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CMS Releases 2021 MPFS and QPP Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) published the Calendar Year (CY) 2021 Proposed Rule for the Medicare Physician Fee Schedule (MPFS), which contains updates to the Quality Payment Program (QPP). The MPFS dictates Medicare rates and policies under Part B, while the QPP implements two value-based payment programs: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Among notable changes, CMS has proposed to make permanent certain telehealth changes that have been implemented in response to the COVID-19 public health emergency (PHE); generally confirmed the evaluation and management (E/M) documentation guidelines and payment changes finalized in the 2020 MPFS; and proposed changes to the MIPS and APM participation options and requirements for 2021.

Comments on the proposed rule are due on October 5, 2020. Due to the public health emergency (PHE), CMS plans to implement the rule 30-days after it is finalized instead of the standard 60-day period. The Final Rule will likely be released in early December, providing little time for providers to adapt to changes made by the Final Rule before they take effect on January 1, 2021.

Review the [Proposed Rule](#), the [MPFS fact sheet](#), and the [QPP fact sheet](#).

Below is a summary of the highlights of the Proposed Rule.

Physician Fee Schedule Proposed Decreased Conversion Factor (CF)

The 2021 proposed physician CF is \$32.2605. This represents a decrease of \$3.83 from the 2020 conversion factor of \$36.0896. This proposed negative adjustment results from a statutorily mandated budget neutrality adjustment to account for changes in work relative value units (RVUs). The change in work RVUs is primarily driven by updates to E/M services that were finalized in the CY 2020 MPFS Final Rule, which is not effective until January 1, 2021, as well as other proposed changes in work. Absent reversal of the E/M work RVU changes; congressional action would be required to avoid a reduction in the conversion factor in CY 2021 by suspending the budget neutrality adjustment for E/M changes effective CY 2021.

Federally Qualified Health Center (FQHC) Market Basket Update

CMS proposes to rebase and revise the FQHC market basket to reflect a 2017 base year. The proposed 2017-based FQHC market basket update for CY 2021 is 2.5 percent. The proposed multifactor productivity adjustment for CY 2021 is 0.6 percent. As such, the proposed CY 2021 FQHC payment update is 1.9 percent.

Evaluation and Management (E/M) Visits

Effective January 1, 2021, CMS will implement payment rate increases for office/outpatient E/M codes and simplified coding and billing requirements for E/M visits. CMS finalized this policy in the CY 2020 PFS Final Rule but delayed implementation until 2021. Specialties that don't generally bill office/outpatient E/M visits would experience the most significant decreases, while specialties and practices that bill

higher level established patient visits would see the most significant increases. Table 90 (pages 897 and 898) in the proposed rule shows the impact by practice. To the extent that there are year-to-year changes in the volume and mix of services provided by practitioners, the actual impact on total Medicare revenues will be different from those shown in Table 90. Specialty impacts range from -11% for radiology to +13 percent family practice. As noted above, congressional action would be required to avoid a reduction in the conversion factor in CY 2021 by suspending the budget neutrality adjustment for E/M changes effective CY 2021. If Congress does engage, it will considerably change the specialty impact.

Revalue Services Similar to E/M Services

In the CY 2020 PFS Final Rule, CMS finalized a policy to adopt new coding, preface language, and an interpretive guidance framework for E/M coding consistent with recommendations from the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel.

CMS also finalized HCPCS code GPC1X to be implemented on January 1, 2021, to describe better the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. CMS was informed the code is unclear and now seeks more specific information regarding what aspects of the definition of HCPCS add-on code GPC1X are unclear, how they might address those concerns, and how they might refine their utilization assumptions for the code.

CMS also proposes to revalue services that include, or are similar to, E/M services:

- 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
- Psychiatric Diagnostic Evaluations and Psychotherapy Services

Telehealth Updates

Through the *Coronavirus Aid, Relief, and Economic Security Act (CARES Act)*, CMS temporarily removed the geographic and site of service originating site restrictions for Medicare telehealth services. The proposed rule does not address these provisions because CMS is limited by statute and cannot permanently expand the list of telehealth providers. CMS notes that making these flexibilities permanent requires an act of Congress.

However, CMS did propose the following telehealth changes:

Permanent Telehealth Services Additions

In the March 31st interim final rule (IFC), CMS added services to the Medicare telehealth list for the duration of the COVID-19 PHE. CMS is now proposing to make some of these services permanent.

Changes to the Medicare telehealth services list are made with the annual MPFS rulemaking process. When a request to add a service to the list is submitted, Medicare assigns it to one of two categories. Category 1 is for services similar to consultations and office visits currently on the list, and Category 2 is for services that are not similar to those currently on the list. CMS proposes to add the following services to the list on a Category 1 basis:

- Group Psychotherapy (CPT code 90853)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347- 99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X)
- Prolonged Services (CPT code 99XXX)
- Psychological and Neuropsychological Testing (CPT code 96121)

Temporary Telehealth Services Additions

For the services that CMS does not permanently add to the Medicare telehealth list, CMS proposes to create a new temporary category, Category 3. This will allow the agency to collect public comments on whether to add these services permanently in future PFS annual rulemaking. These services were added during the PHE, which will remain on the list through the calendar year in which the PHE ends.

CMS is proposing to add the following services to Medicare telehealth list on a Category 3 basis:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337)
- Home Visits, Established Patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133)

A variety of services included temporarily on the Medicare telehealth list due to the COVID-19 PHE are not being proposed for inclusion as either Category 1 or Category 3. These include codes related to initial nursing facility visits, ESRD monthly capitation payment codes, radiation treatment management, and home visits for new patients, among others. CMS is seeking public comment on services the administration added to the Medicare telehealth services list under the declared PHE that the agency hasn't suggested adding to the list on a potential or temporary basis under the proposed rule.

Discontinuing Audio-Only Telehealth Services

CMS notes that they are not proposing to continue payment for audio-only telephone visits beyond the PHE. After the conclusion of the PHE, telehealth services will once again be required to be furnished using an interactive two-way video and audio telecommunications system. However, CMS is seeking comments on whether the audio-only services should be made permanent or whether CMS should develop coding and payment for a similar virtual check-in for a longer unit of time. Notably, discontinuing coverage of audio-only visits runs against recent trends at the state level.

Teaching Hospitals – Telehealth with Residents

CMS proposes to allow physicians teaching residents in a teaching hospital to use telehealth technology to provide the direction, management, and review that is required. The rule also proposes expanded billing flexibilities for residents providing services in an inpatient setting at a teaching hospital. These include higher-level E/M visits and services to Medicare beneficiaries that are otherwise outside the scope of the Graduate Medical Education (GME) program. CMS is asking for comments on the proposal to include whether these flexibilities should be temporary through the end of the PHE or should be made permanent.

Additional Areas for Comment- Telehealth

CMS identified several areas in particular where it is seeking comment. These include:

Removal of Frequency Limitations for Subsequent SNF Visits – CMS seeks comment on whether it would enhance patient access to care to remove frequency limitations for subsequent nursing facility visits furnished via Medicare telehealth altogether, and how best to ensure that patients would continue to receive necessary in-person care.

Expanded Virtual Check-In – CMS seeks comment on whether the agency should develop coding and payment for a service similar to the virtual check-in but for a more extended unit of time and subsequently with a higher value. CMS also seeks input on the duration of the services, the resources in both work and practice expense (PE) associated with furnishing this service, and whether this should be a provisional or permanent policy.

Updates for Remote Physiologic Monitoring (RPM) Services

In a prior rulemaking, CMS added reimbursement for development and management of a plan of treatment based upon patient physiologic data in 2020, and for 2021 is adding a payment for prolonged face-to-face and/or non-face to face E/M work related to an office/outpatient E/M visit in addition to their other care management codes.

CMS proposes to clarify Medicare payment policies for certain remote physiologic monitoring (RPM) services. For example, the agency proposed clarifying that:

- CMS considers RPM services to be evaluation and management (E/M) services;
- CMS will again require that an established patient-physician relationship already exist for RPM services to qualify for Medicare coverage once the PHE declaration ends;

- Only non-physician practitioners (NPPs) and physicians eligible to provide E/M services are eligible to bill Medicare for RPM services; and
- Qualifying clinicians may provide RPM services to patients with acute conditions and those with chronic conditions.

CMS also proposed permanently adopting two clarifications to RPM services that the agency had implemented under the federally declared PHE:

- Allowing auxiliary personnel, including contracted employees, to provide certain RPM services if they are under a physician's supervision; and
- Allowing providers to obtain patients' consent at the time RPM services are furnished.

In addition, CMS said it is seeking public comment on whether current RPM codes accurately capture the full scope of clinical scenarios in which RPM services may benefit Medicare beneficiaries.

CMS is seeking comments on whether the current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients. For example, CPT codes 99453 and 99454 currently require the use of a medical device (as defined by the FDA) that digitally collects and transmits 16 or more days of data every 30 days for the codes to be billed. CMS is interested in understanding whether one or more codes that describe a shorter duration, for example, eight or more days of remote monitoring within 30 days, might be useful.

CMS is also seeking comments on how RPM services are used in clinical practice and how they might be coded, billed, and valued under the Medicare PFS.

Updates Related to the Scope of Practice

CMS proposes updates and clarifications regarding professional scopes of practice and related issues. CMS under the proposal would allow CNMs, CNSs, NPs, and PAs—in addition to physicians—to supervise the administration of diagnostic tests within their state scope of practice and applicable state laws, as long as they maintain required relationships with collaborating or supervising physicians. CMS already has implemented those allowances under the federal PHE declaration, but the agency is proposing to make the change permanent.

CMS under the proposed rule also would extend some policies implemented under the PHE declaration that relate to services furnished by pharmacists and physical therapists, as well as certain flexibilities related to medical record reviews and verification.

Expanded Transitional Care Management Billing

CPT Codes 99495 and 99496 describe management of a patient's transition from acute care or certain outpatient stays to a community setting, with a face-to-face visit, once per patient within 30 days post-discharge. CMS maintains a list of 57 codes that cannot be billed concurrently with those codes because of the potential duplication of those services. CMS is proposing to remove 15 codes from that list. One of the codes is for complex chronic care management services. The rest of the codes relate to services furnished to patients with end-stage renal disease (ESRD).

Opioid Use Disorder (OUD) Treatment

CMS proposes to add naloxone to the definition of OUD treatment services to increase access. To account for the additional cost for these drugs, CMS proposes to adjust payment for OUD services through two new add-on codes: GOTP1 and GOTP2. CMS proposes payment rates for these new add-on codes that will be established through the same process used to price the bundled OUD services. Table 30 in the proposed rule provides a summary of the proposed add-on codes.

Removal of National Coverage Determinations (NCDs)

CMS seeks comments on its proposal to remove nine NCDs. CMS believes that these NCDs may no longer contain pertinent or clinically relevant information and are rarely used by beneficiaries. The NCDs are - Extracorporeal Immunoabsorption (ECI) using A Columns; Electrosleep Therapy; Implantation of Gastroesophageal Reflux Device; Apheresis (Therapeutic Pheresis); Abarelix for the Treatment of Prostate Cancer; Histocompatibility Testing; Cytogenetic Studies; Magnetic Resonance Spectroscopy; and FDG PET for Inflammation and Infection.

Quality Payment Program (QPP)

Under the QPP, eligible clinicians will elect either to be subject to payment adjustments based upon performance under the Merit-based Incentive Payment System (MIPS) or to participate in the Advanced Alternative Payment Model (APM) track. The Proposed Rule includes notable proposed changes to the MIPS and APM participation options and requirements for 2021. The tenor of these proposed changes is that providers will not recover from COVID overnight and will need support.

Notable proposed changes include:

Changes to Accountable Care Organization (ACO) Scoring and Policies

For the performance year (PY) 2021, Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) would be required to report quality measure data via the new APM Performance Pathway (APP) under the QPP, instead of the CMS Web Interface. ACOs would only need to report one set of quality metrics to meet requirements for MIPS and MSSP. In addition, the total number of measures included in the ACO quality measure would be reduced from 23 to 6.

CMS is also proposing to raise the performance standard for these ACOs and strengthen compliance policies by broadening the conditions under which CMS may terminate an ACO's participation agreement when an ACO demonstrates a pattern of failure to meet the quality performance standard. As part of the extreme and uncontrollable circumstances policy, CMS is proposing to waive the requirement for the performance year 2020 to field a CAHPS survey because of the impact of COVID-19.

MIPS Value Pathways (MVP)

In CY 2020, CMS finalized the creation of MIPS Value Pathways (MVPs), which were designed to align activities from the four MIPS performance categories around a specialty, medical condition, or patient population. While CMS intended to begin transitioning to MVPS during the 2021 performance year, the agency is delaying this until at least 2022 in response to the COVID-19 pandemic. CMS is proposing to update the MVP guiding principles to say that MVP measures should be selected to include the patient voice wherever possible.

MIPS Category Weights

MIPS includes four performance categories: quality, cost, improvement activities, and promoting interoperability. A total of 206 quality measures are proposed for the upcoming 2021 MIPS performance year.

The proposed weights for 2021 are as follows:

- Quality 40% (5% decrease): CMS Web Interface submission method no longer available and CMS will use performance year benchmarks NOT historical to score measures for PY 2021 due to COVID-19 PHE
- Cost 20% (5% increase): Update measure specifications to include telehealth services for existing episode-based cost measures and TPCC measures;
- Improvement Activities (IA) 15%: Minimal changes focus on the process for nominating new activities; and
- Promoting Interoperability 25%: New optional HIE bidirectional exchange measure and the query of the Prescription Drug Monitoring Program (PDMP) measure will remain voluntary and worth ten bonus points.