Medical Group Management Association®

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Proposed 2021 Medicare Physician Payment and Quality Reporting Changes
MGMA Member-Exclusive Analysis

The Centers for Medicare & Medicaid Services (CMS) released the proposed 2021 Physician Fee Schedule (PFS) in August, which makes changes to both Medicare physician payment and quality reporting program policies that generally take effect Jan. 1, 2021. These policies are only proposals and could be changed in the final PFS, which is usually released on or around Nov. 1 each year. However, for this year only, CMS notes that the final 2021 PFS may be delayed up to 30 days (e.g., on or around Dec. 1) due to the Agency's "significant devotion of resources to the COVID-19 response."

MGMA will submit formal comments in response to the proposed rule by the Oct. 5 deadline and share them with members in the MGMA *Washington Connection* newsletter. If you have any questions or reactions to proposed policies, please reach out to MGMA Government Affairs at govaff@mgma.org.

Medical Practice Executive Insights and MGMA Takeaways

CMS estimates the 2021 Medicare PFS conversion factor will be $32.26, a decrease of $3.83, or almost 11%, from the 2020 PFS conversion factor of $36.09. MGMA and many other physician societies are actively engaging with the Administration and Congress to convey the negative implications of these planned cuts and urge reversal of the proposed conversion factor reduction.

Additional key takeaways from this proposal include changes to E/M and telehealth services. Updates to telehealth are relatively modest given CMS has limited authority to expand coverage. MGMA is working with Congress to make the legislative changes needed to expand access to telehealth, including making telehealth services available to patients in their homes, regardless of geographic location. Proposals in the rule include additional covered codes and other small updates.

CMS intends to largely implement increases to E/M payment rates and policies to reduce documentation burden that were finalized in the 2020 PFS. MGMA is supportive of these efforts but is advocating that CMS allow the payment increases without negatively impacting certain specialists, including procedural-based providers.

Physician Payment Update

CMS estimates the 2021 Medicare PFS conversion factor will be $32.26, a decrease of $3.83 from the CY 2020 PFS conversion factor of $36.09. The proposed 2021 anesthesia conversion factor is $19.9631, in comparison to the 2020 CF of $22.2016.

CMS is required by law to adjust the conversion factor to maintain budget neutrality when it increases or decreases relative value units (RVUs) for services paid under the fee schedule by a certain amount. For 2021, CMS states the proposed decrease to the conversion factor is necessary to offset the payment increases for E/M and other services. Table 90, attached as an appendix, illustrates the anticipated impact on medical providers across various specialties as a result.

Office/Outpatient E/M Services

Through the CY 2020 PFS final rule, CMS finalized a series of policies set to begin Jan. 1, 2021, which largely align with changes laid out by the CPT Editorial Panel. In the CY 2021 PFS proposed rule, CMS proposes to move forward with these policies, including:

- Maintaining separate payments for all E/M levels for new and established patients;
- Removing the code for level 1 new patient visits (CPT code 99201);
- Adopting increased RVUs, which will increase payments for these services;
- Modifying the code framework so that E/M level is selected based on medical decision making (MDM) or total time spent by the reporting practitioner on the day of the visit (including both face-to-face and non-face-to-face time), rather than using history or exam elements;
- Adopting the new time ranges within the CPT codes as revised by the CPT Editorial Panel; and
- Creating two add-on codes, one for extended visits (CPT code 99XXX) and another for complexity associated with certain visits (HCPCS code GPC1X).

Proposed Documentation Changes for E/M Visits in 2021

Practitioners will be permitted to select the appropriate level of E/M visit based on MDM in the exam or time spent with the patient by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). Documentation of patient history and medical examination would only be required when clinically appropriate. This policy was finalized in the 2020 PFS to begin in 2021, and CMS does not propose to change it.

Proposed Payment Changes for E/M Visits in CY 2021

CMS proposes to implement the policy finalized in the CY 2020 PFS final rule to maintain separate payment rates for all E/M levels and delete CPT code 99201 (level 1 new patient office/outpatient E/M visits). CMS proposes to move forward with implementing two add-on codes:

- **CPT code 99XXX:** Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes. (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services).
- **HCPCS code GPC1X:** Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or medical care services that are part of ongoing care related to a patient's single, serious or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

CMS would revalue the following code sets to align them with the value increases for E/M visits for 2021 because these codes either include, rely upon, or are analogous to E/M visits: End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services, Transitional Care Management (TCM) Services, Maternity Services, Cognitive Impairment Assessment and Care Planning, Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits, Emergency Department Visits, Therapy Evaluations, and Psychiatric Diagnostic Evaluations and Psychotherapy Services.

CMS proposes to adopt the RUC-recommended work RVUs for all office/outpatient E/M codes:

HCPCS Code	Current wRVU	2021 Proposed wRVU
99201	.48	N/A
99202	.93	.93
99203	1.42	1.6
99204	2.43	2.6
99205	3.17	3.5
99211	.18	.18
99212	.48	.7
99213	.97	1.3
99214	1.5	1.92
99215	2.11	2.8
99XXX	N/A	.61
GPC1X	N/A	.33

Medicare Telehealth Services

In response to the COVID-19 pandemic and congressional action, CMS exercised its waiver authority to allow for a variety of telehealth flexibilities during the public health emergency (PHE). Under ordinary circumstances, CMS' authority to make changes to telehealth billing guidelines is generally restricted to the list of services approved for telehealth coverage. Through this proposed rule, CMS intends to expand the set of covered codes and make other modest modifications, including:

- Adding nine services to the Medicare telehealth list permanently;
- Adding 13 services to the Medicare telehealth list temporarily (e.g., these codes would remain covered until the end of the calendar year in which the COVID-19 PHE ends);
- Discontinuing payment for audio-only visits (CPT codes 99441-99443), but soliciting comments on whether Medicare should develop coding and payment for such services;
- Extending the policy that direct supervision can include the presence of a supervising practitioner using interactive audio/video real-time communication technology through Dec. 31, 2021; and
- Revising frequency limitation for subsequent nursing facility visits from one visit every 30 days to one visit every three days.

Proposed Permanent Additions	Proposed Temporary Additions
Visit complexity associated with certain office/outpatient E/M services (GPC1X)	Domiciliary, rest home, or custodial care services, established patients (99336-99337)
Prolonged services (99XXX)	Home visits, established patient (99349-99350)
Group psychotherapy (90853)	Emergency department visits (99281-99283)
Neurobehavioral status exam (96121)	Nursing facilities discharge day management (99315-99316)
Care planning for patients with cognitive impairment (99483)	Psychological and neuropsychological testing (96130-96133)
Domiciliary, rest home, or custodial care services (99334-99345)	
Home visits, established patient (99347-99348)	

Communication Technology-Based Services (CTBS)

In 2019, CMS finalized a series of communications technology-based services (CTBS) that involve non-face-to-face care but are not subject to Medicare telehealth billing restrictions, as summarized in MGMA's member-exclusive resource.

For all CTBS codes, CMS clarifies that patient consent can be documented by auxiliary staff under general supervision.

Services furnished by non-physician practitioners (NPPs)

CMS proposes to allow licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists to bill additional CTBS services. Specifically, starting in 2021, these clinicians could begin billing for G2061-G2063, which describe an online assessment and management for established patients.

CMS also proposes to create two additional G-codes for practitioners who cannot independently bill for E/M services; these align with G2010 and G2012, which were finalized in 2019:

- **G20X0**: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
- **G20X2**: Brief communication technology-based service (e.g., virtual check-in) by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

To facilitate billing of CTBS by therapists, CMS proposes to designate HCPCS codes G20X0, G20X2, G2061, G2062, and G2063 as "sometimes therapy" services, so codes must include corresponding GO, GP, or GN therapy modifiers when billed by physical therapists, occupational therapists, or speech language pathologists.

Remote Physiologic Monitoring (RPM)

CMS previously established payment for several RPM codes (CPT codes 99453 – 99454; 99091). In response to questions around billing guidance, the proposed rule clarifies existing policies for RPM codes and proposes a new permanent policy.

During the PHE, clinicians can furnish RPM services to both new and established patients. However, the proposed rule clarifies that following the PHE, CMS will again limit these services to established patients only. RPM services require the use of "interactive technology," which CMS clarifies to mean real-time synchronous two-way audio interactions that are capable of being enhanced with video or other data transmission. Only non-physician practitioners (NPPs) and physicians eligible to provide E/M services are permitted to bill Medicare for RPM services, however CMS proposes to allow auxiliary staff to furnish CPT codes 99453 and 99454 services under a physician's supervision.

Clinical Laboratory Fee Schedule (CLFS)

CMS will not implement planned payment reductions to certain clinical diagnostic laboratory tests paid under the CLFS for 2021. Congress modified the phased-in payment cuts to these services through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and CMS' proposals reflect these statutory changes.

The CARES Act also requires CMS to delay by an additional year the requirement that certain "applicable laboratories," including some physician office laboratories, report private payer data to CMS to inform future CLFS valuations. Therefore, the next CLFS data reporting period will be Jan. 1, 2022, through March 31, 2022. The data to be reported in 2022 will still be based on the original data collection period, which was Jan. 1, 2019, through June 30, 2019.

Scope of Practice

CMS proposes several changes to scope of practice policies in an effort to facilitate healthcare professionals practicing at the top of their licenses, including making permanent some changes implemented during the COVID-19 PHE.

Specifically, CMS proposes to make permanent the policy allowing nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests. These practitioners would be permitted to supervise the performance of diagnostic tests within their state scope of practice, provided they maintain the required relationships with supervising or collaborating physicians.

Appropriate Use Criteria (AUC)

While the proposed rule does not discuss the AUC program, CMS announced on Aug. 10 that the educational and operations testing period will be extended through 2021. As a result, there are no payment consequences associated with the AUC program and instead CMS encourages providers to use 2021 to learn, test, and prepare.

Medicare Shared Savings Program (MSSP)

CMS proposes changes to quality performance under the MSSP, updates to the definition of primary care services for the purpose of beneficiary assignment, and revisions to how repayment amounts are determined for two-sided models.

CMS proposes to replace the current quality performance structure for accountable care organizations (ACOs) participating in the MSSP by:

- Eliminating the Web Interface reporting mechanism and replacing it with a new "APM Performance Pathway." Quality measures reported through the APM Performance Pathway would automatically be used for purposes of both the MSSP and MIPS reporting, if the ACO is in a track that must report for MIPS (e.g., Track 1 or Basic Levels A through D);
- Reducing the quality measures an ACO must report from 23 to six and removing the pay-for-reporting year; and
- Increasing the minimum quality performance threshold and making changes to the way quality scores contribute to shared savings and loss calculations. ACOs would be required to receive a quality performance score equivalent to or above the 40th percentile. Based on 2018 data, CMS estimates that 95% of ACOs would achieve this score. This policy would apply to all MSSP ACOs except for those eligible for facility-based scoring.

2021 Quality Payment Program (QPP) Proposals

2020 Proposals

CMS proposes a few policies that would impact the 2020 reporting year:

- For 2020 only, doubling the complex patient bonus from five points to a maximum of ten points added to the overall MIPS performance score to account for additional complexities due to the COVID-19 pandemic;

- For 2020 only, providing automatic full credit for CAHPS for ACOs measures; and
- Starting in 2020 and continuing thereafter, permitting APM entities to submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances.

In addition to these proposals, CMS established a 2020 hardship exception policy due to the COVID-19 pandemic, which allows physicians and groups to either (1) opt-out of MIPS completely and be held harmless from a penalty, or (2) opt-out of any of the individual MIPS categories. This is not a proposal, but rather an official self-executing administrative policy.

2021 QPP Estimates

In the regulatory impact analysis of proposed policies, CMS estimates there will be between 196,000 and 252,000 qualifying participants (QPs) in advanced APMs for 2021. This number is less than estimates for 2019 and 2020.

CMS estimates there will be 930,000 MIPS eligible clinicians and projects that the maximum MIPS bonus will be between 6.9% and 7.4%.

MIPS Score and Payment Adjustments

Per the proposed rule, clinicians and group practices would need to earn at least 50 points in 2021 to avoid a Medicare payment penalty of up to 9% in 2023. In addition, $500 million would be available for clinicians and group practices whose final score meets or exceeds the proposed exceptional performance threshold of 85 points. The maximum exceptional performance bonus is 10%, which would be in addition to the possible maximum 9% positive payment adjustment.

CMS proposes to increase the weight of the cost category in 2021 to 20% (from 15% in 2020), in turn reducing the quality category weight to 40% (from 45% in 2020). The category weights for improvement activities (15%) and promoting interoperability (25%) would remain the same.

Quality Category (40%): Generally, CMS uses historical benchmarks to score quality measures based on performance data gathered two years before the performance year. For the 2021 performance period, CMS proposes to use 2021 performance period benchmarks to score quality measures due to concern there will not be a representative sample of historic data from 2019 because of the national COVID-19 pandemic, as it may skew benchmarks. This means that groups will not be able to review measure benchmarks in advance of reporting them.

CMS proposes to end the CMS Web Interface as a quality reporting option for ACOs, APM entities, groups, and virtual groups starting in 2021.

Cost Category (20%): CMS proposes to modify existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the total per-capita cost measure.

Improvement Activities Category (15%): There are no significant updates to this category or activity inventory.

Promoting Interoperability Category (25%): CMS proposes to retain the query of prescription drug monitoring programs (PDMPs) as an optional measure and to increase the bonus from five to 10 points. The PDMP measure would continue to be a "yes" or "no" measure that does not require the reporting of numerators and denominators

CMS also proposes to add an optional Health Information Exchange (HIE) measure for bi-directional exchanges, worth 40 points.

MIPS Value Pathways (MVPs)

In 2020, CMS adopted a new framework for MIPS called MVPs, which would organize reporting requirements for each MIPS category around specific specialties, treatments, or other priorities, such as public health. The MVP framework was set to begin in 2021, but CMS proposes to delay this reporting option until 2022.

MIPS APMs

In past years, clinicians participating in MIPS APMs reported for MIPS through their APM entity and were scored under the APM scoring standard. CMS proposes to eliminate the APM scoring standard starting in 2021 and replace it with a new, voluntary reporting structure called the APM Performance Pathway. APMs could report via the APM Performance Pathway or choose one of the options available to general MIPS participants (e.g., reporting as a group or individual; selecting quality measures from the generally available measure set).

The APM Performance Pathway would be available only to participants in MIPS APMs and may be reported by the individual eligible clinician, group, or APM entity. The scoring policies for cost and improvement activities would generally be the same under the APM Performance Pathway as the current policies for MIPS APMs. Specifically, MIPS APM participants would not be scored on cost and would be assigned an improvement activity score based on their model specifications (which would result in full credit for all APMs in 2021). The promoting interoperability performance category would be reported and scored at the individual or group level, as is required for the rest of MIPS. The quality category under the APM Performance Pathway would be composed of a fixed set of six measures that are focused on population health:

Measure #	Measure Title	Collection Type	Submitter Type
Quality ID 321	CAHPS for MIPS	CAHPS Survey	Third party
Quality ID 001	Diabetes: A1c poor control	CQM	APM entity/third party
Quality ID 134	Preventative care and screening: screening for depression with follow up plan	CWM	APM entity/third party
Quality ID 236	Controlling high blood pressure	CQM	APM entity/third party
TBD	Hospital-wide, 30-day all cause unplanned readmission rate	Administrative claims	N/A
TBD	Risk-standardized, all-cause unplanned readmissions for multiple chronic conditions	Administrative claims	N/A

2021 Advanced APM Proposals

QP Status

To become a QP, a clinician must receive at least 75% of Medicare Part B payments or see at least 50% of Medicare patients through an Advanced APM entity at one of the determination periods (snapshots). This is an increase from 2020 and is required by statute.

A clinician that becomes a QP is excluded from MIPS. This exclusion applies at the National Provider Identifier (NPI) level across all of the clinician's tax identification number (TIN)/NPI combinations. This

means if a clinician participates in multiple group practice TINs and only achieves QP status through one TIN, they will remain excluded from MIPS even when participating in TINs not in an Advanced APM.

Partial QP Status

To become a Partial QP, a clinician must receive at least 50% of Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM entity at one of the snapshots. All clinicians who become Partial QPs may choose whether or not they want to participate in MIPS. If these clinicians choose to participate, they must meet all MIPS reporting and scoring requirements or receive a payment penalty. If these clinicians choose not to participate, they will not be required to report to MIPS and will not receive a MIPS payment adjustment.

Partial QPs that choose to report for MIPS could opt to participate in the APM Performance Pathway.

Targeted Review Option

Beginning with the 2021 QP Performance Period, CMS would accept targeted review requests for cases in which an eligible clinician or APM entity believes CMS made a clerical error such that an eligible clinician was not included on a Participation List of an APM entity participating in an Advanced APM for the purposes of QP or Partial QP determinations.

TABLE 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$246	5%	4%	0%	9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Audiologist	$74	-4%	-2%	0%	-7%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Cardiology	$6,849	1%	0%	0%	1%
Chiropractor	$759	-7%	-3%	0%	-10%
Clinical Psychologist	$824	-1%	1%	0%	0%
Clinical Social Worker	$851	-1%	1%	0%	0%
Colon And Rectal Surgery	$168	-4%	-1%	0%	-5%
Critical Care	$376	-6%	-2%	0%	-8%
Dermatology	$3,758	-1%	-1%	0%	-2%
Diagnostic Testing Facility	$813	-1%	-5%	0%	-6%
Emergency Medicine	$3,065	-5%	-1%	0%	-6%
Endocrinology	$506	11%	6%	1%	17%
Family Practice	$5,982	9%	4%	1%	13%
Gastroenterology	$1,749	-3%	-1%	0%	-5%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,041	-4%	-2%	0%	-7%
Geriatrics	$190	2%	2%	0%	4%
Hand Surgery	$245	-2%	-1%	0%	-3%
Hematology/Oncology	$1,702	9%	5%	1%	14%
Independent Laboratory	$639	-3%	-2%	0%	-5%
Infectious Disease	$653	-4%	-1%	0%	-4%
Internal Medicine	$10,654	2%	2%	0%	4%
Interventional Pain Mgmt	$932	4%	3%	0%	7%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Multispecialty Clinic/Other Phys	$152	-3%	-1%	0%	-4%
Nephrology	$2,213	4%	2%	0%	6%
Neurology	$1,513	3%	2%	0%	6%
Neurosurgery	$806	-4%	-2%	-1%	-7%
Nuclear Medicine	$56	-5%	-3%	0%	-8%
Nurse Anes / Anes Asst	$1,316	-9%	-1%	0%	-11%
Nurse Practitioner	$5,069	5%	3%	0%	8%
Obstetrics/Gynecology	$633	4%	3%	0%	8%
Ophthalmology	$5,328	-4%	-2%	0%	-6%
Optometry	$1,349	-2%	-2%	0%	-5%
Oral/Maxillofacial Surgery	$78	-2%	-3%	0%	-5%
Orthopedic Surgery	$3,796	-3%	-1%	0%	-5%
Other	$47	-3%	-2%	0%	-5%
Otolarngology	$1,264	4%	3%	0%	7%
Pathology	$1,257	-6%	-4%	0%	-9%
Pediatrics	$66	4%	2%	0%	6%
Physical Medicine	$1,157	-3%	0%	0%	-3%
Physical/Occupational Therapy	$4,946	-5%	-5%	0%	-9%
Physician Assistant	$2,888	5%	3%	0%	8%
Plastic Surgery	$378	-4%	-3%	0%	-7%
Podiatry	$2,111	-1%	0%	0%	-1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Portable X-Ray Supplier	$94	-2%	-4%	0%	-6%
Psychiatry	$1,099	4%	3%	0%	8%
Pulmonary Disease	$1,647	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,803	-3%	-3%	0%	-6%
Radiology	$5,253	-6%	-5%	0%	-11%
Rheumatology	$546	10%	6%	1%	16%
Thoracic Surgery	$350	-5%	-2%	-1%	-8%
Urology	$1,803	4%	4%	0%	8%
Vascular Surgery	$1,287	-2%	-5%	0%	-7%
TOTAL	**$96,557**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.