

Summary of the 2021 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) released a [Medicare annual payment rule](#) for calendar year (CY) 2021 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). Below is a summary of key proposals, separated by proposed PFS and QPP policies. Over the next few weeks, ACEP will be working on a comprehensive response. Comments are due to CMS on October 5, 2020.

In most years, CMS issues the PFS/QPP proposed rule by late June or early July in order to have enough time to sort through comments and issue a final rule by November 1, 60 days prior to the start of the following calendar year (which is required by law). It is important to note that due to the COVID-19 pandemic and CMS' associated work responding to the crisis, CMS issued the proposed rule late and is planning to waive the 60-day requirement for the final rule. CMS instead will issue the final rule in early December, 30 days prior to the start of the calendar year.

Physician Fee Schedule (PFS)

A summary of the major proposals is below:

1. **Conversion Factor:** 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.

The American Medical Association (AMA) estimates that the total increase in spending that CMS must offset through the budget neutrality adjustment is \$10.2 billion (the office and outpatient E/M increases represent \$5.6 billion of this amount and the additional add-on code for complexity represents another \$3.3 billion). **To preserve budget neutrality, CMS is proposing 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.**

2. **Emergency Medicine Reimbursement and Emergency Department (ED) E/M services:** The cut to the conversion factor will reduce reimbursement levels for all physicians and other health care practitioners. However, the actual impact of the cut on reimbursement depends on the codes that the physicians and other health care practitioners typically bill. As seen below, the total payment clinicians receive for a service depends on both the amount of RVUs for the

service (which include work, practice expense, and malpractice RVUs) and the size of the conversion factor (as well as a geographic adjustment).

Total payment under the PFS = total RVUs x geographic adjustment x conversion factor

Therefore, for specialties that primarily bill the office and outpatient E/M codes, the magnitude of the increase in these code values outweighs the cut to the conversion factor—so overall these clinicians will expect to see an increase to their reimbursement in 2021. Most emergency physicians however do not bill office and outpatient E/M codes. Rather, they bill ED E/M services (CPT codes 99281 to 99285). Therefore, we would expect to see an overall cut to reimbursement for emergency physicians.

ACEP knew that the office and outpatient E/M policy would cause a significant across the board reduction in payment in 2021 and therefore made it a priority to offset some of that cut for emergency medicine. ACEP [strongly advocated](#) for CMS to increase the value of the ED E/M codes to appropriately align with the revised office and outpatient E/M code levels for new patients. **In the rule, CMS is proposing to accept our recommendation, and increase ED E/M codes to match the values that we had specifically advocated for (found below).**

Work RVU Changes

Code	2021 RVWs	2020 RVWs	% chg.
99283	1.60	1.48	+12.68%
99284	2.74	2.60	+5.38%
99285	4.00	3.80	+5.26%

According to CMS, the increase in the value of these codes will cause your payments to bump up by approximately 3 percent. After taking into account this increase and other adjustments, **the overall reduction to emergency medicine is expected to be 6 percent, significantly less than the 10.6 percent cut to the conversion factor.** All in all, ACEP got emergency physicians a raise, but CMS’ budget neutrality rules cancelled it out.

It is important to remember that this is just a proposed rule, and in our formal comments on the rule, ACEP will urge CMS to do everything that it can to mitigate the impact of the budget neutrality adjustment to the conversion factor. However, we know it is unacceptable for you as emergency physicians to experience a 6 percent reduction to your Medicare reimbursement in 2021, and we have already taken action to try to stop this from happening. Just hours after CMS released the proposed rule, ACEP sent a [letter](#) to key committees in Congress requesting that it waive the budget neutrality requirement, since it is the only entity with authority to do so. The letter expresses our strong concerns on this proposed cut and notes the unprecedented strain emergency physician practices already are facing due to the ongoing COVID-19 pandemic. If Congress acts, emergency medicine reimbursement would actually increase by around 3 percent, instead of decrease by 6 percent.

We are also relying on you to contact your member of Congress to ask him/her to support legislation that would waive budget neutrality. [Click here](#) to send a message to your member of Congress today.

- 3. Telehealth Services:** During the COVID-19 public health emergency (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. That means that these codes are reimbursable under Medicare when performed remotely via telehealth at the same rate as they are when the services are delivered in-person. Further, CMS used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas. These waivers have significantly expanded the use of telehealth during the pandemic.

Over the last several months, administration officials, including the CMS Administrator, Seema Verma, have been vocal in their support of making some of the telehealth flexibilities available during the PHE permanent. However, CMS does not have the legal authority to permanently waive the originating site and geographic restrictions. Only Congress has the authority to make these waivers permanent. What CMS can do is decide which of the codes that it temporarily added to the list of approved Medicare services should become permanent additions to the list. In fact, on the same day that the rule was released, President Trump signed an [Executive Order](#) asking that CMS issue a rule that examines which additional telehealth services should continue to be offered to Medicare beneficiaries past the PHE.

Three Buckets

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 is proposing to be included on the list of approved telehealth services permanently.
- BUCKET 2: Codes that CMS is proposing 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 is proposing to be removed from the list of approved telehealth services once the PHE ends.

CMS is proposing to only include in Bucket 1 those codes that are similar to office-based codes which are already permanently on the list of approved telehealth services. **However, CMS is proposing to include the ED E/M codes levels 1-3 (CPT codes 99281-99283) in Bucket 2, which means these codes are at least temporarily added to the list for a period of time after the PHE ends.** CMS states in the rule that it believes that these codes have the potential to add clinical benefit outside of the PHE and could therefore be added to the list permanently. However, CMS is looking for additional information from the public that would supplement its clinical assessment of these codes. While CMS recognized that formal analyses may not be available during the pandemic, it is looking for comments on the following:

- By whom and for whom are the services being delivered via telehealth during the PHE;
- What safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth;
- What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit;
- How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person
- Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list,
- Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth; and
- What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list.

CMS is proposing 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. Although CMS is proposing not to add these codes to the list of approved services past the end of the PHE, it is seeking comment on whether any of these codes should be shifted to bucket 2.

Audio-only Codes

CMS is not proposing to continue to include telephone codes (audio-only) on the list of approved telehealth services past the PHE. CMS states that it does not have the authority to waive the requirement that telehealth services include both an audio and visual requirement. However, CMS is seeking comment on whether the agency should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with an accordingly higher value. CMS is also seeking comment on whether separate payment for such

telephone-only services should be a provisional policy to remain in effect until a year or some other period after the end of the PHE or if it should be PFS payment policy permanently.

Direct Supervision

Many services under the PFS can be delivered by auxiliary personnel under the direct supervision of a physician. In these cases, the supervision requirements necessitate the presence of the physician in a particular location, usually in the same location as the beneficiary when the service is provided. During the PHE, CMS is temporarily modifying the direct supervision requirement to allow for the virtual presence of the supervising physician using interactive audio/ video real-time communications technology. In the rule, CMS is proposing to extend this policy until the later of the end of the calendar year in which the PHE ends or December 31, 2021. CMS will solicit public input on circumstances where the flexibility to use interactive audio/video real-time communications technology to provide virtual direct supervision could still be needed and appropriate.

Clarification of Current Telehealth Rules

Finally, CMS is clarifying under existing telehealth rules that “incident-to” services may be provided via telehealth if they are under the direct supervision of the billing professional. CMS is also clarifying that clinicians are allowed to use telehealth equipment to provide a service to a patient in their same location, but the service should not be billed as a telehealth service.

4. **Scope of Practice:** CMS is proposing to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians. CMS granted this flexibility during the COVID-19 PHE and is now proposing to extend it permanently. CMS is concerned about ensuring an adequate workforce in areas where there are shortages and seeks information about states that have scope of practice laws in place.
5. **PFS Payment for Services of Teaching Physicians:** CMS is seeking comment on whether to permanently or at least temporarily extend the policy instituted during the COVID-19 PHE that allows teaching physicians to supervise residents remotely using telehealth (audio-visual) equipment as mentioned above. There is also consideration to extend the temporary waiver to allow residents to “moonlight” in the inpatient setting.
6. **Medical Documentation Requirements:** In last year’s rule, finalized numerous changes to the medical record documentation requirements for physicians and other health care practitioners. In this proposed rule, CMS is clarifying that physicians and other health care practitioners, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS.
7. **Appropriate Use Criteria Program:** CMS does not address the Appropriate Use Criteria (AUC) program in the rule, but the agency announced on August 10 that it would delay the full implementation of the program until at least the start of CY 2022. The program is currently

in an educational phase, which means that clinicians are strongly encouraged but not required to comply with the requirements. While CMS had initially stated that clinicians must start complying with the requirements beginning on January 1, 2021, due to the COVID-19 PHE, CMS is now extending the educational period through the end of CY 2021.

As background, the AUC program requires clinicians to consult appropriate use criteria using clinical decision support tools prior to ordering advance imaging services for Medicare beneficiaries. As background, the Protecting Access to Medicare Act (PAMA), which created the program, exempts emergency services defined as an “applicable imaging service ordered for an individual with an emergency medical condition” from the requirements. As a result of ACEP’s advocacy, in the CY 2019 Physician Fee Schedule final rule, CMS clarified that exceptions granted for an individual with an emergency medical condition include instances where an emergency medical condition **is suspected, but not yet confirmed**. This may include, for example, instances of severe pain or severe allergic reactions. In these instances, the exception is applicable even if it is determined later that the patient did not, in fact, have an emergency medical condition. In other words, if physicians think their patients are having a medical emergency (even if they wind up not having one), they are excluded from the AUC requirements.

ACEP has a [webpage](#) dedicated to the action we have taken on this and other electronic health record (EHR)-related issues.

8. **Payment for Medication Assisted Treatment (MAT) in the ED:** Due to ACEP’s advocacy, CMS is proposing to pay for MAT delivered in the ED starting in 2021. Specifically, CMS is proposing 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. The add on code would have a work RVU value of 1.30, which is between a 99282 and 99283 (ED E/M code levels 2 and 3).
9. **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 also recently issued a Request for Information, available [here](#). CMS is proposing 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 Request for Information and to help ensure that the agency is not burdening clinicians during the COVID–19 pandemic.
10. **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 opioid use disorder (OUD) furnished by Opioid Treatment Programs (OTPs). In doing so, CMS established new codes describing the bundled payments for certain episodes of care that include methadone, oral buprenorphine, implantable buprenorphine, injectable buprenorphine or naltrexone, and non-drug episodes of care, as well as add-on codes for intake and periodic assessments, take-home dosages for methadone and

oral buprenorphine, and additional counseling. In this year's rule, CMS is proposing 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. It is important to remember that this benefit only applies to services delivered by OTPs. ACEP believes that at least some of these services should also be paid for when delivered in the ED, such as the administration of naloxone.

- 11. Medicare Shared Savings Program:** The Medicare Shared Savings Program (MSSP) is the national accountable care organization (ACO) program. CMS is proposing changes to the MSSP quality performance standard as well as to its quality reporting requirements to align with CMS' Meaningful Measures initiative and reduce reporting burden. Further, CMS is proposing refinements to the list of codes that are used to assign beneficiaries to ACOs and altering the methodology for determining shared savings and shared losses based on ACO quality performance.

[The Quality Payment Program](#)

CMS introduces policies that impact the fifth performance year (2021) of the Quality Payment Program (QPP). The QPP includes two tracks: [the Merit-based Incentive Payment System \(MIPS\)](#) and Advanced Alternative Payment Models (APMs).

MIPS Policies

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2021 will impact Medicare payments in 2023).

The first five years of MIPS include some flexibilities that allow for a transition into the Program. In this year's rule, CMS is delaying the new MIPS Values Pathway (MVP) framework that CMS originally intended to begin in 2021. Further, CMS proposes numerous other changes to MIPS, including to the four performance categories and their associated weights, the overall performance threshold, and reporting requirements for qualified clinical data registries (QCDR)—which directly affect ACEP's QCDR the [Clinical Emergency Data Registry \(CEDR\)](#).

- 1. 2020 Reporting Exemptions Due to COVID-19:** As described [here](#), CMS is granting hardship exemptions on a case-by-case basis due to COVID-19. It is therefore possible for a clinician or group to request to be exempted from all four performance categories in 2020. If clinicians submit a hardship exception application for all four MIPS performance categories, and their application is approved, they will be held harmless from a payment adjustment in 2022—meaning that they will not be eligible for a bonus or potentially face a penalty based on their MIPS performance in 2020.

To account for the additional complexity of treating patients due to COVID-19, CMS is proposing in this rule to double the complex patient bonus for the 2020 performance period only. Clinicians would be able to earn up to 10 bonus points instead of 5 bonus points.

- 2. MIPS Value Pathways (MVP) Delay:** 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.

- 3. APM Performance Pathway:** CMS is proposing a new, complementary pathway to MVPs that will be available for clinicians who participate in APMs and who must still report in MIPS. The APM Performance Pathway (APP) would be required for participants in the MSSP. The APP, like an MVP, would be comprised of a fixed set of measures for each performance category. The Cost performance category would be weighted at 0 percent and the Improvement Activity performance category score would automatically be assigned to the APM. All APM participants reporting the APP would earn a score of 100 percent for the 2021 performance period. The Promoting Interoperability performance category would be reported and scored as required for the rest of MIPS. The Quality performance category would be comprised of 6 measures designed specifically focused on population health and believed to be widely available to all MIPS APM participants. Finally, as CMS transitions to the APP, CMS is proposing to eliminate the CMS Web Interface as a collection type and submission type beginning with the 2021 performance period.
- 4. Performance Category Weighting in Final Score:** As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. Under current law, CMS has the flexibility to keep the Cost category percentage less than 30 percent until 2022, when this category is required to have a 30 percent weight. In the rule, CMS proposes to increase the Cost category in 2021 incrementally in order to reach the required 30 percent by 2022. CMS proposes to make corresponding decreases to the Quality category weight each year.

- General Performance Category Weights Proposed for 2021:
 - **Quality: 40% (down from 45% in 2020)**
 - **Cost: 20% (up from 15% in 2020)**
 - Promoting Interoperability (EHR): 25% (same as 2020)
 - Improvement Activities: 15% (same as 2020)
- General Performance Category Weights Proposed for 2022:
 - **Quality: 30%**
 - **Cost: 30%**

- Promoting Interoperability (EHR): 25%
- Improvement Activities: 15%

- 5. Performance Threshold:** The performance threshold is the point total a clinician must surpass to be eligible for an upward payment adjustment (bonus). CMS is proposing 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 is proposing to maintain the exceptional bonus threshold at **85 points** in 2021.

As required by statute, the maximum negative payment adjustment in 2023 (based on performance in 2021) is -9%, and the positive payment adjustment can be up to 9% (before any exceptional performance bonus). Since MIPS is a budget neutral program, the size of the positive payment adjustments is ultimately controlled by the amount of money available through the pool of negative payment adjustments. In other words, the 9% positive payment adjustment can be scaled up or down (capped at a factor of + 3%). Likewise, the exceptional performance bonus is capped at \$500 million across all eligible Medicare providers, so the more providers who qualify for the bonus, the smaller it is. In the first three years of the program, most clinicians qualified for a positive payment adjustment, so the size of the adjustment was relatively small. For example, if a clinician received a perfect score of 100 in 2019, the clinician will only receive a positive adjustment of 1.79 percent in 2021 (much less than the 7 percent permissible under law).

- 6. Quality Performance Category:** CMS is proposing 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 is proposing 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.

- 7. Cost Category:** CMS is not proposing any new cost measures this year but is proposing to include telehealth services in the current cost measure calculations, as applicable.

8. **Improvement Activities:** CMS is proposing 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.”
9. **Promoting Interoperability:** CMS is proposing 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.
10. **Qualified Clinical Data Registries (QCDRs):** QCDRs are third-party intermediaries that help clinicians report under MIPS. As stated above, ACEP has its own QCDR called the Clinical Emergency Data Registry (CEDR). CMS has separate policies governing QCDRs and the approval of QCDR measures.

Due to the COVID-19 pandemic, CMS has delayed two new requirements finalized in last year’s rule:

- The QCDR measure testing requirement is delayed until the 2022 performance period; and
- The QCDR measure data collection requirement is delayed until the 2022 performance period. QCDRs are required to collect data on a QCDR measure prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

In the rule, CMS is proposing to allow QCDRs to develop measures that can be used in MVPs, as long as the measures are fully tested at the clinician level prior to being submitted for consideration. This is a significant proposal, as previously, it was unclear what role QCDRs could play in MVPs.

CMS is also proposing that QCDRs conduct data validation audits, with specific obligations, on an annual basis.

Alternative Payment Model (APM) Policies

1. **Qualifying APM Participant (QP) determinations:** 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.