A GUIDE TO PARTICIPATION IN PERFORMANCE YEAR 2021

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DECEMBER 2020

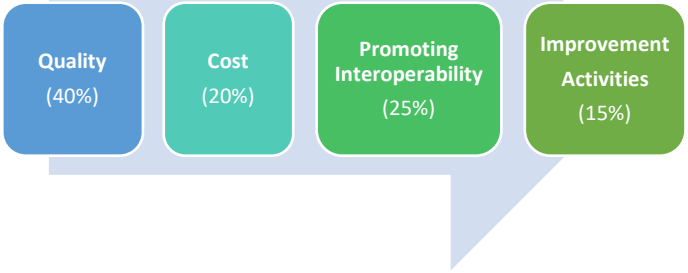
The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law April 2015, repealing the flawed sustainable growth rate (SGR) and establishing a two-track Quality Payment Program (QPP) that emphasizes Medicare's transition to value-based payment and delivery. Under the QPP, eligible pain medicine practitioners will either participate in the Merit-based Incentive Payment System (MIPS) or be considered a qualifying participant in an Advanced Alternative Payment Model (APM). With the QPP moving into its fifth year – the 2021 performance period – pain medicine practitioners should note important changes that impact participation.

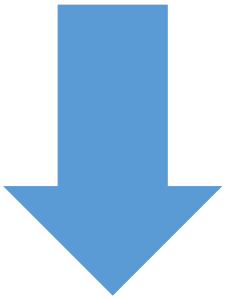
Merit-Based Incentive Payment System

Performance Categories, Weights and Thresholds

MIPS incorporates four weighted performance categories – Quality, Cost, Promoting Interoperability, and Improvement Activities – that contribute to an annual MIPS final score of between 0 and 100 points. The final score is compared to a performance threshold to determine Medicare payment adjustments. Final scores above the threshold will receive a positive payment adjustment, those below the threshold will receive a negative payment adjustment, and those equal to the threshold will receive no adjustment. The performance threshold for the 2021 performance period is 60 points, and the exceptional performance threshold is 85 points.

MIPS Performance Categories and Weights: Year 5





Final scores at or above the performance threshold will yield a neutral or positive payment adjustment

Final scores below the performance threshold will yield a negative payment adjustment

Payment Adjustments

MIPS is a budget neutral program (i.e., negative payment adjustments create the funding pool for positive payment adjustments) and payment adjustments are made on a sliding scale (i.e., the lower a clinician scores below the performance threshold, the higher the penalty). To maintain budget neutrality, clinicians with higher final scores may earn a positive payment adjustment up to three times the baseline positive payment adjustment for a given year. The MIPS payment adjustments are applied to Part B payments for Medicare physician fee schedule services two years after the performance period (i.e., final scores for the 2021 performance period will determine 2023 payment adjustments). For 2021 performance, the maximum downward payment adjustment is -9 percent.

In addition, those with exceptional performance, may earn "bonus" incentives from a special pool of funding, in addition to their positive MIPS payment adjustment (up to an additional 10 percent).

To date, positive payment adjustments – including exceptional performance bonuses – have been low due to a relatively small number of clinicians qualifying for penalties; for example, the maximum positive payment adjustment in 2019 was 1.88 percent, and 1.68 percent in 2020.

MIPS Payment Adjustments by Payment Year

Clinicians can participate in MIPS as individuals and/or as group practices. CMS will apply the MIPS payment adjustment at the Tax Identification Number/National Provider Identifier (TIN/NPI) level. If a TIN does not opt to participate as a group, each clinician will

receive his/her own performance score and payment adjustment. If a TIN participates as a group, and none of the clinicians participate as individuals, each clinician will receive the same score and payment adjustment based on the group's performance across all four categories of MIPS. If both an individual and group score applies for a given TIN/NPI combination, CMS will apply the higher score. Special rules also apply to individuals participating in certain APMs. Payment adjustments are made at the Medicare Part B claim level.

MIPS Eligibility & Facility-Based Determinations

The clinician types to the right are eligible for and required to participate in MIPS, as long as they also meet certain other requirements as outlined by CMS.

CMS will evaluate each TIN/NPI combination for MIPS eligibility; it will use TINs to evaluate group practices for eligibility. A single clinician (NPI) that bills Medicare under multiple TINs will receive an eligibility determination under each unique TIN/NPI combination and may be required to satisfy the requirements of MIPS under each unique practice.

CMS reviews past and current Medicare Part B Claims and Provider Enrollment, Chain, and Ownership System (PECOS) data for clinicians and practices during two determination periods for each performance year. From those data, CMS will determine MIPS eligibility, including whether a clinician or group exceeds the low-volume threshold.

CMS will also use these data to assign special statuses to clinicians and groups (e.g., hospital-based, small practice, etc.). Those with a special status must still participate in MIPS, but qualify for reduced reporting requirements in certain performance categories.

In addition, CMS will identify practices and clinicians who are facility-based and eligible for facility-based scoring. In general, practices and clinicians identified as facility-based are attributed to a facility with a Hospital Value-Based Purchasing (VBP) score. CMS will automatically use the VBP Program score in lieu of a MIPS score for the Quality and Cost performance categories if the VBP score is more favorable than the clinician's combined Quality and Cost score under MIPS. In the future, this could result in a reduced reporting burden for these types of clinicians.

MIPS Eligible Clinician Types: Year 5

MIPS eligible clinicians are defined as:

- ✓ Physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry)
- ✓ Osteopathic practitioners
- ✓ Chiropractors
- ✓ Physician assistants
- ✓ Nurse practitioners
- ✓ Clinical nurse specialists
- ✓ Certified registered nurse anesthetists
- ✓ Physical therapists
- ✓ Occupational therapists
- ✓ Clinical psychologists
- ✓ Qualified speech-language pathologists
- ✓ Qualified audiologists
- ✓ Registered dietitians or nutrition professionals

Excluded from MIPS are those who are:

- ✗ **Newly-enrolled in Medicare** (*Enrolled in Medicare for the first time during the performance period*)
- ✗ Below the **Low-Volume Threshold** (*Medicare Part B allowed charges less than or equal to $90,000 a year; see 200 or fewer Medicare Part B patients a year; or provide 200 or more covered professional services to Medicare Part B patients*)
- ✗ **Qualifying APM Participants** ("QPs")

Of note, physicians who have opted out of Medicare and do not accept payments from Medicare are not required to participate in MIPS as they would fall below the low-volume threshold and will therefore not be affected by payment adjustments in MIPS.

Clinicians should check their MIPS eligibility and Qualifying APM Participant (QP) status using the QPP Participation Status Tool. The tool is searchable by NPI and will show eligibility for each unique group practice that the NPI is affiliated with.

Participation Options

Clinicians may participate in MIPS as individuals or as a member of a group (or virtual group). In general, clinicians that report as an individual (i.e., a single NPI tied to a single TIN) will have their payments adjusted based only on their own performance, and clinicians that report as part of a group (i.e., defined as a set of clinicians, identified by their NPI, who share a common TIN no matter the specialty or practice site) will have their payments adjusted based on the group's performance across all four MIPS categories. However, if both an individual and group score applies for a given TIN/NPI combination, CMS will apply the higher score to determine the payment adjustment for that TIN/NPI combination.

Clinicians may also participate as a "virtual group," which is a combination of two or more TINs made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually (regardless of specialty or location) to participate in MIPS for a performance period of a year. Learn more about this option by reviewing CMS' Virtual Groups Toolkit.

Finally, special rules apply to MIPS eligible participants in certain APMs called MIPS APMs.

Reporting Mechanisms

Clinicians may also choose to collect and report data via multiple mechanisms, including claims (limited to physicians in small practices), registry, certified EHR, and web-based attestation (via the QPP Portal). Although most clinicians stick with a single reporting mechanism, clinicians may use different mechanisms across performance categories (e.g., report quality measures via claims and improvement activities via registry) and within performance categories (e.g., report quality measure A through claims and quality measure B through a registry). For members seeking to collect data via a registry, a list of Qualified Registries (QRs) and Qualified Clinical Data Registries (QCDR) approved for 2021 is posted to CMS' QPP Resource Library. Clinicians can find out if their EHR is certified by searching the Certified Health IT Product List.

Quality Performance Category

For 2021, clinicians and groups must report at least six measures, including one outcome or high-priority measure, for at least 70 percent of *all* patients eligible for the measure (i.e., not just Medicare, except in the case of claims-based reporting) to meet CMS' data completeness requirement. Clinicians and groups who report a quality measure, but fail to satisfy the data completeness requirement will receive 0 points on that measure (except for small practices, who will receive 3 points). For groups of 16 or more, CMS will also automatically calculate performance on new claims-based measures, including (as applicable) a hospital-wide, 30-day, all-cause unplanned readmission rate measure and a measure assessing the risk-standardized complicate rate following elective primary total hip arthroplasty and/or total knee arthroplasty.

For the 2021 performance period, CMS removed 11 measures that it deemed low-priority, low-bar and/or did not meet certain reporting volumes. CMS will continue to evaluate measures for removal using these and other factors as part of its Meaningful Measures initiative. CMS also made substantive changes to a number of quality measures for 2021.

Each measure is generally worth up to 10 points (note that certain "topped out" measures with historically high performance are subject to a 7 point cap). CMS awards a clinician or group points for each measure based on their performance compared to national benchmarks (which should also be available for download through the CMS QPP Resource Library[1]).

Clinicians can earn bonus points in the quality performance category by submitting two or more outcome or high priority quality measures (bonus awarded for the second outcome or high priority quality measure, which includes opioid-related measures) or submitting quality measures using end-to-end electronic reporting, with quality data directly reported from certified EHR technology (CEHRT). Clinicians can also earn points of up to 10 additional percent for the Quality performance category based on their improvement in the category relative to the previous year.

Small practices are also eligible for a bonus of 6 points added to the numerator of their Quality performance category score.

CMS has organized available MIPS quality measures into specialty measure sets to assist clinicians with selecting relevant measures. For 2021, there is a specialty measure set available for Anesthesiology, but not for Pain Medicine. Note that these sets are offered for guidance only-- clinicians are not required to rely on these sets or to report all of the measures in a set measures so long as they satisfy the 6 measure reporting requirement. See Appendix A and Appendix B for a list of suggested measures for use by pain medicine practitioners. A list of all available measures is available for download from CMS' QPP website. Review all claims and registry measure specifications the for the 2021 performance period on CMS' QPP website.[2]

[1] Benchmark data for 2021 was not available as of the development of this guide.

[2] Measure specifications for registry measures for 2021 were not posted to the QPP website as of the development of this guide.

Cost Performance Category

CMS calculates cost performance using claims data; no reporting is required under this category. If attributed a sufficient number of beneficiaries, clinicians may be assessed on a Total per Capita Cost (TPCC) measure, a Medicare Spending per Beneficiary (MSPB) measure, and where applicable, more focused episode-based measures. For the 2021 performance period, there are 18 episode-based cost measures that focus on specific conditions and procedures. Learn more about cost measures on CMS' QPP website.

Promoting Interoperability (PI) Performance Category

Clinicians must submit data for certain measures across four objectives that align with 2015 Edition CEHRT and for a period of 90 continuous days or more during the 2021 performance period. Reporting the optional measures Query of Prescription Drug Monitoring Program (PDMP) will earn 10 bonus points for this category. Review the full list of PI measures on CMS' QPP website.

Clinicians must also attest "yes" to the following attestation statements:

- ✓ The Prevention of Information Blocking Attestation,
- ✓ The ONC Direct Review Attestation, and;
- ✓ The security risk analysis measure.

Hardship exceptions are available in this category for clinicians and groups who are deemed as a small practice, use decertified EHR technology, have insufficient internet connectivity, face extreme and uncontrollable circumstances, or lack of control over the availability of CEHRT. Clinicians with a specified special status (e.g., hospital-based) will have their PI performance category score automatically reweighted to the Quality performance category and will not need to submit a hardship exception application.

Improvement Activities Performance Category

Generally, clinicians and groups must attest to two high-weighted (20 points each), four medium-weighted (10 points each) activities, or a combination of both to achieve a total of 40 points in this category. In general, an activity must be performed for at least 90 consecutive days during the performance period to receive credit.

For small practices (15 or fewer ECs), practices in rural areas or health professional shortage areas (HPSAs), CMS requires submission of one high-weighted activity or two medium-weighted activities.

Of note, for the 2020 performance period and future years, CMS increased the participation threshold for group reporting. Groups may only earn credit for an improvement activity if at least 50% of the clinicians in the TIN fulfill the activity during *any* continuous 90-day period within the performance year. CMS also made minor changes to the list of improvement activities, including to modify IA_BE_4: Engagement of patient through implementation of improvemetns in patient portal, and to permanently add IA_ERP_3: COVID-19 Clinical Data Reporting with or without Clinical Trial.

A full list of improvement activities can be downloaded from CMS' QPP Resource Library.

Alternative Payment Models

Alternative Payment Models (APMs) are a payment approach that gives added payment incentives to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs that meet specific requirements, such as taking on financial risk for the value of patients' care. Clinicians participating sufficiently in an Advanced APM in 2021 (i.e., a minimum number of payments or patients affiliated with the APM) will be determined to be Qualifying APM Participants, or QPs, will be exempt from MIPS for 2021, and will earn a 5% Medicare incentive payment in 2023.

The number of clinicians in this track will remain relatively small compared to those in the MIPS track, particularly among specialists for which few Advanced APMs are currently available. For a list of Advanced APMs approved for 2021, please visit the QPP Resource Library. Physicians can use the QPP Participation Status Look-up Tool to determine whether they qualify as a QP in 2021. CMS will post initial predictive QP determinations for 2021 starting in the spring of 2021.

MIPS APMs

Clinicians who participate in what is known as a "MIPS APM," but do not meet the criteria to be considered a QP, must still participate in MIPS. However, they have multiple options for participation, including participation through the APM Performance Pathway (APP) under MIPS at their the individual, group, or APM entity level. The APP is new for performance year 2021, and it provides special scoring accommodations to those who elect to report under the APP, in recognition of the work completed under the MIPS APM to improve quality and control costs. More information about the APP is available here.

MIPS Value Pathways (MVP)

Starting in performance year 2022, clinicians are expected to be able to participate in MIPS Value Pathways, or "MVPs," which are defined as "subsets of MIPS measures and activities established through rulemaking." This new framework aims to allow clinicians to fully participate in MIPS based on reporting a subset of measures and activities that are relevant to a clinician's scope of practice and integrated across each of the MIPS performance categories. Read more in CMS' MVP Fact Sheet. CMS is still working on finalizing the details for this participation pathway.

Appendix A: Key Measures for Pain Management Specialists (Chronic Pain) and Available Collection Types

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
021	Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	✓	✓		
044^	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery		✓		
076^	Prevention of Central Venous Catheter-Related Bloodstream Infections	✓	✓		
128*	Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan	✓	✓	✓	
130*	Documentation of Current Medications in the Medical Record	✓	✓	✓	
134*	Preventive Care & Screening: Screening for Clinical Depression & Follow-Up Plan	✓	✓	✓	✓
145*	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	✓	✓		
154	Falls: Risk Assessment	✓	✓		
155	Falls: Plan of Care	✓	✓		
182*	Functional Outcome Assessment	✓	✓		
220*	Functional Status Change for Patients with Low Back Impairments		✓		
226*	Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	✓	✓	✓	✓
238*	Use of High-Risk Medications in Older Adults		✓	✓	
318*	Falls: Screening for Future Fall Risk			✓	✓

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
342	Pain Brought Under Control Within 48 Hours		✓		
357	Surgical Site Infection (SSI)		✓		
374*	Closing the Referral Loop: Receipt of Specialist Report		✓	✓	
375	Functional Status Assessment for Total Knee Replacement			✓	
376	Functional Status Assessment for Total Hip Replacement			✓	
404^	Anesthesiology Smoking Abstinence		✓		
424^	Perioperative Temperature Management		✓		
430^	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy		✓		
463^	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)		✓		
477^	Multimodal Pain Management		✓		
478*	Functional Status Change for Patients with Neck Impairments		✓		

KEY: *Red text indicates a high-priority measure; * indicates a change in measure specifications; ^ indicates measure is part of the Anesthesiology specialty measure set; + indicates measure is new for reporting in the 2021 performance year and beyond. Review claims and registry specifications the for 2020 performance period on CMS' QPP website.*

Appendix B: Key Measures for Pain Management Specialists (Regional Anesthesia and Acute Pain) and Available Collection Types

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
023	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	✓	✓		
044^	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery		✓		
076^	Prevention of Central Venous Catheter-Related Bloodstream Infections	✓	✓		
130*	Documentation of Current Medications in the Medical Record	✓	✓	✓	
317*	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	✓	✓	✓	

Key Measures for Pain Management Specialists and Available Collection Types					
CMS Measure #	Measure Title	Claims	Registry	CEHRT	CMS Web Interface
322	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients		✓		
324	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients		✓		
342	Pain Brought Under Control Within 48 Hours		✓		
351	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation		✓		
357	Surgical Site Infection (SSI)		✓		
375	Functional Status Assessment for Total Knee Replacement			✓	
376	Functional Status Assessment for Total Hip Replacement			✓	
404^	Anesthesiology Smoking Abstinence		✓		
424^	Perioperative Temperature Management		✓		
430^	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy		✓		
431*	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		✓		
444*	Medication Management for People with Asthma		✓		
463^	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)		✓		
477^	Multimodal Pain Management		✓		
478*	Functional Status Change for Patients with Neck Impairments		✓		

KEY: *Red text indicates a high-priority measure; * indicates a change in measure specifications; ^ indicates measure is part of the Anesthesiology specialty measure set; + indicates measure is new for reporting in the 2021 performance year and beyond. Review claims and registry specifications the for the 2021 performance period on CMS' QPP website.*

Note that the following measures have been removed from the MIPS program for performance year 2021 onward:

- 408: Opioid Therapy Follow-up Evaluation
- 412: Documentation of Signed Opioid Treatment Agreement
- 414: Evaluation or Interview for Risk of Opioid Misuse
- 435: Quality of Life Assessment for Patients with Primary Headache Disorders