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Welcome to Today's Meeting!

- Housekeeping reminders:
  - Please **mute** yourself when **not** speaking
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPClinician@qualityforum.org

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Measure Applications Partnership (MAP)

Clinician Workgroup Orientation Web Meeting

November 5, 2021

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003 Option Year 3

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Agenda

- Welcome, Introductions, Review of Meeting Objectives
- CMS Welcoming Remarks
- MAP Pre-Rulemaking Approach
- Overview of Programs Under Consideration
- 2021 – 2022 MAP Clinician Overarching Themes
- MAP Rural Health and Health Equity Advisory Groups Review of Measures Under Consideration (MUCs)
- CMS Presentations
- Opportunity for Public Comment
- Next Steps
- Adjourn

Welcome, Introductions, and Review of Meeting Objectives

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Workgroup Staff

- **Tricia Elliott, MBA,CPHQ, FNAHQ,** Senior Managing Director
- **Ivory Harding, MS,** Manager
- **Ashlan Ruth, BS IE,** Project Manager
- **Victoria Freire, MPH, CHES,** Analyst
- **Gus Zimmerman, MPP,** Coordinator
- **Joelencia LeFlore,** Coordinator
- **Taroon Amin, PhD,** Consultant

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Clinician Membership

Workgroup Co-Chairs: Rob Fields, MD; Diane Padden PhD, CRNP, FAANP

Organizational Members (Voting)

- American Academy of Family Physicians
- American College of Cardiology
- American College of Radiology
- Blue Cross Blue Shield of Massachusetts
- Consumer's Checkbook
- Council of Medical Specialty Societies
- Genentech, Inc.
- HealthPartners, Inc.
- Kaiser Permanente
- Louise Batz Patient Safety Foundation
- Magellan Health, Inc.
- OCHIN, Inc.
- Patient Safety Action Network
- Pharmacy Quality Alliance
- Purchaser Business Group on Health
- St. Louis Area Business Health Coalition

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Clinician Membership (continued)

Individual Subject Matter Experts (Voting)

- Nishant Anand, MD
- William Fleischman, MD, MHS
- Stephanie Fry, MHS
- Amy Nguyen Howell, MD, MBA, FAAFP

Federal Government Liaisons (Non-voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)

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Objectives for Today's Meeting

- Review the goals and structure of each program
- Review the critical objectives of each program
- Identify measurement gap areas

CMS Welcoming Remarks

MAP Pre-Rulemaking Approach

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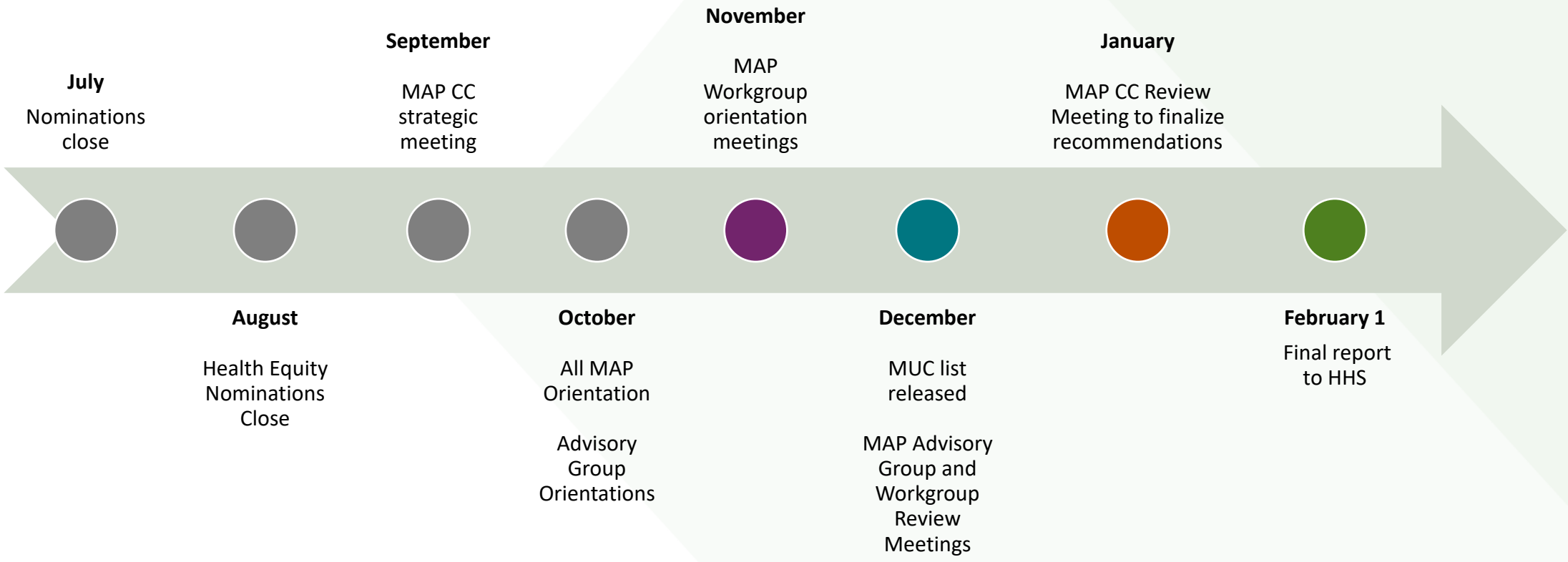
Timeline of MAP Activities



Measure Set Review (MSR) – 2021 Pilot and Future State

- In partnership with CMS, NQF developed a pilot process and measure review criteria (MRC) for federal quality programs covering the Clinician, Hospital and Post-Acute Care/Long-Term Care (PAC/LTC) settings.
- For the 2021-2022 cycle, the MAP Coordinating Committee conducted a pilot MSR meeting and provided input on the MRC.
  - Measures were reviewed from Hospital programs
  - The MSR final report is available online
- For the 2022-2023 cycle, the MAP will fully implement the MSR to include input from all workgroups and advisory groups.
  - Further information will be provided in early 2022

Overview of Clinician Programs Under Consideration

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Programs to be Considered by the Clinician Workgroup

Merit-based Incentive Payment System (MIPS)

Medicare Part C and D Star Ratings

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Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
  - Pay-for-performance
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and finalized 2021 weights:
    - Quality (40%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (20%)
    - The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare FFS.
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

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2021 MIPS Current Measures
Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Effective Prevention and Treatment	94
Making Care Safer	21
Communication/Care Coordination	25
Making Care Affordable	37
Person and Family Engagement	32
Total	**209**

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MIPS – CMS High-Priority for Future Measure Consideration

MIPS has a priority focus on:

- **Outcome measures** – includes outcome, intermediate outcome and patient reported outcome (PRO).
  - Outcome measures show how a health care service or intervention influences the health status of patients.
- **Person or family** - reported experiences of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations.
- **Population Health** - health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group.

Measures that:

- Provide new measure options within a topped-out specialty area;
- Reduce reporting burden – includes digital quality measures (dQMs), administrative claims measures and measures that align across programs;
- Capture relevant specialty clinicians;
- Focus on patient-centered care and include the patient voice;
- Reflect the quality of a group's overall health and wellbeing including access to care, coordination of care and community services, health behaviors, preventive care screening, and utilization of health care services;
- Address behavioral health; and
- Support health equity.

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Workgroup Discussion-MIPS

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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Part C and D Star Ratings

- **Program Type:** Quality Payment Program & Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments (QBP)
  - Stand-alone Prescription Drug Plans: Public reporting
- **Program Goal:**
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
  - Incentivize high performing plans (Part C)
  - The April 2018 final rule (CMS-4282-F) initially codified the methodology for the Part C and D Star Ratings

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2022 Star Ratings Measure List
Divided by Meaningful Measure Area

Healthcare Priority	Meaningful Measure Title	# of Measures
Effective Prevention and Treatment	Management of Chronic Conditions	12
	Preventive Care	5
	Prevention, Treatment, and Management of Mental Health	0
Making Care Safer	Preventable Healthcare Harm	1
Communication/Care Coordination	Medication Management	3
	Transfer of Health Information and Interoperability	2
Making Care Affordable	Appropriate Use of Healthcare	2
	Patient Focused Episode of Care	2
Person and Family Engagement	Patient's Experience of Care	13
	Patient's Reported Functional Outcomes	0
Total		**40***

*38 unique measures

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Summary of Changes for 2022 Part C & D Star Ratings

- CMS resumed the use of the most recent data for HEDIS and CAHPS measures.
- Re-specified Medicare Plan Finder (MPF) Pricy Accuracy measure moved into the 2022 Star Ratings as a new measure.
- Mean resampling added to the hierarchical clustering methodology that is used to set cut points for non-CAHPS measures to minimize the influence of outliers.
- Part C measure - Care of Older Adults: Functional Status Assessment - temporarily moved to the display page for the 2022- and 2023-Star Ratings because NCQA made substantive changes to the measure specification.
- The following measures were retired from Part C & D Star Ratings: Adult BMI Assessment, Appeals Auto-Forward, and Appeals Upheld.

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Summary of Changes for Part C & D Star Ratings Due to the COVID-19 Public Health Emergency

- For the 2022 Star Ratings only, expanded the existing improvement measure hold harmless provision to all contracts at the overall and summary rating levels.
- For the 2022 Star Ratings only, modified the disaster policy to remove application of the 60% rule and avoid the exclusion of contracts with 60% or more of their enrollees living in FEMA-designated Individual Assistance areas from calculation of the non-CAHPS measure-level cut points and calculation of the Reward Factor.
- For the 2022 and 2023 Star Ratings, two Part C measures – Improving or Maintaining Physical Health and Improving or Maintaining Mental Health – are moved to the display page due to validity concerns related to the COVID-19 public health emergency.

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Part C and D – CMS High-Priority for Future Measure Consideration

The Medicare population includes a large number of individuals and older adults with high-risk multiple chronic conditions (MCC) who often receive care from multiple providers and settings and, as a result, are more likely to experience fragmented care and adverse healthcare outcomes.

- **Equity of Care**
- **Functional Outcomes**
- **Management of Chronic conditions**
- **Prevention and Treatment of Opioid Use Disorders**

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Workgroup Discussion- Part C & D

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

2021 - 2022 MAP Overarching Themes

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Overarching Themes

- Measures to Address COVID-19 Vaccination Rates
- Evolving Trends in Service Setting
- Connections Between Cost Measures and Quality Measures
- Measure Burden and Digital Measures
- Composite Measures
- Care Coordination

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Measures to Address COVID-19 Vaccination Rates

- Measures are necessary to help providers understand how they are performing at vaccinating their patients, and for patients to understand the extent to which providers are vaccinating their personnel

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Evolving Trends in Service Setting

- Clinical services are increasingly moving from inpatient to ambulatory settings
- Increasing shift towards outpatient and ambulatory services may jeopardize certain minimum case thresholds over time, as the inpatient volume decreases
- Opportunity: explore the major groupings of the types of services and procedures offered in the outpatient setting to identify gaps for measure development

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Connections Between Cost Measures and Quality Measures

- MAP expressed concerns related to explicit connections between cost and quality for measures considered for MIPS
- Currently no clear standard or consensus among stakeholders on how to use appropriately correlated cost and quality measures together to assess health system efficiency
- Cost measures carry implicit concern associated with care stinting
- There is a need for clear connections to upstream interventions that result in downstream cost savings, and for further analysis of episode-based cost measures that focus on chronic conditions

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Measure Burden and Digital Measures

- Digital quality measures, especially electronic clinical quality measures (eCQMs), give opportunities for real-time feedback to providers
- Many eCQMs are not entirely ready for use in accountability programs, and electronic health record (EHR) vendors should be engaged throughout the process to ensure that such measures are ready for deployment
- There is a need to ensure that digital quality measures are transparent to all entities, including health plans
- Potential means to decrease measurement costs and burden through alignment between public and private payors on core measures
- Patient-reported outcomes-based performance measures (PRO-PMs) are more burdensome to collect and require additional infrastructure and support

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Composite Measures

- Composite measures may provide an important comprehensive view of how a given provider is performing on a series of important measures
- It is challenging for the provider to determine how to deploy quality improvement resources to improve performance if the individual measure rates are not presented
- Individual components of such measures should not always be equally weighted

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Care Coordination

- Coordination across and among all providers helps enable the most effective team-based care for patients
- Communication and the transfer of information should be components under the larger umbrella of coordination of care
- Care coordination remains a prioritized gap for all PAC/LTC programs
  - Patients receiving care from PAC/LTC providers are clinically complex and may frequently transition between care settings
  - The ability to manage care and services after discharge has a direct impact on patient and caregiver burden and on patient readmissions

MAP Rural Health Advisory Group Review of Measures Under Consideration (MUCs)

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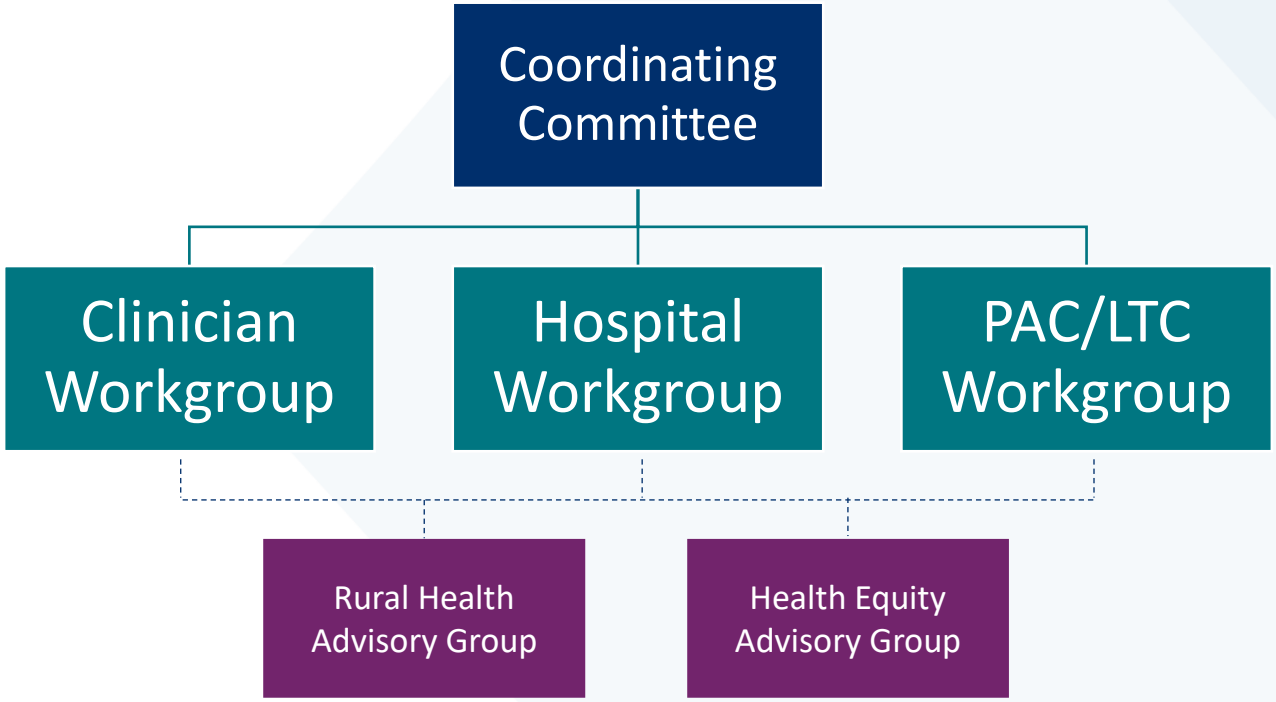
MAP Structure 2021



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MAP Rural Health Advisory Group Charge

- To provide:
  - Timely input on measurement issues to other MAP Workgroups and committees
  - Rural perspectives on the selection of quality measures in MAP
- To help address priority rural health issues, including the challenge of low case-volume

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Rural Health Advisory Group Review of MUCs

- The Rural Health Advisory Group will review all the MUCs and provide the following feedback to the setting-specific Workgroups:
  - Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences related to rural health if the measure is included in specific programs
  - Gap areas in measurement relevant to rural residents/providers for specific programs
- The Rural Health Advisory Group will be polled on whether the measure is suitable for use with rural providers within the specific program of interest

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Rural Health Advisory Group Review of MUCs (Continued)

- Rural Health Advisory Group feedback will be provided to the setting-specific Workgroups through the following mechanisms:
  - The preliminary analyses (PAs):
    - A qualitative summary of Rural Health Advisory Group's discussion of the MUCs
    - Polling results that quantify the Rural Health Advisory Group's perception of suitability of the MUCs for various programs
  - Rural Health Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December

MAP Health Equity Advisory Group Review of MUCs

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MAP Health Equity Advisory Group Charge

- Provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Provide input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages

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Health Equity Advisory Group Review of MUCs

- The Health Equity Advisory Group will review all the MUCs and provide the following feedback to the setting-specific Workgroups:
  - Relative priority in terms of advancing health equity for all
  - Data collection and/or reporting challenges regarding health disparities
  - Methodological problems of calculating performance measures adjusting for health disparities
  - Potential unintended consequences related to health disparities if the measure is included in specific programs
  - Gap areas in measurement relevant to health disparities and critical access hospitals for specific programs
- The Health Equity Advisory Group will be polled on the potential impact on health disparities if the measure is included within the specific program of interest

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Health Equity Advisory Group Review of MUCs (Continued)

- Health Equity Advisory Group feedback will be provided to the setting-specific Workgroups through the following mechanisms:
  - The PAs:
    - A qualitative summary of Health Equity Advisory Group's discussion of the MUCs
    - Polling results that quantify the Health Equity Advisory Group's perception of the potential impact on health disparities if the measure is included within the specific program
  - Health Equity Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December

CMS Presentation

Overview of the Part C and D Star Ratings Program

The Part C & D Star Ratings Program

A quality and performance measures program whose participants include:

- Medicare Advantage-Prescription Drug Plans (MA-PD plans) – offering both health (Part C) and drug (Part D) benefits;
- Medicare Advantage Only Health Plans (MA-only plans) – offering only health benefits; and
- Standalone Prescription Drug Plans (PDPs) – offering only drug benefits to supplement benefits received through Original Medicare.

The Part C & D Star Ratings Program (continued)

- Approximately 27 million beneficiaries are enrolled in MA Plans.
  - Approximately 3 million (10%) in MA-only plans.
  - Approximately 24 million (90%) in MA-PDs plans.

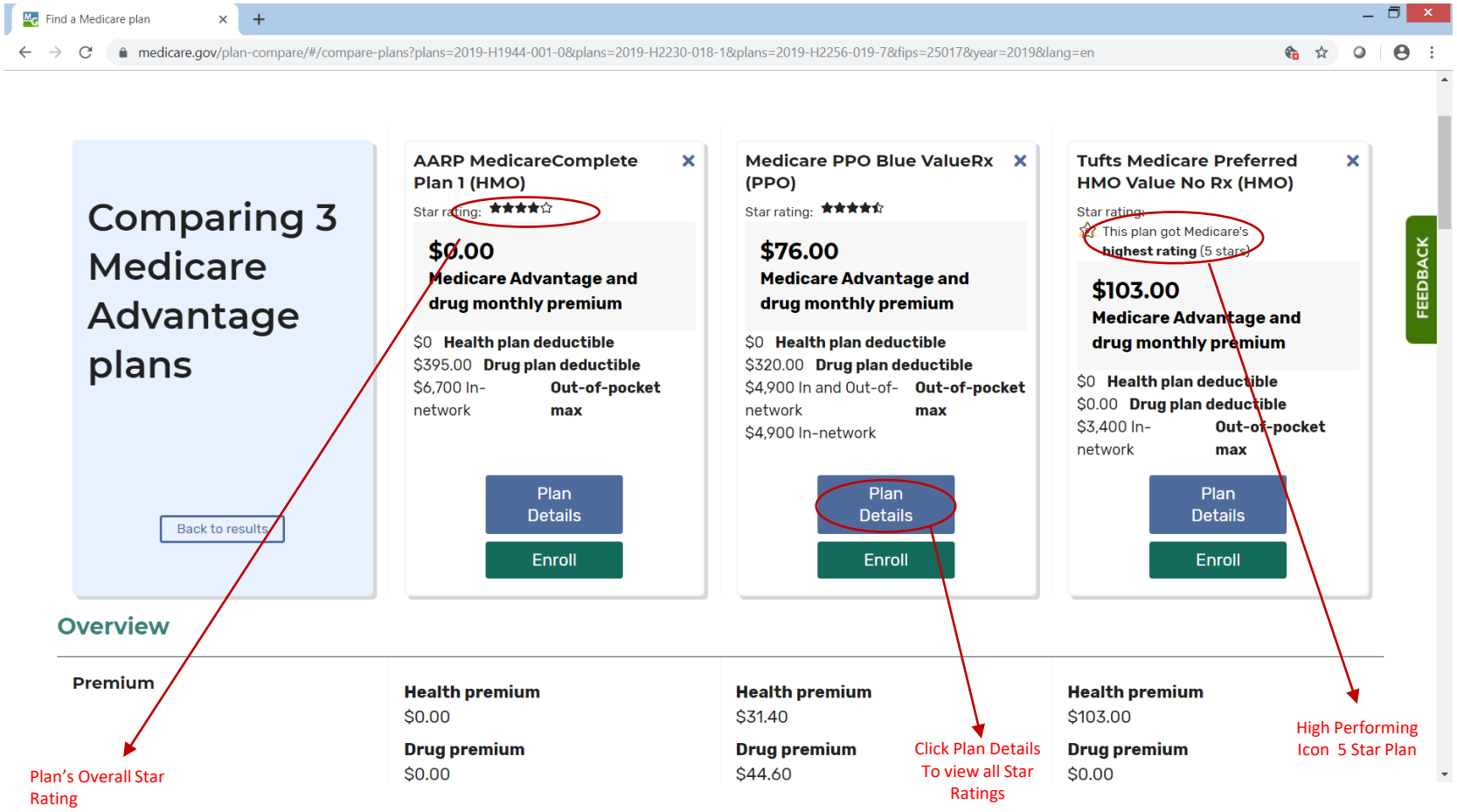
- Approximately 24 million beneficiaries are enrolled in PDPs.

- Source: https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/contract-summary-2021-09

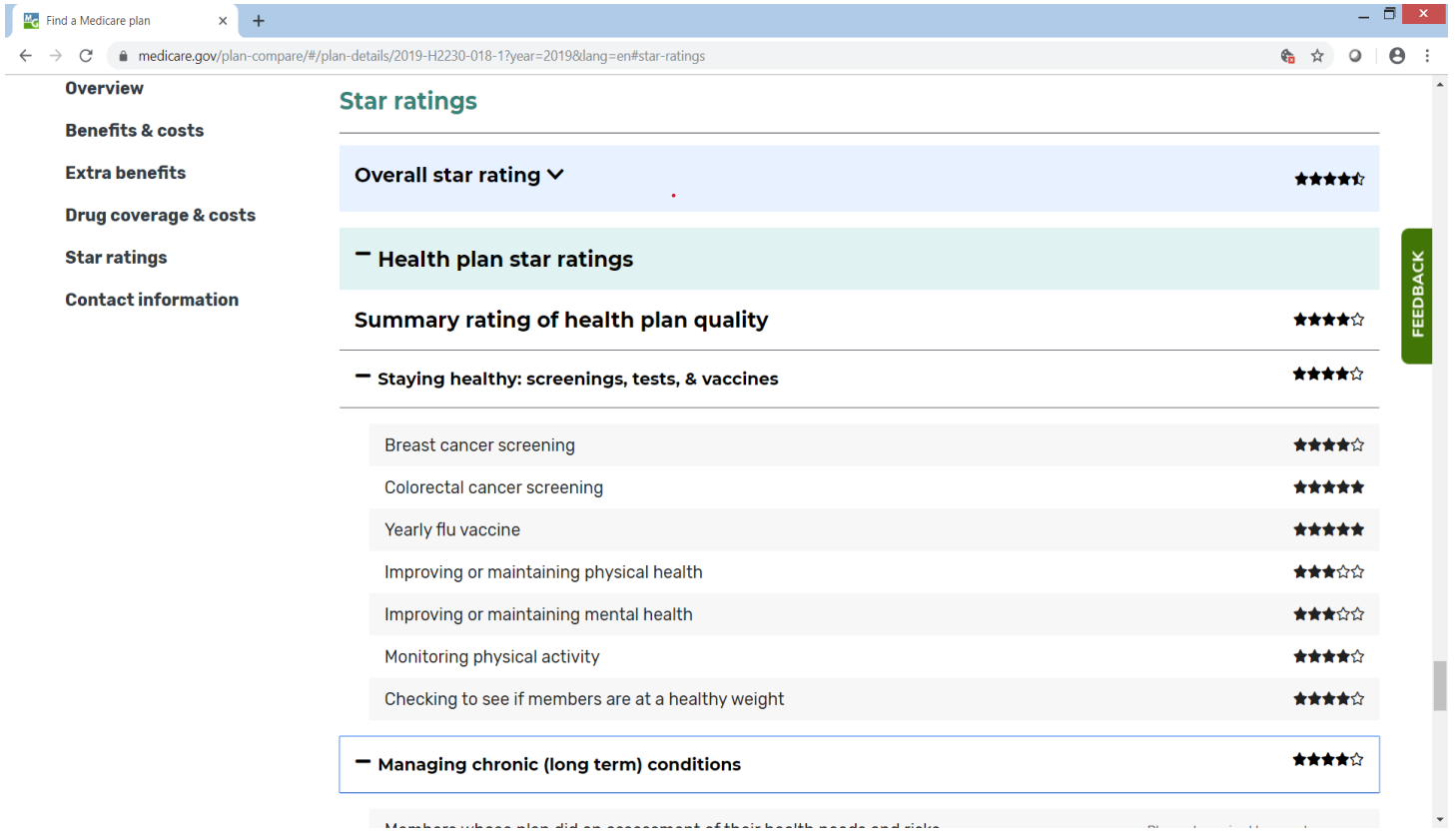
Goals of the Star Ratings Program

- Public Reporting on Medicare Plan Finder (MPF)
- Quality Improvement
- Marketing/Enrollment
- Financial Incentives

Medicare Plan Finder: Your Results Page

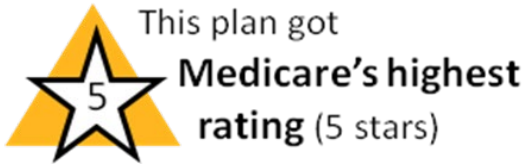


Medicare Plan Finder: Your Star Ratings Page



High Performing Plans

- CMS highlights contracts receiving an overall rating of 5 stars:



- Beneficiaries may enroll in a 5-Star PDP, MA-PD, or MA-only plan through a Special Election Period (SEP).
- 5-star plans may market year-round.

Consistently Low Performing Plans

- Icon displayed for contracts rated less than 3 stars for at least the last 3 years in a row for their Part C or D summary rating.
- Beneficiaries may not enroll online via the MPF in a Low Performing Icon (LPI) plan. Beneficiaries must contact the plan directly.
- Beneficiaries in LPI plans are eligible for a Special Enrollment Period (SEP) to move to a higher quality plan.

MA Quality Bonus Payments

- Per the Affordable Care Act, CMS makes Quality Bonus Payments (QBPs) to MA organizations that meet quality standards measured using a five-star quality rating.
- The QBP percentage for each Star Rating for 2022 payments:

Star Rating	QBP Percentage
3.5 stars or below	0%
4 stars or more	5%

- The MA rebate level for plans is tied to the contract's Star Rating.

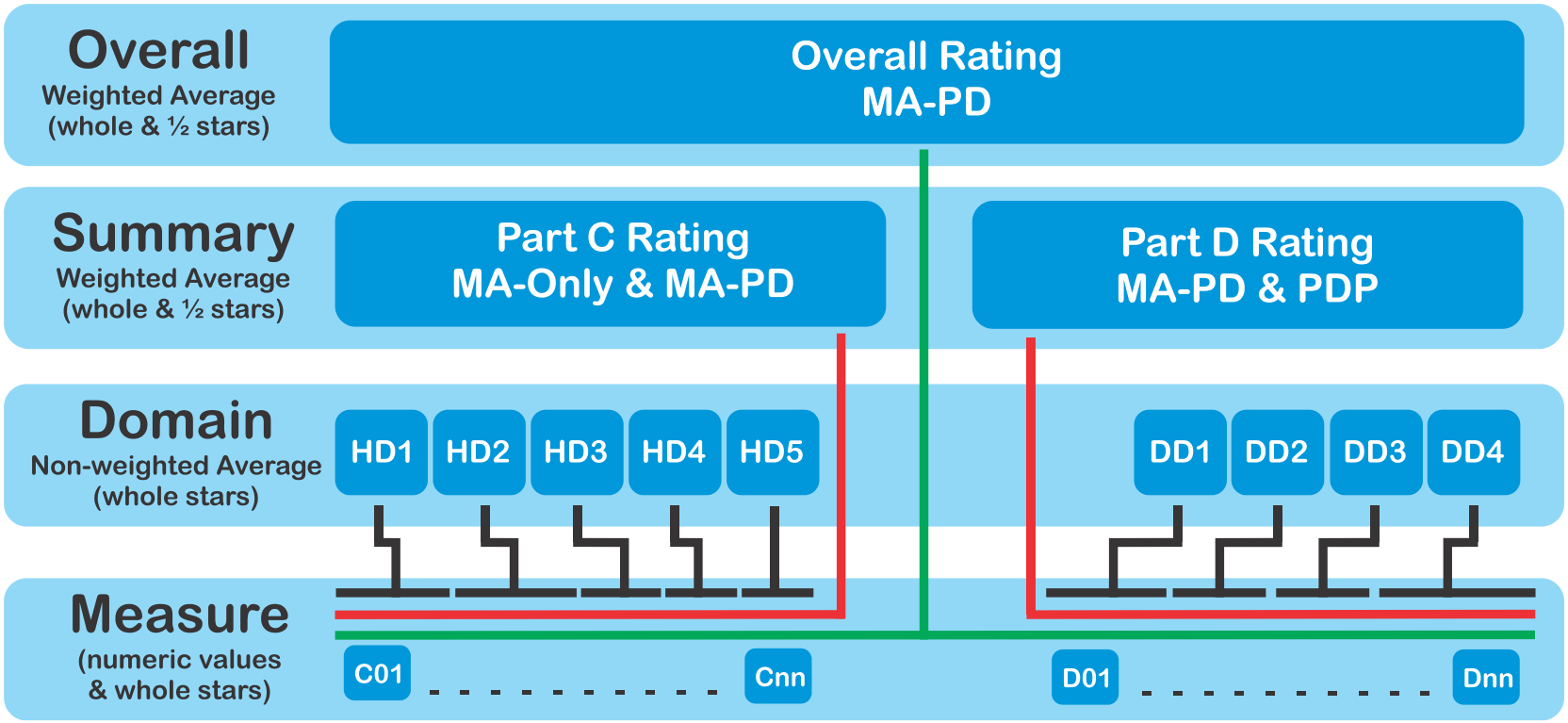
Overview of Star Ratings Methodology

Measure Development

- CMS looks to consensus-building entities such as National Committee for Quality Assurance and Pharmacy Quality Alliance for measure concept development, specifications, and endorsement.
- Measure set reviewed each year; move towards more outcome measures.
- Measures moved from the Star Ratings to CMS's display page are still used for compliance and monitoring.

2022 Star Ratings measures listed in Appendix

Structure of the Star Ratings



Star Ratings Cover 9 Domains (38 unique measures across Parts C & D)

Ratings of Health Plans (Part C)
Staying healthy: screenings, tests and vaccines
Managing chronic (long-term) conditions
Member experience with health plan
Member complaints and changes in the health plan's performance
Health plan customer service

Ratings of Drug Plans (Part D)
Drug plan customer service
Member complaints and changes in the drug plan's performance
Member experience with the drug plan
Drug safety and accuracy of drug pricing

Part C and Part D Improvement Measures

- The improvement measures are derived through the comparison of a contract's current and prior year measure scores.
- The Part C improvement measure includes only Part C measure scores; the Part D improvement measure includes only Part D measure scores.
- For high performing contracts/sponsors, due to limited opportunities for improvement, CMS has a Hold Harmless Provision.

Measure Weights

- The Star Ratings measures span five broad categories:
  - Improvement – 5
  - Outcomes/Intermediate Outcomes – 3
  - Patient Experience and Complaints – 2
  - Access – 2
  - Process – 1
- Each measure is assigned a weight using category definitions included in the Star Ratings Technical Notes.
- New measures are given a weight of 1 for their first year in the ratings.

Additional Resources

Part C & D Star Ratings and Display Measure data, Technical Notes, and other key information posted on CMS website:

https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata

Mailbox for questions:

PartCandDStarRatings@cms.hhs.gov

Appendix – 2022 Star Ratings measures

Part C Domain: Staying Healthy: Screenings, Tests and Vaccines

- Breast Cancer Screening
- Colorectal Cancer Screening
- Annual Flu Vaccine
- Monitoring Physical Activity

Part C Domain: Managing Chronic (Long Term) Conditions

- Special Needs Plan (SNP) Care Management
- Care for Older Adults – Medication Review
- Care for Older Adults – Pain Assessment
- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Diabetes Care – Blood Sugar Controlled
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling
- Improving Bladder Control
- Medication Reconciliation Post-Discharge
- Statin Therapy for Patients with Cardiovascular Disease

Part C Domain: Member Experience with Health Plan

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan
- Care Coordination

Part C Domain:
Member Complaints and Changes in the Health Plan's Performance

- Complaints about the Health Plan
- Members Choosing to Leave the Plan
- Health Plan Quality Improvement

Part C Domain: Health Plan Customer Service

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center - Foreign Language Interpreter and TTY Availability

Part D Domain: Drug Plan Customer Service

- Call Center – Foreign Language Interpreter and TTY Availability

Part D Domain: Member Complaints and Changes in the Drug Plan's Performance

- Complaints about the Drug Plan
- Members Choosing to Leave the Plan
- Drug Plan Quality Improvement

Part D Domain: Member Experience with Drug Plan

- Rating of Drug Plan
- Getting Needed Prescription Drugs

Part D Domain: Drug Safety and Accuracy of Drug Pricing

- MPF Price Accuracy
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Cholesterol (Statins)
- MTM Program Completion Rate for CMR
- Statin Use in Persons with Diabetes (SUPD)

Quality Payment Program

Quality Payment Program Year 5 (2021)

Disclaimer

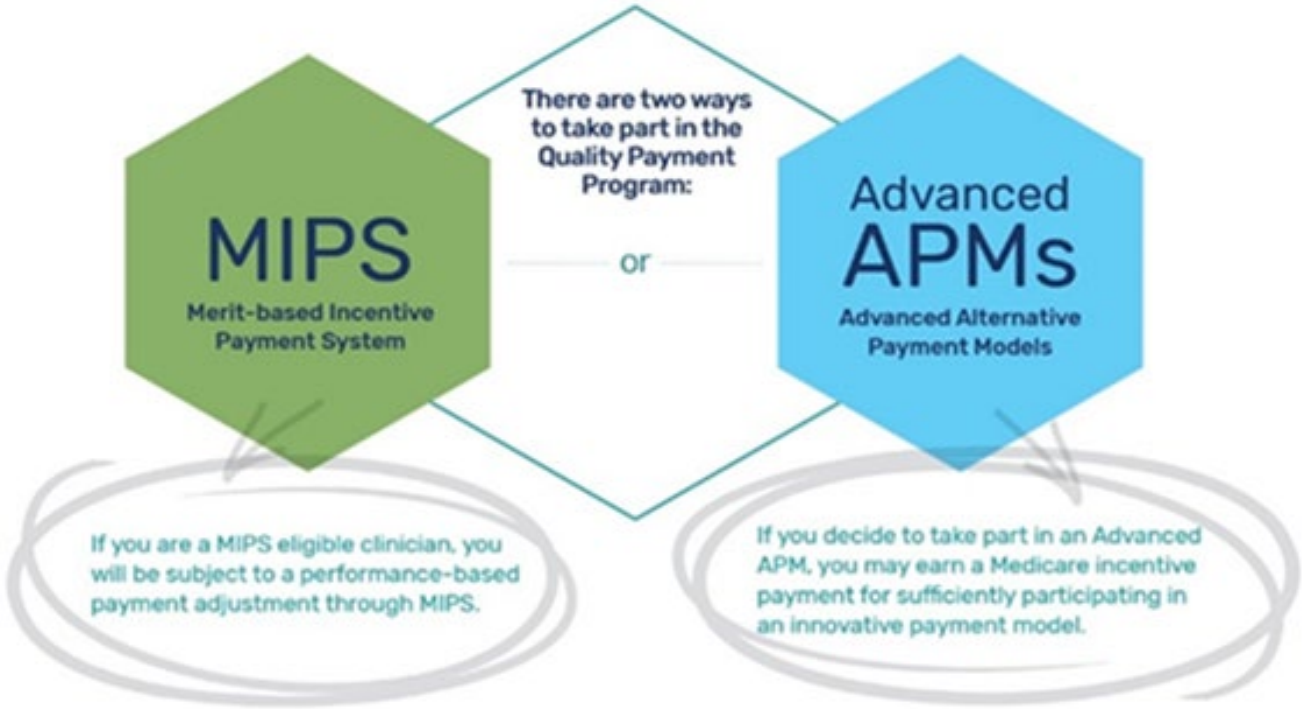
- This presentation was prepared as a tool and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Resource Library

- Information on the Quality Payment Program can be found in the library of QPP resources.
    - QPP Resource Library: https://qpp.cms.gov/about/resource-library

Quality Payment Programs
MIPS and Advanced APMs

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:



Quality Payment Program Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

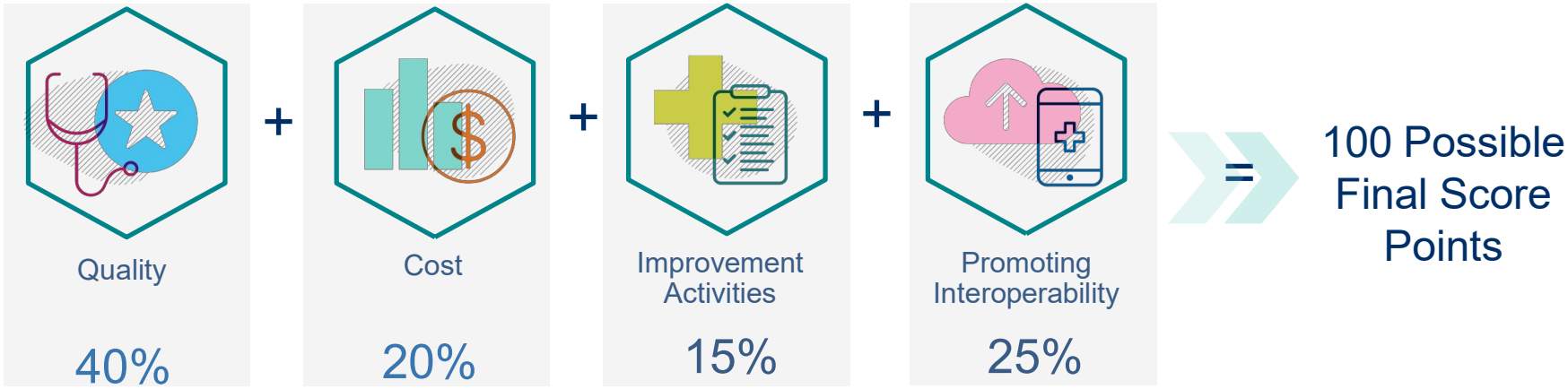
Quick Tip: For additional information on the Quality Payment Program, please visit https://qpp.cms.gov.

Merit-based Incentive Payment System (MIPS) Quick Overview

- Combined legacy programs into a single, improved program.

Merit-based Incentive Payment System (MIPS) Quick Overview (continued)

MIPS Performance Categories for Year 5 (2021)



- In the CY 2021 PFS Final Rule, the weight of the quality performance category was decreased to 40 percent while the weight of the cost performance category was increased to 20 percent.
- All performance categories are calculated for the MIPS final score.
- *The points from each performance category are added together to give you a MIPS final score.*

MIPS Year 5 (2021)
Who is Included?

MIPS eligible clinicians include:

Physicians+

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

+ *The definition of Physicians includes: Doctors of Medicine; Doctors of Osteopathy (including Osteopathic Practitioners); Doctors of Dental Surgery; Doctors of Dental Medicine; Doctors of Podiatric Medicine; Doctors of Optometry; Chiropractors*

- Osteopathic Practitioners
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Clinical Psychologists
- Registered Dieticians or Nutrition Professionals
- Chiropractors

MIPS Year 5 (2021)
Who is Included? (continued)

- Include MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule **AND** furnishing covered professional services to more than 200 Medicare patients **AND** providing more than 200 covered professional services under the PFS.

Note: Beginning with the 2021 performance year, clinicians in a MIPS Alternative Payment Model (APM) will be evaluated for MIPS eligibility at the individual and group levels; we'll no longer evaluate MIPS APM Entities for the low-volume threshold.

MIPS Year 5 (2021)
Who is Exempt?

Newly-enrolled in Medicare

- Enrolled as a Medicare provider for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year for professional covered services.

OR

- Provided covered professional services to **200** or fewer Medicare Part B patients a year.

OR

- Furnished **200** or fewer covered professional services.

Advanced APMs

Significantly participating in Advanced APMs

- Qualifying APM Participants (QPs) are eligible clinicians who have met or exceeded the payment amount or patient count thresholds based on participation in an Advanced APM.
- They are exempt from reporting in MIPS and may earn a 5% payment on Part B claims for performance year 2021.

MIPS Year 5 (2021) Opt-In Policy

- **Opt-in** policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.
  - MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

Dollars	Medicare Patients	Covered Professional Services	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 5 (2021) Performance Period

Year 5 (2021) Finalized

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Inter-operability	90-days

MIPS Year 5 (2021)
Virtual Groups

What is a virtual group?

– A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period of a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed at least one element of the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds at least one element of the low-volume threshold at the group level.

MIPS Year 5 (2021) Quality

Basics:

- ***New***: **40%** of Final Score in 2021
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures or report the 10 CMS Web Interface measures

Component	Year 4 (2020) Final	Year 5 (2021) Final
Weight to Final Score	• 45%	• 40%
Data Completeness	• 70% for submission mechanisms except for CMS Web Interface and CAHPS. • Data submitted on each measure is expected to be representative of the clinician's or group's performance. If quality data is submitted selectively such that data are unrepresentative of a MIPS eligible clinician or group's performance, any such data would not be true, accurate, or complete.	• Same requirements as Year 4.

MIPS Year 5 (2021) Quality (continued)

Basics:

- **40%** of Final Score in 2021
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures or report the 10 CMS Web Interface measures

Component	Year 4 (2020) Final	Year 5 (2021) Final
Scoring	• 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or meet case minimum. • Bonus points: Two for each additional outcome or patient experience measures. One for other high-priority measures. One for each measure submitted using electronic end-to-end reporting. • Cap bonus points at 10% of category denominator. • Benchmarks based on flat percentages in specific cases where it is determined that the measure's benchmark incentivizes inappropriate treatment.	Same requirements as Year 4.

MIPS Year 5 (2021) Quality (contin.)

Basics:

- **40%** of Final Score in 2021
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures or report the 10 CMS Web Interface measures

Topped Out Measures:

- Use a four-year lifecycle to identify and remove topped out measures.
- Scoring cap of 7 points for certain topped out measures.
- Topped out policies **don't apply** to CMS Web Interface measures, but this will be monitored for differences with other submission options.
- Topped out policies also don't apply to CAHPS for MIPS Summary Survey Measures (SSMs) .
- Once a measure has reached extremely topped out status (average mean performance in the 98th to 100th percentile range), CMS can propose the measure for removal in the next rulemaking cycle.
- QCDR measures aren't subject to the topped out measure life-cycle and special scoring.

MIPS Year 5 (2021)
Cost

Basics:

- ***New:*** **20%** of Final Score in 2021

- *Change*: Cost performance category weight is now **20% for 2021.**
- Inclusion of services provided via telehealth into existing episode-based cost measures and TPCC measure.
- No changes to cost measure inventory
  - TPCC measure,
  - MSPB Clinician measure,
  - 18 existing episode-based cost measures.

MIPS Year 5 (2021)
MIPS: Scoring Improvements

MIPS Improvement Scoring for Quality and Cost

- For Quality:
  - Eligible clinicians must fully participate (i.e., submit all required measures and have met data completeness criteria) for the performance period.
  - If the eligible clinician has a previous performance period score (2020) and meets the current performance period (2021) requirements, we will compare the 2020 quality achievement percentage score to the current 2021 quality achievement percentage score for an improvement percent score.

- For Cost:
  - There will be no cost improvement scoring for MIPS Year 5.
  - The cost performance category percent score won't account for improvement until the 2022 MIPS performance year/ 2024 MIPS payment year.

MIPS Year 5 (2021) Improvement Activities

Basics:

- **15%** of Final Score in 2021
- Select Improvement Activities and attest "yes" to completing
  - Activity Weights remain the same from Year 4
    - Medium = 10 points
    - High = 20 points
- Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than 2 activities to receive the highest score

Number of Activities:

- Modified 2 existing Improvement Activities
- Removed 1 existing Improvement Activities
- Continuation of the COVID-19 clinical data reporting improvement activity with modification as outlined in IFC.

Finalized Changes for 2021:

- Added 1 new criterion to the criteria for nominating new improvement activities beginning with CY 2021 performance period and future years:
  - Include activities which can be linked to existing and related MIPS quality and cost measures, as feasible.
- Updated the pathways for nominating a new improvement activity to include:
  - Stakeholders may nominate activities outside of the Annual Call for Activities nomination period timeframe during a public health emergency.
  - HHS may nominate improvement activities all year long in order to address HHS initiatives in an expedited manner.

MIPS Year 5 (2021)
Promoting Interoperability

Basics:

- **25%** of Final Score in 2021
- Automatic reweighting policies will continue for the eligible clinician types in 2021.

CEHRT Requirements:

- MIPS eligible clinicians may use
  - Technology certified to the existing 2015 Edition certification criteria,
  - Technology certified to the 2015 Edition Cures Update certification criteria,
  - A combination of both

Measure and Objectives:

- The Query of Prescription Drug Monitoring Program (PDMP) measure will remain as an optional measure, now worth 10 bonus points.
- The name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information will be changed to Support Electronic Referral Loops by Receiving **and Reconciling** Health Information.
- A new optional Health Information Exchange (HIE) bi-directional exchange measure was added as an alternative reporting option to the 2 existing measures under the HIE objective.

MIPS Year 5 (2021)
MIPS: Performance Threshold & Payment Adjustment

- **Change:** Increase in Performance Threshold

Year 4 (2020) Final

- Performance threshold set at 45 points
- Exceptional performance threshold set at 85 points
- Payment adjustment set at +/- 9%

Year 5 (2021) Final

- Performance threshold set at **60 points**
- Exceptional performance threshold remains set at **85 points**
- Payment adjustment remains set at **+/- 9%**

- The MIPS payment adjustment and exceptional performance adjustment are based on comparing the clinician's final score to the performance threshold and the additional performance threshold for exceptional performance.
- Positive payment adjustments are subject to a scaling factor to preserve budget neutrality and, for exceptional performance, to account for available funds.

MIPS Year 5 (2021)
Extreme and Uncontrollable Circumstances

Automatic Policy

- MIPS eligible clinicians affected by extreme and uncontrollable circumstances (e.g., a natural disaster or public health emergency) may qualify for automatic reweighting of 4 performance categories (quality, cost, Promoting Interoperability, and improvement activities).
- This determination is made by CMS and applies to individual participation only.
- Data submission will override performance category reweighting on a category-by-category basis.

Exception Applications

- MIPS eligible clinicians, groups, virtual groups and APM Entities also have the ability to request performance category reweighting due to extreme and uncontrollable circumstances through our web-based application.

Opportunity for Public Comment

Next Steps

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Timeline of Upcoming Activities

- **Release of the MUC List** – by December 1
- **Public Comment Period 1** – Timing based on MUC List release
- **Advisory Group Review Meetings**
  - Rural Health: **December 8**
  - Health Equity: **December 9**
- **Workgroup & Coordinating Committee Review Meetings**
  - Clinician Workgroup – **December 14**
  - Hospital Workgroup – **December 15**
  - PAC/LTC Workgroup – **December 16**
  - Coordinating Committee – **January 19, 2022**
- **Public Comment Period 2** – December 30, 2021 – January 13, 2022.

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Resources

- CMS 2021 Program-Specific Measurement Needs and Priorities Document
- Pre-Rulemaking Website

Questions

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Contact Information

- **Project Page:** MAP Clinician Webpage
- **Email: MAP Clinician Project Team** MAPClinician@qualityforum.org

THANK YOU.

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