

Detailed Breakdown: CMS Releases Proposed 2021 Medicare Physician Fee Schedule and Hospital Outpatient Rules

The Centers for Medicare and Medicaid Services (CMS) on Aug. 3 released the [proposed 2021 Medicare Physician Fee Schedule](#), addressing Medicare payment and quality provisions for physicians in 2021. Under the proposal, physicians will see a reduced conversion factor from \$36.09 to \$32.26, effective Jan. 1, 2021. This reduction mostly stems from adjustments that must be made to accommodate new spending resulting from implementation of changes to evaluation and management (E/M) payments in the budget neutral system. CMS estimates that the physician rule will increase payments to cardiologists by one percent from 2020 to 2021 through updates to work, practice expense and malpractice RVUs, depending on the mix of services provided in a practice.

The Physician Fee Schedule was released in tandem with the [proposed 2021 Hospital Outpatient Prospective Payment System rule](#). The outpatient rule indicates a 2.6 percent payment update for hospitals and other proposals. Highlights from both proposed rules include:

Physician Fee Schedule

- After proposing and revising changes to E/M documentation and payment in 2019 and 2020, the proposed 2021 rule includes final policies and rates for these services. Among the changes:
 - Walking back a 2019 plan to pay a blended rate for level 2-4 visits, CMS will implement [revised E/M code definitions developed by the AMA CPT Editorial Panel](#) starting Jan. 1, 2021. Members from across the House of Medicine worked together on the revised definitions in order to address concerns about documentation burden in a manner that was less disruptive and correctly discerned differences in levels of E/M services.
 - The proposal to adopt revised coding definitions is paired with a decision to pay for each level of service rather than use a blended rate.
 - CMS proposes to adopt revised and increased work RVUs for E/M services based on recommendations from the AMA Relative Value Scale Update Committee (RUC).
 - Revaluing other services analogous to office E/M services, such as transitional care management, maternity care, and end stage renal disease.
- CMS proposes no changes regarding implementation of the Appropriate Use Criteria (AUC) Mandate when ordering advanced imaging services (i.e., SPECT/PET MPI, CT and MR). Requirements were previously summarized in [this MLN Matters article](#).
- The proposed rule includes updates to work and/or practice expense (PE) values for codes describing E/M, intracardiac echocardiography, electrocardiography, EP infusion stimulation, transthoracic echocardiography, VAD interrogation, venography, and

extracorporeal counterpulsation. More detail will be available after CMS posts supporting data tables. Additionally, the rule includes proposed work and or PE values for new/revised codes describing extended external ECG monitoring, atrial septostomy, nuclear physicist dose consultation, and percutaneous ventricular assist device services.

- The rule addresses professional scope of practice and related issues, including supervision of diagnostic tests by certain NPPs; pharmacists providing services incidents to physician's services; therapy assistants furnishing maintenance therapy; modifications to medical record documentation; and updates to payment for services of teaching physicians.
- The rule includes revisions reflecting the current payment methodology finalized in the 2020 PFS and the addition of two new HCPCS codes, G2064 and G2065, to the general care management HCPCS code, G0511, for Principle Care Management Services furnished in Rural Health Clinic (RHC) and Federally Qualified Health Clinics (FQHC). Additionally, the rule creates new E/M CPT and HCPCS codes based on the methodology used to assign beneficiaries to ACOs to reflect services for cognitive impairment and chronic management.
- After creating a process to remove outdated NCDs in 2013, CMS proposes to apply those criteria within physician fee schedule rulemaking to remove nine NCDs.

Medicare Telehealth and Other Services Involving Communications Technology

- The rule includes proposed policy changes to maintain certain elements of the various telehealth flexibilities authorized on a temporary basis during the COVID-19 public health emergency, with some proposals lasting until Dec. 31, 2021, or the end of the calendar year in which the public health emergency ends, whichever is later. Among the services CMS is proposing to add to the Medicare telehealth list:
 - GPC1X - Visit Complexity Associated with Certain Office/Outpatient E/Ms
 - 99XXX - Prolonged Services
 - 99334, 99335 - Domiciliary, Rest Home, or Custodial Care Services
 - 99347, 99248 - Home Visits
- CMS also proposes to create a temporary category of criteria for adding services to the list of Medicare telehealth services. The below are intended to be used during the COVID-19 public health emergency and will remain on the list through the calendar year in which the PHE ends.
 - 99336, 99337 - Domiciliary, Rest Home, or Custodial Care Services
 - 99349, 99350 - Home Visits, Established Patient
 - 99281, 99282, 99283 - Emergency Department Visits
 - 99315, 99316 - Nursing Facilities Discharge Day Management

- 96130, 96131, 96132, 96133 - Psychological and Neuropsychological Testing
- CMS is not proposing to continue separate payment beyond the public health emergency for the audio-only telephone E/M services established in the March 31 COVID-19 interim-final rule. However, the Agency is seeking feedback on developing coding and payment for such a service.
- CMS is also proposing to allow direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through Dec. 31, 2021.

2021 Quality Payment Program Performance Period

As clinicians across the country continue to respond to COVID-19, the Centers for Medicare and Medicaid Services is proposing a limited number of significant changes to the Quality Payment Program in 2021. Highlights include:

- Delayed implementation timeline for the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) until the 2022 performance period. CMS is proposing additions to the framework's guiding principles and development criteria to support stakeholder engagement in co-developing MVPs and establishing a clear path for MVP candidates to be recommended through future rulemaking.
- Introduction of the Alternative Payment Model (APM) Performance Pathway (APP) to align with the MVP framework. As part of APP implementation, the CMS Web Interface would be sunset as a collection type beginning in the 2021 performance period.
- An increase in the performance threshold to be 50 points in 2021 from 45 points in 2020 and an increase in exceptional performance to be 85 points in 2021 from 80 points in 2020.
- A revision of the performance category weights for Quality to 40 percent in 2021, a five percent decrease from 2020. An increase in Cost performance category for Cost to 20 percent in 2021, a five percent increase from 2020. Additionally, Cost and Quality performance categories would be equally weighted at 30 percent beginning in the 2022 performance period. Existing measure specifications in the Cost category would be updated to include telehealth services that are directly applicable to existing episode-based cost measures.
- Promoting Interoperability and Improvement Activities would be maintained at 25 percent and 15 percent, respectively.
- A proposal for the 2020 performance period only to double the complex patient bonus. Clinicians, groups, virtual groups and APM Entities would be able to earn up to 10 bonus points (instead of five bonus points) to account for the additional complexity of treating their patient population due to COVID-19.
- CMS is soliciting comments on a lower performance threshold of 50 points, previously 60 points in CY 2020.

- Updates to the Medicare Shared Savings Program (Shared Savings Program) quality performance standard and quality reporting requirements for performance years beginning on Jan. 1, 2021 to align with Meaningful Measures, reduce reporting burden and focus on patient outcomes.
- A proposal to reduce the total number of measures in the ACO quality measure set from 23 to 6 measures, and the number on which ACOs are required to actively report would be reduced from 10 to 3.
- Expansion of the use of the APM Entity submitter type to allow the use of all MIPS submission mechanisms.
- A proposal to end the APM Scoring Standard beginning with the 2021 performance period. CMS is also proposing to add the APM Entity as a submitter type which may report to MIPS on behalf of associated MIPS eligible clinicians.
- CMS is proposing that Medicare patients who have been prospectively attributed to an APM Entity during a QP Performance Period not be included as attribution-eligible Medicare patients for any APM Entity that is participating in an Advanced APM that does not allow such prospectively attributed Medicare patients to be attributed again.
- A proposal to use the performance period, not historical, benchmarks to score quality measures for 2021; updating the scoring policy for topped-out measures, so that the 7 measure achievement point cap will be applied only if the measure is identified as topped out based on the established benchmarks for both the 2020 and 2021 performance periods.
- The rule addresses changes to 112 existing MIPS quality measures; removes 14 quality measures; and proposes 206 quality measures starting in 2021, including two new administrative claims-based measures, one of which has a three-year measurement period.
- Updated requirements for Qualified Clinical Data Registry (QCDR) measures and the services that third-party intermediaries must provide (beginning with the 2021 performance period). Additionally, QCDR measures would be required to be fully tested at the clinician level in order to be considered for inclusion in an MVP, beginning with the 2022 performance period.

Hospital Outpatient Rule

- CMS proposes the establishment of an Overall Hospital Quality Star Rating system for 2021, aiming to simplify methodology and increase comparability between facilities.
- To allow greater flexibility to facilities, CMS proposes to eliminate the Inpatient Only (IPO) procedure list over the course of three calendar years beginning with the removal of approximately 300 musculoskeletal-related services.
- Proposing for CY 2021 and subsequent years, direct supervision for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services would

include virtual presence of the physician through audio/video real-time communications technology subject to the clinical judgment of the supervising physician.

- In light of the COVID-19 PHE and a desire to promote competition, the Agency proposes to remove exclusion criteria that prevent many services from being placed on the Ambulatory Surgery Center Covered Procedures list for CY 2021.

ACC staff are reviewing the proposed rules to identify additional topics of interest to members. More information will be forthcoming in the *Advocate* newsletter and on [ACC.org](https://www.acc.org) in the coming weeks. CMS fact sheets are available [here](#) and [here](#). The College will submit written comments at the end of the summer.

Not long before the final rules are released in the fall, experts will discuss federal legislative and regulatory topics at ACC's 2020 Virtual Legislative Conference, taking place October 2 – 4. Don't miss this opportunity to learn about hot button issues facing cardiologists and to ensure the voice of cardiology is heard on Capitol Hill. Learn more [here](#).