

FACT SHEET

ACEP's Response to Major Medicare Payment Rule for Calendar Year (CY) 2021

Each year, the Centers for Medicare & Medicaid Services (CMS) issues a major Medicare proposed rule that impacts payments for physicians and other health care practitioners. The rule combines proposed policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA).

Key provisions of the rule and ACEP's responses to them are below. Please note that these policies are all only *proposed* by CMS. We expect final regulations setting CY 2021 payment policy to be released by CMS by the end of November or early December 2020.

To see ACEP's full response to this rule, please click [here](#).

Medicare Physician Fee Schedule Proposals

- ◆ **Emergency Medicine Payment Reduction**— CMS' decision from last year's rule to increase the office and outpatient evaluation and management (E/M) services and add a new add-on code for complexity for these services in 2021, as well as some other technical refinements, results in a significant “budget neutrality” adjustment to the conversion factor. The budget neutrality requirement forces CMS to make an overarching negative adjustment to physician payments in order to offset any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare “conversion factor”—which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount. To preserve budget neutrality, CMS proposes to reduce the conversion factor by 10.6 percent in 2021 from \$36.09 to \$32.26—dropping it to one of the lowest levels it has been in 25 years. CMS estimates that emergency physicians and other health care practitioners practicing under the specialty designation of emergency medicine will experience a -6 percent reduction to their reimbursement in 2021.

ACEP Response:

- Lay out the specific impact that a -6 percent reduction would have on patients' access to emergency care, highlighting how the novel coronavirus (COVID-19) public health emergency (PHE) will exacerbate the effects of such a reduction.
- Make the following three policy recommendations:
 - **To account for the additional expenses that hospital-based clinicians must absorb when treating patients during the COVID-19 PHE, ACEP strongly urges CMS to implement a 20 percent COVID-19 professional services claims-based payment adjustment.**
 - **ACEP urges CMS to delay the implementation of the add-on code for complexity (GPC1X) to CY 2022 or later or to possibly consider eliminating the code altogether.**
 - **ACEP recommends that CMS and the Department of Health and Human Services (HHS) utilize its 1135 waiver authority under the COVID-19 PHE to waive the budget neutrality requirement for all of CY 2021.**
- ◆ **Valuation of Emergency Department Evaluation and Management Codes for CY 2021**— ACEP strongly advocated for CMS to increase the value of the emergency department (ED) E/M codes to appropriately align with the revised office and outpatient E/M code levels for new patients. In this rule, CMS proposes to accept our recommendations and increase ED E/M codes to match the values that we had specifically advocated for. According to CMS, the increase in the value of these codes will cause emergency physician payments to bump

up by approximately 3 percent. However, CMS' budget neutrality rules cancels it out, leaving a net -6 percent reduction to emergency medicine.

ACEP Response:

- **Thank CMS for supporting ACEP's rationale and proposing our recommended values. We strongly urge the agency to finalize the increases as proposed.** These increases are absolutely critical to help offset a portion of the significant budget neutrality adjustment to the conversion factor.

- ◆ Telehealth— During the COVID-19 PHE, CMS took numerous steps to expand the use of telehealth under Medicare. ACEP's fact sheet on these flexibilities can be found [here](#). Specifically, CMS temporarily added many codes, including all five ED E/M codes (CPT codes 99281 to 99295) to the list of approved telehealth services. In the proposed rule, CMS breaks out the codes that it temporarily added to the list of approved telehealth services into three buckets:

- BUCKET 1: Codes that CMS proposes to be included on the list of approved telehealth services permanently.
- BUCKET 2: Codes that CMS proposes to be included on the list of approved telehealth services for the remainder of the calendar year in which the PHE ends (i.e. if the PHE ends in January 2021, the codes would remain on the list until December 31, 2021).
- BUCKET 3: Codes that CMS proposes to be removed from the list of approved telehealth services once the PHE ends.

CMS proposes to include the ED E/M codes levels 1-3 (CPT codes 99281-99283) in Bucket 2. CMS also proposes to place ED E/M codes levels 4 and 5 (CPT codes 99284 and 99285) as well as hospital, intensive care unit, emergency care, and observation stays and critical care services (CPT codes 99217-99220; 99221-99226; 99484-99485, 99468-99472, 99475- 99476, 99477- 99480, and 99291-99292) in Bucket 3. CMS is concerned that these services cannot truly be performed be met via two-way, audio/video telecommunications technology, due to the characteristics of patients who receive the services, the clinical complexity involved, the urgency for care, and the need for complex decision-making.

ACEP Response:

- **Urge CMS to add the ED E/M codes levels 1-3 (CPT codes 99281-99283) permanently to the list of approved Medicare telehealth services. We do appreciate that CMS has proposed to add these codes temporarily under Bucket 2. Since the HHS Secretary, Alex Azar, recently announced that the PHE would be extended for 90 days past its current expiration date of October 23, 2020, we note that the codes would—under CMS' proposal—remain on the list of approved telehealth services until the end of CY 2021.**
- **Request that CMS consider adding higher-level ED E/M codes, the observation codes, and at least a subset of the remaining critical care codes to Bucket 2. Further, CMS should test the use of these high-level ED codes and critical care codes in Centers for Medicare & Medicaid Innovation (CMMI) models.**

- ◆ Payment for Medication Assisted Treatment (MAT) in the ED— CMS proposes to pay for medication assisted treatment (MAT) delivered in the ED starting in 2021. Specifically, CMS proposes to create an add-on code to be billed with E/M visit codes used in the ED setting. This code would include payment for assessment, referral to ongoing care, follow-up after treatment begins, and arranging access to supportive services.

ACEP Response:

- **Strongly support the addition of the new add-on code and urge CMS to finalize the proposal as proposed.**

- ◆ Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)— In last year's rule, CMS implemented a new Medicare benefit for the treatment of OUD furnished by Opioid Treatment Programs (OTPs). In this proposed rule, CMS proposes several refinements to the new benefit. One of the new proposals is to expand the definition of OUD treatment services to include opioid antagonist medications, such as naloxone.

ACEP Response:

- **Support the proposal but strongly recommend that CMS introduce a proposal in next year’s rule that would allow EDs to get reimbursed for administering naloxone and emergency physicians and other clinicians working in EDs to get compensated for the time that is spent counseling patients on how to appropriately use naloxone at home.**
- ◆ Electronic Prescribing of Controlled Substances— CMS is implementing a provision of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires electronic prescribing of controlled substances (EPCS) under Medicare Part D. To help inform CMS’s implementation of this requirement, the agency recently issued a request for information (RFI). ACEP’s response to the RFI can be found [here](#). In this rule, CMS proposes to require EPCS by January 1, 2022 (a delay of one year from the statutorily required date of January 1, 2021) to allow for sufficient time to implement feedback from the RFI and to help ensure that the agency is not burdening clinicians during the COVID–19 pandemic.

ACEP Response:

- Support the proposal to delay the ECPS requirement for Medicare Part D until at least 2022.
- Encourage CMS to work closely with the Drug Enforcement Administration (DEA) on implementing the requirement.

Quality Payment Program Proposals

- ◆ MIPS Value Pathways (MVP) Framework— Over the past few years, CMS has heard feedback, including from ACEP, that MIPS reporting should be streamlined and more meaningful to clinicians. Therefore, CMS proposed in last year’s rule to create the MIPS Value Pathways (MVPs), an approach that would allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. CMS previously indicated that it would propose the first set of MVPs in this rule, so that some MVPs could be implemented in 2021. However, due to the COVID-19 pandemic, CMS did not propose any MVPs for 2021 in this year’s rule. Rather, CMS is postponing MVPs to at least 2022 and is seeking comment on proposed revisions to the MVP guiding principles that CMS established in last year’s rule.

ACEP Response:

- Lay out overall concerns with the process CMS proposes for developing and proposing MVPs.
 - **Highlight issues with CMS’ proposals on capturing the patient voice, incorporating population health measures into MVPs, promoting the use of digital performance measure data submission technologies, adding a criterion that denominators must be consistent across the measures, incorporating QCDR measures into MVPs, and meeting the Promoting Interoperability performance category requirements.**
- ◆ APM Performance Pathway (APP)— CMS proposes a new, complementary pathway to MVPs that will be available for clinicians who participate in alternative payment models (APMs) and who must still report in MIPS. Under CMS’ proposal, MIPS APM participants could report APP measures and have the option of reporting outside the APP for purposes of being scored under MIPS. In all, APM participants can report multiple different measures through different mechanisms, and CMS will use the highest scores to determine each APM participant’s MIPS payment adjustment.

ACEP Response:

- Support the concept of the APP as well as the flexibility it provides to APM participants.
 - **Recommend some measures to include in the APP measure set that are meaningful to emergency medicine.**
- ◆ Performance Category Weighting in Final Score— CMS proposes to increase the Cost category to 20 percent in 2021 and to 30 percent by 2022. CMS proposes to make corresponding decreases to the Quality category

weight (the Quality category weight would be 40 percent in 2021 and 30 percent in 2022).

ACEP Response:

- Support the proposal, recognizing that the Cost category is required by law to reach 30 percent by 2022.
- Continue to express concern about the lack of available cost measures that are meaningful and attributable to emergency physicians.

- ◆ Increasing Performance Threshold— The performance threshold is the point total a clinician must surpass to be eligible for an upward payment adjustment (bonus). CMS proposes to increase the performance threshold from 45 points in 2020 to 50 points in 2021 (in last year’s rule, CMS had stated that the threshold would be 60 points in 2021, but because of the COVID-19 pandemic, CMS is now proposing a lower threshold). There is also an additional performance threshold that is applied to reward clinicians for exceptional performance. Clinicians who surpass this threshold can receive an additional bonus on top of their upward payment adjustment. CMS proposes to maintain the exceptional bonus threshold at 85 points in 2021.

ACEP Response:

- Believe that increasing the performance threshold from 45 points to 50 points is reasonable.
- **Caution CMS against increasing the performance thresholds above 60 points in 2022, given the downstream effects of our continued response to the COVID-19 PHE.**
- Support CMS’ proposal to maintain the additional performance threshold at 85 points for the 2021 MIPS performance period and encourage CMS not to increase this threshold going forward.

- ◆ Quality Performance Category— CMS proposes a total of 206 quality measures for the 2021 performance period. This includes substantive changes to 112 existing MIPS quality measures, changes to specialty sets (including adding one measure and removing one measure from the emergency medicine specialty set), the removal of 14 quality measures, and the addition of two new administrative claims outcome quality measures. Due to the COVID-19 pandemic, CMS proposes to change how it establishes quality benchmarks. Since CMS held clinicians harmless if they were unable to report data from 2019, CMS believes that 2019 data may be unreliable. Therefore, CMS intends to develop performance period benchmarks for the CY 2021 MIPS performance period using the data submitted during the CY 2021 performance period rather than historic data from 2019. Finally, CMS is increasing flexibility in the Quality category scoring methodology by expanding the list of reasons that a quality measure may be impacted during the performance period, and revising when CMS would allow scoring of the measure with clinicians are unable to report a full 12 months-worth of data.

ACEP Response:

- **Oppose the addition of Quality Measure # 418 Osteoporosis Management in Women Who Had a Fracture to the Emergency Medicine specialty set.**
- **Oppose CMS’ proposal to develop performance period benchmarks for the CY 2021 MIPS performance period using the data submitted during the CY 2021 performance period rather than historic data.**
- **Recommend that CMS, to the extent possible, use the 2018 performance year data (2020 benchmarks) for scoring purposes in the 2021 performance year. CMS should also not use 2021 performance to determine whether measures are topped out, but instead determine that status for each measure prior to the start of the CY 2021 performance period.**
- **Support CMS’ proposal to increase flexibility in the Quality category scoring methodology by expanding the list of reasons that a quality measure may be impacted during the performance period, and revising when CMS would allow scoring of the measure with clinicians are unable to report a full 12 months-worth of data. ACEP requests that CMS add some examples specific to hospital-based clinicians to this list.**

- ◆ Cost Category— CMS proposes to keep total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures but does not propose any additional episode-based cost measures.

ACEP Response:

- Express disappointment that CMS is continuing to maintain the MSPB and the Total Per Capita Cost

measures. We have repeatedly asked CMS to remove these measures from the MIPS program.

- Encourage CMS to continue to develop episode-based cost measures that capture the clinical screening, diagnostic testing, and stabilization work done by emergency physicians before a patient is admitted into the hospital.

- ◆ Improvement Activities—CMS proposes to modify two existing improvement activities and add the following new criterion for nominating new improvement activities: “include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible.

ACEP Response:

- Support the addition of the new criterion as long CMS still allows new improvement activities to be added even in situations when it is not possible to connect them to existing quality and cost measures.

- ◆ Promoting Interoperability— CMS proposes to keep the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and propose to make it worth 10 bonus points. CMS is also proposing to change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling” and to add an optional Health Information Exchange (HIE) exchange measure.

ACEP Response:

- Support both proposals, although most emergency physicians are exempt from this performance category of MIPS.

- ◆ Qualified Clinical Data Registries— CMS includes a number of proposals that would affect ACEP’s QCDR, the Clinical Emergency Data Registry (CEDR).

ACEP Response:

- Respond to each individual QCDR proposal directly.
- Express general concern that some of the proposals may make it more difficult and burdensome for QCDRs to participate in MIPS successfully.

- ◆ Alternative Payment Model (APMs)— Clinicians who have a certain proportion of their revenue or patient population tied to an Advanced APM (known as the revenue or patient threshold) is classified as a Qualifying APM Participant (QP) and is eligible for a five percent bonus. In the rule, CMS makes a technical modification to how it determines whether clinicians reach this threshold. CMS is also proposing to accept targeted review requests for QP determinations under limited circumstances where a clinician believes in good faith CMS made a clerical error.

ACEP Response:

- **Strongly encourage CMS to develop more Advanced APMs that emergency physicians can directly participate in, starting with ACEP’s APM, the Acute Unscheduled Care Model.**
- Express concern that the five percent payment bonus for being a QP is expiring in 2024 and the QP threshold is extremely high (the QP payment amount threshold is increasing to 75 percent and the QP patient count threshold is increasing to 50 percent).