

2021 Quality Payment Program Final Rule

Summary

On Tuesday, December 1, 2020, the Centers for Medicare and Medicaid Services (CMS) issued the 2021 Quality Payment Program (QPP) final rule that includes updates to the current program, the Merit-Based Incentive Payment System (MIPS) Value Pathways framework, and a new Alternative Payment Model Performance Pathway (APP).

The QPP encompasses the MIPS and the Alternative Payment Model (APM) programs, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It is important that radiation oncology practices understand key aspects of the QPP, which include a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

Recognizing the impact of the COVID-19 Public Health Emergency (PHE), the Agency continues to consider the extraordinary health system stresses by providing burden relief and delaying key proposals to future performance years.

CMS has implemented [several policies](#) in response to the PHE for the 2020 performance year:

- Clinicians, groups and virtual groups may submit an Extreme and Uncontrollable Circumstances [application](#) requesting reweighting of one or more MIPS performance categories due to the current PHE. The deadline to submit is December 31, 2020 at 8pm ET. Approved applications will reweight performance categories to 0%. Data submission will void approved applications on a category-by-category basis.
- A new high-weighted COVID 19 clinical trials (IA_ERP_3) improvement activity for the 2020 performance period to provide an opportunity for clinicians to receive credit in MIPS. A clinician may participate in a COVID clinical trial and have those data entered into a data platform for that study; or a clinician participating in the care of COVID-19 patients may submit clinical COVID-19 patient data to a clinical data registry for purposes of future study.

CMS has also implemented several policies in response to the PHE for the 2021 performance year:

- Clinicians, groups, and virtual groups may submit an Extreme and Uncontrollable Circumstances application requesting reweighting of one or more MIPS performance categories due to the current PHE. The application will be available in Spring 2021, along with additional resources.
 - *However, if a clinician, group, or virtual group decides to submit data for the 2021 performance period, the data submission will override the application, and the clinician, group, or virtual group will be scored on the data submitted.*

- Due to the anticipated need for continued COVID-19 clinical trials and data collection, MIPS eligible clinicians and groups who meet the activity criteria will be able to receive credit for the COVID-19 Clinical Data Reporting with or without Clinical Trial improvement activity through the MIPS 2021 performance period.

MIPS

MIPS Scoring Methodology

For the 2021 performance year, CMS finalized the following changes to the MIPS performance category weights:

- Quality – 40 percent (5% decrease from the 2020 performance year)
- Improvement Activities – 15 percent (no change)
- Promoting Interoperability – 25 percent (no change)
- Cost – 20 percent (5% increase from the 2020 performance year)

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. CMS is continuing with the 60-point performance threshold for 2021 as finalized in the 2020 Final Rule, instead of 50 points, as proposed for 2021. The Agency did not make any changes to the exceptional performance threshold, currently set at 85 points for the 2021 performance year.

The payment adjustment for 2023 (based on 2021 performance) will range from -9 percent to +9 percent, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), excluding Part B drugs.

Performance Category Reweighting

CMS continues to provide Promoting Interoperability hardship exemptions for the 2021 performance period. In a case where the Promoting Interoperability category is reweighted to zero, the Agency finalized reweighting the Quality category to 65 percent and the Improvement Activities category to 15 percent. Further, the Agency finalized that where the Cost category is reweighted to zero, the Promoting Interoperability category would receive 30 percent, the Improvement Activities category 15 percent, and the Quality Category 55 percent.

Clinician Eligibility

CMS did not propose changes to current MIPS eligibility requirements. For more information, please see ASTRO's [QPP resource page](#).

Bonus Points

Complex Patients

CMS finalized its proposal 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) to account for the additional complexity of treating their patient population due to COVID-19. The Agency finalized the proposal to continue the complex patient bonus of 5 points, for the 2021 performance period.

Small Practice Bonus

CMS is retaining the small practice bonus of six points for the 2021 performance year to be applied to the 2023 payment year. The bonus will continue to be added to the Quality performance category, as it was in 2020, rather than in the MIPS final score calculation, as it was in 2018. To receive the bonus, a small practice must submit Quality data. This applies to individual clinicians, group practices, virtual groups, or MIPS APM entities that consist of 15 or fewer clinicians.

Quality Performance Category

The Agency finalized its proposal to reweight the Quality category to 40 percent for the 2021 performance year, and 30 percent for the 2022 performance year. This is a decrease of 5 percent in 2021 from 2020. The reporting period for the Quality category will continue to be a full calendar year.

In the proposed rule, CMS proposed using the performance period, not historical benchmarks to score quality measures for the 2021 performance period because they were concerned they may not have a representative sample of historic data for 2019 because of the PHE. However, in the final rule, the Agency determined that sufficient data were submitted for the 2019 performance period to allow them to calculate historical benchmarks for the 2021 performance period. For the 2021 performance year, the Agency finalized applying a 3-point floor for each measure that can be reliably scored against the benchmark. Given the use of performance period benchmarks for 2020, CMS also finalized an update to the scoring policy for topped-out measures. 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.

Additionally, the Agency is extending the CMS Web Interface as a collection and submission type for groups and virtual groups through the 2021 performance period, sunseting it, instead, with the 2022 performance period. This is a change from the proposed rule, which proposed ending the CMS Web Interface beginning with the 2021 performance period. CMS believes that the transition to using an alternative collection type for the 2022 performance period would reduce reporting requirements for groups and virtual groups. With this change, groups and virtual groups will 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.

In addition, CMS finalized the addition of two new administrative claims measures: Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive (MIPS) Eligible Clinician Groups and the 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.

Though unlikely, based on the case minimum, the Hospital-Wide, All-Cause Unplanned Readmission claims measure could apply to large radiation oncology or multidisciplinary groups.

- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups.
 - 200 case minimum
 - 1-year measurement period
 - Only applies to groups and virtual groups with 16 or more clinicians that meet the case minimum

CMS is maintaining the data completeness threshold at 70 percent of Medicare Part B patients for the 2021 performance year, regardless of payer, with a minimum of 20 cases per measure. CMS is also maintaining the 1-point floor for measures that do not meet data completeness requirements. This policy does not apply to small practices, who will continue to earn three points for submitting measures that do not meet the data completeness threshold.

Beginning with the 2021 performance period, CMS finalized its expansion of the list of reasons that a quality measure may be impacted during the performance period, in addition to revising when the Agency 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.

CMS finalized a policy to truncate the performance period or suppress a quality measure if the Agency determines that revised clinical guidelines, measure specifications or codes impact clinician's ability to submit information on the measure or may lead to potentially misleading results, beginning with the 2021 performance period. Based on the timing of the changes to clinical guidelines, measure specifications or codes, CMS would assess the measure on 9 months of data, and if 9 consecutive months of data are not available, CMS would suppress the measure by reducing the total available measure achievement points from the quality performance category by 10 points for each measure submitted that is impacted.

The Agency believes that there may be instances when there are changes after the final approval of quality measures, including changes to the measure specification, or updates to coding that may lead to misleading results. If there are no concerns with potential patient harm, CMS would like the ability to assess performance on the quality measure (not including the change) if there is sufficient data. Depending on the timing of the change during the performance period, CMS would like to assess performance on the quality measure. The Agency believes it can assess performance using 9 months of data and will suppress the measure if there is less than 9 months of data.

Cost Performance Category

CMS finalized its proposal to increase the weight of the Cost category from 15 to 20 percent for the 2021 performance year, and 30 percent for the 2022 performance year. By law, the category must be weighted at 30 percent in the 2022 performance year. The Cost category continues to require a full calendar year reporting period. Due to the PHE and the increase in use of telehealth services, CMS is updating existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the total per capita cost measure.

Total Per Capita Cost Measure (TPCC)

CMS did not propose any changes to the attribution methodology for TPCC for the 2021 performance year. The exclusions previously finalized will ensure that the TPCC measure is more accurately applied to clinicians who provide primary care services. Attributed episodes of care are excluded if they are performed by clinicians who (i) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy) or (ii) are in specialties unlikely to be responsible for providing primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology). While radiation therapy would be excluded from this measure, physician assistants and nurse practitioners that may provide services to patients receiving radiation therapy services are still included in the attribution methodology.

Medicare Spending Per Beneficiary Clinician (MSPB)

CMS did not propose any changes to the attribution methodology under the MSPB. Medical episodes are first attributed at the clinician group (TIN) level, and then at the clinician (TIN-NPI) level. A medical episode is attributed to the TIN, if the TIN bills at least 30 percent of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay. Then the episode is attributed to a clinician in the TIN, who bills at least one inpatient E/M service out of the 30 percent or more of inpatient E/M services attributed to the TIN. For example, a surgical episode is attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure. Unrelated services specific to groups of Diagnosis Related Groups (DRGs) aggregated by Major Diagnostic Category (MDC) level are excluded.

Improvement Activities Performance Category

CMS is retaining the weight for Improvement Activities performance at 15 percent, based on a selection of medium and high weighted activities. The Agency is also retaining the 90-day minimum performance period, as well as the simple attestation reporting requirement. CMS finalized one new element to the criteria for nomination of new improvement activities beginning with the 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. The Agency believes that when possible, it is important to establish a strong linkage between Quality, Cost, and Improvement Activities.

CMS finalized the modification of two existing Improvement Activities:

- Beneficiary Engagement: Engagement of patient through implementation of improvements in patient portal.
- Achieving Health Equity: Comprehensive eye exams.

Promoting Interoperability (PI) Performance Category

The Agency is retaining both the 25 percent weight for the PI category and the 90-day minimum performance period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

The Agency finalized its proposal to retain the Query of Prescription Drug Monitoring Program measure as an optional measure worth 10 bonus points.

For the 2021 performance year, CMS finalized its proposal to change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information to Support Electronic Referral Loops by Receiving and *Reconciling* Health Information to better reflect specific actions required by the measure's numerator and denominator.

The Agency also finalized the addition of an optional Health Information Exchange (HIE) Bi-Directional Exchange measure, worth 40 points. As finalized, clinicians may either report the two existing measures and associated exclusions OR may choose to report the new measure. The measure would be reported through attestation.

CMS believes that HIEs allow for the sharing of health information among clinicians, hospitals, care coordinators, labs, radiology centers, and other healthcare providers through secure, electronic means so that healthcare providers can have the benefit of the most recent information available from other providers.

Finalized Scoring Methodology for 2021 Performance Period

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 <i>Reconciling</i> Health Information	20 points
<i>Health Information Exchange (alternative)</i>	<i>HIE Bi-Directional Exchange</i>	<i>40 points</i>
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: <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting 	10 points

Certified Electronic Health Record Technology (CEHRT)

CMS is continuing the requirement that eligible clinicians use 2015 Edition CEHRT for 2020. In May 2020, the Office of the National Coordinator for Health Information Technology (ONC) finalized additional updates to the 2015 Edition in the 21st Century Cures Act Final Rule, including an e-prescribing standard required for alignment with other CMS programs.

The 21st Century Cures Act final rule finalized updates to a number of certification criteria, which are currently associated with objectives and measures under the Promoting Interoperability Program, as well as criteria that are included in the 2015 Edition Base EHR¹ definition. In general, ONC finalized that health IT developers have until May 2, 2022 to make

¹ 2015 Edition Base EHR means an electronic record of health-related information on an individual that:
 (1) Includes patient demographic and clinical health information, such as medical history and problem lists; (2) Has the capacity: (i) To provide clinical decision support; (ii) To support physician order entry; (iii) To capture and query information relevant to health care quality; (iv) To exchange electronic health information with, and integrate such information from other sources; and (3) Has been certified to the certification criteria adopted by the Secretary.

technology certified to these updated criteria available to their customers. During this time, developers are expected to continue supporting technology certified to the prior version of certification criteria for use by their customers.

In general, health IT developers have up to 24 months from May 1, 2020 to make technology certified to the updated criteria available to their customers, plus the additional three-month period during which ONC will exercise enforcement discretion around compliance dates finalized in the 21st Century Cures Act final rule in response to the COVID-19 PHE. As a result, where the 21st Century Cures Act final rule requires health IT developers to make technology meeting new and updated certification criteria available by May 2, 2022, developers taking advantage of enforcement discretion would be permitted to delay making updated certified technology available until August 2, 2022. *After this date, technology that has not been updated in accordance with the 2015 Edition Cures Update will no longer be considered certified.*

Health IT developers are expected to continue supporting technology certified to the prior version of the certification criteria for use by their customers prior to implementing updates, and healthcare providers participating in QPP may use such technology for the purposes of these programs while working with health IT developers to implement updates in a manner that best meets their needs. Several certification criteria were removed because they are already in widespread use, including medications, medication allergies and smoking status. A new criterion, “electronic health information export,” was established. This new criterion requires a certified health IT module to electronically export all electronic health information (EHI) that can be stored at the time of certification by the product of which the health IT module is a part. A health IT developer of a certified health IT products, which, at the time presented for certification, electronically stores EHI must certify such products to this new criterion and make these products available to their customers by May 2, 2023. However, the new EHI Export criterion is not included in the Base EHR definition, and it is not associated with any objectives or measures in the Promoting Interoperability Programs or MIPS.

Qualified Clinical Data Registry (QCDR)

CMS did not make any changes to the performance category data submission requirements finalized in the 2020 final rule. For the 2021 performance period, CMS finalized its proposal that QCDRs, Qualified Registries, and Health IT Vendors may support data submission for the APM Performance Pathway (see below for more information on the APM Performance Pathway). For the 2022 performance period, CMS finalized its proposal that QCDRs, Qualified Registries, and Health IT vendors may support data submission for MIPS Value Pathways (see below for more information on the MIPS Value Pathways).

Beginning with the 2022 performance period, the Agency finalized its proposal that QCDR measures be fully tested at the clinician level to be considered for inclusion in an MVP. CMS also finalized two proposals in light of the PHE:

1. A proposal that delays the QCDR measure testing requirement until the 2022 performance period and 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), and
2. A proposal that delays 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.

Extreme and Uncontrollable Circumstances Reweighting Application

Beginning with the 2020 performance period, CMS finalized its proposal 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. This is different than the policy for individuals, groups, and virtual groups, which did not change.

MIPS Value Pathways (MVP)

Due to the current PHE, CMS is delaying the implementation of MVP until the 2022 performance period, or later. MVP must be proposed and finalized through the notice-and-comment rulemaking process. The Agency will formulate a standardized process in which stakeholders can submit formal MVP candidates for CMS' consideration.

In the meantime, the Agency finalized the guiding principles for MVP (revisions in italics):

1. MVP 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. MVP 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; *MVP will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.*
3. MVP 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. MVP should reduce barriers to APM participation by including measures that are part of APM where feasible, and by linking cost and quality measurement.
5. *MVP should support the transition to digital quality measures.*

Alternative Payment Models (APM)

Advanced APM

The 2021 MPFS proposed rule does not provide any information regarding the RO Model. **However, 2021 Hospital Outpatient Prospective Payment System (HOPPS) final rule includes a number of modifications to the RO Model that specifically apply to the first**

performance period that begins on July 1, 2021. Please refer to ASTRO’s HOPPS final rule [summary](#) for more information regarding the RO Model modifications.

The following summary encompasses changes to aspects of the broader QPP APM program that are effective January 1, 2021.

Qualified APM Participant (QP)

In the 2017 QPP final rule, CMS established Qualified APM Participant (QP) status requirements that allowed for the determination of QP status first at the APM Entity Level, after which the Agency would make further QP determinations at the individual level for Eligible Clinicians who are either participating in multiple Advanced APM Entities or are included on an Affiliated Practitioner List that is used for QP determination. The QP determination Threshold Score calculations are aggregated using data for all Eligible Clinicians participating in an APM Entity on each snapshot date (March 31, June 30, August 31, and December 31) during the QP Performance Period. If the APM Entity’s Threshold Score meets the relevant QP threshold then all individual eligible clinicians in that APM Entity would receive the same QP determination.

CMS includes “attribution eligible beneficiaries” in the denominator of the patient count and payment amount methods used to calculate the QP Threshold Scores. Beneficiaries may only be counted once in the numerator and denominator for a single APM Entity but may also be counted in other APM Entity calculations. The calculation involves the ratio of payment amounts or patient counts for “attributed beneficiaries” to the payment amounts or patient counts for “attribution eligible beneficiaries.” If the ratio meets or exceeds the relevant QP thresholds, the Eligible Clinician will have attained QP status for the year.

The Agency has come to recognize that this policy disadvantages some APM Entities, as it includes “attribution eligible beneficiaries” in the denominator of the calculation that could not be included in the numerator as “attributed beneficiaries”. For example, beneficiaries prospectively attributed to an ACO are not available to be attributed to other APMs, thus limiting the number of “attribution-eligible beneficiaries”.

In the 2021 MPFS final rule, CMS finalized a modification to the policy to specify that beneficiaries who have been prospectively attributed to an APM Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity’s attributed beneficiary list. This removes the prospectively attributed beneficiaries from the denominators when calculating Threshold Scores for APM Entities or individual Eligible Clinicians in Advanced APMs denominator when calculating the QP threshold score. The Agency also finalized the establishment of a QP determination review process for eligible clinicians or entities that believe they may have been omitted from the QP participation list.

Finally, CMS established a targeted review process involving QP determinations that will allow Eligible Clinicians to bring to the Agency’s attention any potential clerical errors or necessary corrections, if warranted. The review process will align with the existing [MIPS targeted review process](#). An Eligible Clinician or APM Entity may request targeted review of a QP or Partial QP

determination only if they believe, in good faith, that, due to a CMS clerical error, an Eligible Clinician was omitted from a Participation List used for QP determinations.

Partial QP Participant

CMS anticipates that there will be a greater number of Eligible Clinicians who are determined to be Partial Qualified APM Participants or Partial QPs in the 2021 QP Performance Period in comparison to the 2020 QP Performance Period, due to increases in the QP thresholds. Beginning with the 2021 QP Performance Period, the QP payment amount threshold increases from 50 percent to 75 percent, while the QP patient threshold increases from 35 percent to 50 percent. Partial QPs who do not elect to participate in MIPS as MIPS Eligible Clinicians are excluded from MIPS, and thus, not subject to the MIPS reporting requirements or payment adjustments. In the 2021 MPFS final rule, CMS revised existing policy to allow an APM Entity to make the Partial QP election on behalf of all of the individual eligible clinicians associated with the APM Entity, rather than requiring each eligible clinician to make the election individually.

Advanced APM Incentive Payment

In the 2021 MPFS final rule, CMS clarified that the 5 percent APM Incentive Payment is based on the *paid amount* of applicable claims for covered professional services. The Agency points out that it would not be appropriate to calculate the APM Incentive Payment based on amounts that were allowed, but not actually paid by Medicare. CMS also reasserts its opinion that certain payments, including MIPS payment adjustments, will not be included when calculating the APM Incentive Payment amount.

Distribution of the APM Incentive Payment is made to the TIN affiliated with an APM Entity. If Eligible Clinicians become a QP through participation in multiple Advanced APMs, the Agency will divide the APM Incentive Payment proportionally, based on payments for covered professional services during the performance period. CMS has found that Eligible Clinicians may change TINs, APM Entities, or make other changes that impact their relationship with the Medicare program. Due to the two-year time lapse between the end of the performance period and the issuance of the APM Incentive Payment, these changes make it difficult for CMS to ensure that the APM Incentive Payment is received by the appropriate TIN. In the 2021 MPFS final rule, the Agency modified its approach to identifying the TIN(s) to which it makes APM Incentive Payments. This new approach would allow CMS to review a QP's relationship with their TIN(s) over time, as well as consider the relationship the TIN(s) have with the APM Entity or Entities through which the Eligible Clinician earned QP status, or other APM Entities the QP may have joined in the interim. CMS believes this approach will reduce the burden on the payee TIN(s) who under the current structure must find QPs that are no longer affiliated with them.

Additionally, CMS finalized a hierarchy for recipient TIN affiliation identification when making the APM Incentive Payment. The Agency believes this will help it make the APM Incentive Payment in a more timely and efficient manner. The first step of the hierarchy requires the identification of any TIN associated with the QP that, during the QP Performance Period, is associated with an APM Entity through which the Eligible Clinician achieved QP status. If CMS

is unable to identify one or more TINs with which the QP has a current affiliation, then the Agency will move on to successive steps of the hierarchy until it identifies one or more TINs with which the QP has an affiliation. If more than one TIN is identified, then CMS will divide the APM Incentive Payment proportionally between the TINs based on the relative paid amount for Part B covered professional services. If CMS is unable to identify a TIN associated with a QP, then the Agency will attempt to contact the QP via public notice.

The Agency established a cutoff date of November 1 of each payment year or 60 days from the day on which the Agency made the initial round of APM Incentive Payments, whichever is later, as a point in time after which the Agency will no longer accept new help desk requests from QPs or their representatives who have not received payment. After that time, any claims by a QP to an APM Incentive Payment will be forfeited.

COVID-19 Public Health Emergency (PHE) Advanced APM Determination and QP Determinations

CMS anticipates that the COVID-19 PHE will result in changes to existing APMs. The Agency may publish regulations or amend existing APM Participation Agreements to address issues resulting from the COVID-19 PHE. That said, CMS is modifying the existing Advanced APM determination structure in the 2021 MPFS final rule. CMS will not reconsider the Advanced APM determinations of APMs which have already been evaluated and determined to meet Advanced APM criteria for 2020. Furthermore, the Agency plans to evaluate all APMs in future years with the understanding that any revisions to the Participation Agreement or governing regulation in response to the COVID-19 PHE will not be considered to the extent that they would prevent the APM from meeting Advanced APM criteria.

The Agency also understands that the COVID-19 PHE may lead to an earlier end date for certain APMs based on amendments to the APM's governing documentation, such as the Participation Agreement. This would not revoke the QP status of Eligible Clinician participants in Advanced APMs.

Alternative Payment Model Performance Pathway (APP)

CMS finalized the establishment of an Alternative Payment Model Performance Pathway (APP) under the MIPS program, effective January 1, 2021. The new, voluntary APP will be available to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the snapshot dates (March 21, June 30, August 31 or December 31) during a performance period, as well as participants in the CMS Shared Savings Program ACOs.

Individual MIPS Eligible Clinicians who are participants in MIPS APMs may report through the APP at the individual level. Groups and APM Entities may report through the APP on behalf of their constituent MIPS Eligible Clinicians; however, the final score earned by the group through the APP would be applied only to those MIPS Eligible Clinicians who appear on a MIPS APM's Participation List or Affiliated Practitioner List on one or more snapshot dates. The final score

applied to each individual MIPS eligible clinical would be the highest available score for that clinician or a Virtual Group score, if applicable.

The APP allows for the reporting of a single quality measure set with broad applicability. Participants would receive an Improvement Activities Category credit and the Cost Category will be waived. The APP establishes six measures, which, according to CMS, address the highest priorities for quality measurement and improvement, while also reducing reporting burden, promoting alignment of measures and consolidation of reporting requirements across CMS programs. The table below describes the measures included in the Proposed APM Performance Pathway program:

TABLE 36: Measures included in the Proposed APM Performance Pathway 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

CMS will remove those quality measures that MIPS Eligible Clinicians, groups or APM Entities are unable to report on due to the size of the available patient population or because they are unable to meet the minimum case threshold for a measure. Furthermore, the Agency will not apply the quality measure scoring cap in the event that a measure in the APP measure set is determined to be topped out. Because the measure set is fixed, CMS does not believe it is appropriate to limit the maximum quality performance category available to them.

CMS will waive the Cost Performance Category for APP because APM Entities in the MIPS APMs are already subject to cost performance assessment. Additionally, CMS will establish a baseline score for each MIPS APM based on the Improvement Activity requirements of the particular MIPS APM. The Agency will review the MIPS APM's requirements in relation to activities specified under the generally applicable MIPS Improvement Activities Performance Category and assign for each MIPS APM an Improvement Activities Performance Category

score that is applicable to all MIPS Eligible Clinicians reporting through the APP. Finally, the Promoting Interoperability Performance Category score be reported and calculated for APP participants just as it is for regular MIPS participants.

CMS finalized its decision to reweight the MIPS Performance Categories as follows for APP participants:

- Quality 50%
- Cost 0%
- Promoting Interoperability 30%
- Improvement Activities 20%

Finally, scoring for Eligible Clinicians reporting to MIPS through the APP would follow the same methodology as established for MIPS generally. That includes scoring each performance category and multiplying each performance category score by the applicable performance category weight, and then calculating the sum of each weighted performance category score and apply any applicable adjustments.

MIPS APMs

In the 2017 MPFS, CMS established the following requirements for MIPS APMs: 1) APM entities participate in an APM under an agreement with CMS or by law or regulation; 2) the APM requires that the APM Entities include at least one MIPS eligible clinician on a Participation List; and 3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures. CMS modified the third criterion in the 2020 MPFS to specify that a MIPS APM must be designed in such a way that participating APM Entities are incented to reduce costs of care or utilization of services, or both.

In the 2021 MPFS proposed rule, CMS finalized its proposal to amend its definition of MIPS APM participants to include Affiliated Practitioner List, in addition to the existing requirement that APM Entities include at least one MIPS Eligible Clinician on a Participation List.

APM Scoring Standard

The APM Scoring Standard was designed to encourage greater participation in APMs, as well as to reduce reporting burden for participants in MIPS APMs by eliminating the need for MIPS Eligible Clinicians to submit data for both MIPS and their respective APMs. As the program has matured, CMS has recognized that the APM Scoring Standard is infeasible to fully implement due to its complexity and inflexibility in adapting to changes in APM participation and design. The Scoring Standard has become an additional burden for APM Entities and their participant MIPS Eligible Clinicians. In the 2021 MPFS final rule, the Agency eliminated the APM scoring Standard for the 2021 performance year to allow MIPS APM participants to participate in MIPS as individuals, groups, Virtual Groups, or APM entities. This will allow participants to report through any MIPS reporting and scoring pathway, including the newly formed APP.

Due to this proposal, CMS will no longer depend on the availability of quality data reported directly to the APM Entity, as is required under the existing APM Scoring Standard. This discontinues the requirement that MIPS APMs be in operation and collecting quality data for the duration of the performance period. The Agency does not believe that there is a substantial risk of the MIPS final scores being inappropriately influenced by MIPS Eligible Clinicians moving in to or out of APM Entities late in the performance year. Therefore, MIPS Eligible Clinicians identified on either a Participation List or Affiliated Practitioner list would only need to appear as a MIPS APM participant on any one of the four snap shot dates (March 31, June 30, August 31 or December 31) in order to be considered participants in an APM Entity.

Extreme and Uncontrollable Circumstances

The CFR establishing policies for APM Entities allows for the submission of an application to CMS to request reweighting of one or more MIPS Performance Categories due to “extreme and uncontrollable circumstances”. In the 2021 MPFS final rule, CMS finalized the policy effective beginning with the 2020 performance year/2022 MIPS Payment year. The application applies to all Performance Categories and all MIPS Eligible Clinicians. The APM Entity must demonstrate in its application that more than 75 percent of its participant MIPS Eligible Clinicians would be eligible for reweighting the Promoting Interoperability Category. If CMS approves the request, MIPS Eligible Clinicians participating in the APM Entity would be exempt from MIPS reporting requirements for the applicable performance period, and the APM Entity would receive a final score equal to the performance threshold.

Additional Resources:

CMS 2021 Quality Payment Program Final Rule [Resources](#)

2021 Quality Payment Program [final rule](#)

ASTRO [Quality Payment Program resources](#)