Initial AAFP summary of the 2021 proposed Medicare Physician Fee Schedule

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2021 Medicare Physician Fee Schedule (MPFS). This regulation also impacts the Quality Payment Program (QPP). CMS released a related fact sheet on the fee schedule. Importantly, CMS is planning to move forward with changes to evaluation and management (E/M) visit coding that the AAFP has consistently advocated for and defended including increasing the RVUs for office/outpatient E/M visits, creating a new code for prolonged visits, and streamlining documentation requirements. These changes will take effect January 1, 2021 and the estimated financial impact is a 13 percent net increase in total allowed charges for family practice. Unfortunately, due to Medicare budget neutrality rules, CMS is proposing a decrease in the annual conversion factor to offset other changes. The AAFP has joined with other medical groups in calling on Congress to waive budget neutrality in the wake of COVID-19.

Comments on the proposal are due by October 5, 2020. The AAFP will thoroughly review the proposal and provide formal comments to the agency. CMS has signaled that the MPFS rule may be finalized later than usual this year, due to COVID-19; however, changes will still take effect on January 1, 2021.

Proposals Impacting 2021 Medicare Physician Payment

E/M coding, documentation and valuation changes – As finalized in the final rule on the 2020 physician fee schedule, CMS will be largely aligning its E/M visit coding and documentation policies with changes laid out by the Current Procedural Terminology Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021. CMS proposes a refinement to clarify the times for which prolonged office/outpatient E/M visits can be reported and proposes to revise the times used for rate setting for this code set. Additionally, CMS proposes to follow through with its plans to increase the relative value units (RVUs) for office/outpatient E/M visits in 2021 and to create and pay for a new code that family physicians may list separately in addition to an E/M visit to be compensated for "Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services."

Other codes RVU changes – CMS proposes to revalue multiple code sets that include, rely upon, or are analogous to office/outpatient E/M visits. These revalued code sets include:

- Transitional Care Management (TCM) Services
- Maternity Services
- Cognitive Impairment Assessment and Care Planning
- Initial Preventive Physical Examination (i.e. "Welcome to Medicare" visit) and Initial and Subsequent Annual Wellness Visits
- Emergency Department Visits

CMS also proposes to establish new payment rates for immunization administration services, so Medicare payment better reflects the relative resources involved in furnishing such services. Because of all its proposals, CMS estimates family physicians will experience a 13% increase in their Medicare allowed charges in 2021.

Conversion factor update – CMS has proposed a 2021 conversion factor of $32.26, a decrease of $3.83 from the 2020 conversion factor of $36.09. CMS attributes this decrease to the budget neutrality adjustment it's legally required to make to account for changes in RVUs. Despite this decrease, the Medicare allowances for the E/M services family physicians do most often are still projected to increase in 2021.

Proposals Impacting Telehealth

For 2021, CMS has proposed to add the following services to the Medicare telehealth list:

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- Visit complexity (GPC1X)
- Group psychotherapy (90853)
- Neurobehavioral status exam (96121)
- Prolonged office or outpatient E/M service (99XXX)
- Assessment of and care planning for a patient with cognitive impairment (99483)
- Domiciliary or rest home visit for E/M of established patient (99334, 99335)
- Home visit for E/M of established patient (99347, 99348)

CMS has proposed the temporarily adding services to the Medicare telehealth list that were added during the public health emergency (PHE) for which there is likely to be a clinical benefit when furnished via telehealth, but for which there is not yet evidence available to consider the services as permanent additions. These services would remain on the list until the end of the calendar year in which the PHE ends. CMS has proposed adding the following services on a temporary basis:

- Domiciliary or rest home visit for E/M of established patient (99336, 99337)
- Home visit for E/M of established patient (99349, 99350)
- Emergency Department visits (99281, 99282, 99283)
- Nursing facilities discharge day management (99315, 99316)
- Psychological and neurological testing (96130, 96131, 96132, 96133)

CMS did not propose to continue paying for audio-only E/M visits after the conclusion of the PHE. CMS is seeking comment on whether they should develop coding and payment for a service similar to the virtual check-in but for longer time and with higher value.

During the PHE, CMS revised the definition of direct supervision to include virtual presence of the supervising physician using interactive audio/video real-time communications technology. CMS proposed extending this policy until the end of the calendar year in which the PHE ends.

CMS is proposing several changes to remote physiologic monitoring (RPM) services including permanently allowing consent to be obtained at the time RPM services are furnished, allowing auxiliary personnel to furnish services (99453 and 99454) under the supervision of the billing physician, clarifying that RPM services can be furnished to patients with acute conditions as well as those with chronic conditions, and clarifying that interactive communications (for the purposes of 99457 and 99458) involve real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other data transmission. CMS proposes to resume requiring that an established patient-physician relationship exist for RPM services to be furnished.

CMS is proposing to allow the new CCM code (G2058) to be billed concurrently with TCM when reasonable and necessary.

Proposals Impacting the Quality Payment Program

For the Merit-based Incentive Payment System (MIPS), CMS is proposing to:

- Increase the performance threshold to 50 points and retain the exceptional performer threshold of 85 points;
- Reduce the quality performance threshold to 40% and increase the cost performance category to 20%. The improvement activities and promoting interoperability performance category weights will remain unchanged at 15% and 25%, respectively. The quality and cost categories will be equally weighted at 30% beginning with the 2022 performance year.
- CMS is proposing to postpone the implementation of MIPS Value Pathways (MVPs) until performance year 2022. CMS is also proposing refinements to the MVP guiding principles.
- For the quality category, CMS is proposing to use the 2021 performance year to establish benchmarks. CMS is also proposing two new administrative claims measures:
    - Hospital-wide 30-day all cause unplanned readmissions for groups of 16 or more clinicians with a case minimum of 200, and

    - Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TRA) for eligible clinicians, groups, and virtual groups with a 25-case minimum. This measure has a three-year measurement period.
- CMS is proposing to sunset the Web Interface as a MIPS reporting mechanism.
- CMS is proposing to update the cost measure specifications to include telehealth services that are directly applicable to episode-based cost measures and the total per capita cost measure.
- CMS is proposing a continuous 90-day performance period for the promoting interoperability category. CMS is also proposing to maintain the Query of Prescription Drug Monitoring Program as an optional measure worth up to 10 bonus points and add an optional Health Information Exchange bi-directional exchange measure.

For the 2021 performance year, CMS is allowing eligible clinicians to apply for an extreme and uncontrollable circumstances exception. Groups, virtual groups, and APM entities can also apply for an exception. In light of the COVID-19 pandemic, CMS is proposing to increase the complex patient bonus to 10 points. CMS is not proposing to automatically apply the extreme and uncontrollable circumstances to all MIPS-eligible clinicians for the 2020 performance period, as the AAFP previously called for.

CMS is proposing to end the APM Scoring Standard and implement the Alternative Payment Model (APM) Performance Pathway (APP). APPs may be reported by individual eligible clinicians, group TINs, and APM Entities. The APP would include a fixed set of quality measures.

For Advance Alternative Payment Model (AAPM) participants, CMS is proposing to modify the qualified participant (QPs) threshold score calculation. CMS is also proposing a targeted review option for QPs and Partial QPs for eligible clinicians who believe they were erroneously excluded from an APM Entity's Participation List.

CMS is proposing to waive the CAHPS for ACOs reporting requirement for 2020 and give all ACOs automatic full credit for the CAHPS survey. ACOs may apply for reweighting of MIPS categories in 2020 due to extreme and uncontrollable circumstances. CMS is also proposing to modify the extreme and uncontrollable circumstances policy to allow ACOs that completely and accurately report 2020 quality data to receive the higher of their 2020 or 2019 score.

Medicare Shared Savings Program (MSSP) changes
CMS is proposing to align the MSSP quality standard with the proposed APP. MSSP ACOs would be required to report quality data via the APP. The number of quality measures for MSSP ACOs would be reduced from 23 to six, with ACOs required to actively report on three measures. CMS is also proposing to increase quality performance standard for MSSP ACOs.

CMS is proposing to revise how it establishes the final sharing rate for all MSSP tracks. Beginning in 2021, if an ACO is eligible to share in savings and meets the quality performance standard, the ACO will share in savings at the maximum sharing rate for the ACO's track.

CMS is proposing to update its extreme and uncontrollable circumstances policy so that an ACO affected by extreme and uncontrollable circumstances would receive the minimum quality performance score equal to the 40th percentile. If an ACO submits quality data, CMS would use the higher of the ACO's MIPS quality performance score or the 40th percentile MIPS quality performance category score. CMS is proposing to expand the list of primary care services used in beneficiary assignment.

Proposals Impacting Federally Qualified Health Center and Rural Health Clinic Payments
CMS is proposing to rebase and revise the 2013-based FQHC market basket to reflect a 2017 base year. The 2017-based FQHC market basket is based primarily on Medicare cost report data for FQHCs for 2017.

Questions or comments on the 2021 proposed MPFS? Please email regulations@aafp.org