the initial round of APM Incentive Payments, whichever is later.

   - *TIN Hierarchy for Payment*: Identifying the appropriate TIN to receive the incentive payment represents a significant challenge that CMS proposes to resolve by establishing a hierarchy of TINs for payment, comprising steps to be followed sequentially until payment is made successfully or the final step has been completed. The hierarchy takes into account all TINs having relationships with the clinician and the nature of those relationships (e.g., the TIN associated with an APM Entity through which the clinician achieved QP status). The detail level and complexity of the eight-step hierarchy reflects the complexity of accounting for multiple TINs and multiple relationships and is best appreciated by reading its full description in the rule (pp. 787-788 of the display copy). The eighth and final step indicates how CMS would proceed when no appropriate TIN has been identified to receive the incentive payment. At that time, CMS would attempt to contact the QP directly through a public notice requesting Medicare payment information, and the QP would have until November 1 of the payment year to respond as directed in the notice (or 60 days after CMS announces having made initial bonus payments for the year, whichever comes later). A QP who fails to respond by the deadline would forfeit any claim to an APM incentive payment for that payment year.

7) **Targeted Review of QP Determinations***:* CMS proposes that a targeted review of a QP determination could only be requested by a clinician or APM Entity based upon a good faith belief that a CMS clerical error resulted in a clinician being omitted from the APM's Participation List upon which the QP determination was based. CMS proposes that if, upon review, a clerical

error is confirmed, CMS would assign to the affected clinician the most favorable QP status as determined by CMS for the APM Entity on any snapshot date of the relevant performance period on which that clinician participated in that APM Entity.

CMS proposes that targeted reviews of potential omissions to Affiliated Practitioner Lists would not be made because:

- QP status determinations for clinicians on those lists are made at the individual level and therefore CMS would not have conducted a determination for an omitted clinician prior to a targeted review being requested.

- The calculations that would be required would not be operationally feasible to allow for timely APM incentive payment. CMS additionally notes that targeted reviews of omissions from Other Payer Advanced APM Participation Lists would not be conducted since those lists are provided to CMS by the clinicians and the APM Entities themselves.

Appendix: Select Tables from the Proposed Rule

Exhibit 1: Performance Category Redistribution for the MIPS 2021 Performance (2023 Payment) Year

TABLE 45: Performance Category Redistribution Policies Proposed for the 2023 MIPS Payment Year (2021 Performance Year)

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	40%	20%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	65%	20%	15%	0%
-No Quality	0%	20%	15%	65%
-No Improvement Activities	55%	20%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	80%	20%	0%	0%
-No Quality and no Improvement Activities	0%	20%	0%	80%

Exhibit 2: Performance Category Redistribution for the MIPS 2021 Performance (2023 Payment) Year

TABLE 46: Performance Category Redistribution Policies Proposed for the 2024 MIPS Payment Year (2022 Performance Year)

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	30%	30%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	55%	30%	15%	0%
-No Quality	0%	30%	15%	55%
-No Improvement Activities	45%	30%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	70%	30%	0%	0%
-No Quality and no Improvement Activities	0%	30%	0%	70%

Exhibit 3: Promoting Interoperability Scoring Methodology for the CY21 Performance Period

TABLE 42: Scoring Methodology for the Performance Period in CY 2021		
Objective	**Measure**	**Maximum Points**
Electronic Prescribing	e-Prescribing	10 points
	Bonus: Query of PDMP	10 points (*bonus*)
Health Information Exchange OR	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information *	20 points
Health Information Exchange (alternative)	HIE Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	10 Points

Exhibit 4: Proposed APM Performance Pathway Proposed 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	Management 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	Management of chronic conditions
Measure # TBD	Hospital-wide, 30-day, all-cause unplanned readmission rate for MIPS-eligible clinician groups	Administrative claims	N/A	Admissions and readmissions
Measure # TBD	Risk standardized, all-cause unplanned admissions for multiple chronic conditions for ACOs	Administrative claims	N/A	Admissions and readmissions

Exhibit 5: Final Score Hierarchy for TIN/NPIs with Multiple MIPS Scores

TABLE 48: Hierarchy for Final Score When More than One Final Score Is Associated with a TIN/NPI	
Scenario	**Final Score Used to Determine Payment Adjustments**
TIN/NPI has a virtual group final score, an APM Entity final score, an APP final score, a group final score, and/or an individual final score.	Virtual group final score.
TIN/NPI has an APM Entity final score, an APP final score, a group final score, and/or an individual final score, but is not in a virtual group.	The highest of the available final scores.

Exhibit 6: MIPS Performance Threshold Progression

	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year	*2022 MIPS Payment Year	**2023 MIPS Payment Year	2024 MIPS Payment Year
	Year 1	Year 2	Year 3	*Year 4	**Year 5	Year 6
Performance Threshold	3 points	15 points	30 points	*45 points *N/A for those who do not participate in year 4	**50 points	74.01 points

*Assumed affected payment year due to PHE resulting in measures not being available for reporting for MIPS participants.
** Proposed new performance threshold for the fifth year.