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CY 2021 PHYSICIAN FEE SCHEDULE PROPOSED RULE SUMMARY

On August 3, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2021. This proposal updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here.

The proposal is currently open for comment through October 5. The rule's provisions, if finalized, will be effective January 1, 2021 unless stated otherwise. The following summarizes the major policies in the proposal.

Planned 30-day Delayed Effective Date for the Final Rule (p. 801)

Normally, CMS provides a 60-day delay in the effective date of final rules after the date that they are issued. However, the Congressional Review Act allows an agency to change the effective date if there is good cause to not follow regular notice and public procedures. Since CMS is prioritizing efforts to contain and combat the COVID-19 public health emergency (PHE), the work needed to complete the PFS payment rule will not be completed in accordance with their usual schedule, which aims for a publication date of at least 60 days before the start of the applicable fiscal year, approximately November 1. The agency expects to need at least 30 additional days to complete the work on the payment rule. Therefore, the agency expects that the PFS final rule will be released December 1 and will have an effective 30 days after publication of January 1.

Conversion Factor and Specialty Impact (p. 894)

The proposed conversion factor for 2021 is $32.26, a decrease of almost $4 from the current conversion factor of $36.09. This reduction of 10.61 percent stems from adjustments that statutorily required to accommodate the new spending on the outpatient evaluation and management (E/M) changes as well as other changes in the budget neutral system. Table 90 (see Appendix A), extracted from the rule, provides a summary of the impact of the changes in the proposed rule by specialty. The changes in the rule are budget-neutral in the aggregate, which explains why the impact for all physicians is shown as zero. The proposed rule shows changes in the range of minus 11 percent to plus 17 percent with allergy and otolaryngology seeing 9 and 7 percent increases respectively. However, the ultimate impact on an individual physician's reimbursement will depend on their case mix as the majority of services that are not E/M have decreased. As you will see in the attached chart, the budget neutrality adjustment is resulting in significant increases to many of the specific codes billed by AAOA members.

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic (p. 144)

BACKGROUND: In the CY 2020 PFS final rule, CMS adopted the CPT Panel's changes to the outpatient E/M family that will be effective on January 1, 2021. Providers will no longer use history and physical exam to select the appropriate visit level, and E/M visits will include a medically appropriate history and exam when it is reasonable and necessary, and clinically appropriate. Visit level selection will be based on either the level of medical decision making (MDM) as redefined by CPT or the total face-to-face and non-face-to-face time spent by the reporting practitioner on the day of the visit.

CMS also finalized separate payment for a new prolonged visit add-on code, CPT code 99XXX, to report prolonged time associated with E/M visits, as well as separate payment for GPC1X to provide payment for inherent visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of the ongoing care related to a patient's single, serious, or complex chronic condition.

The agency included the time and work RVUs for the revised code family in Table 16, which can be found below.

TABLE 16: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
99XXX	N/A	N/A	15	0.61
GPC1X	N/A	N/A	11	0.33

A detailed description of the E/M policies proposed in this rule for implementation in 2021 follows:

TIME VALUES FOR LEVEL 2-5 OUTPATIENT E/M VISIT CODES: The RUC survey of the revised code set asked respondents to consider the total time spent on the day of the visit, as well as any pre- and post-service time occurring within 3 days prior to and 7 days after the visit. The RUC separately averaged the survey results for pre-service, day of service, and post-service times, and the survey results for total time, which for some codes the sum of the times associated with the three services periods did not match the RUC-recommended total time. CMS finalized the RUC-recommended times in last year's rule despite these discrepancies in time, but this year the agency is proposing to adopt total times for this code family that equal the sum of the component parts. Table 17 in the rule shows the discrepancy in times.

TABLE 17: RUC-Recommended Pre-, Intra-, Post-Service Times, RUC-Recommended Total Times for CPT codes 99202-99215 and Actual Total Time

HCPCS	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Actual Total Time	RUC-recommended Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

COMMENT SOLICITATION ON DEFINITION OF GPC1X: CMS finalized the HCPCS add-on code GPC1X which describes the "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 with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition" to more accurately describe and reflect the resources associated with primary care and certain types of specialty visits. Billing for this service would not be restricted by specialty as had been proposed for the initial add-on codes in the CY 2019 PFS proposed rule.

Some specialties communicated to CMS that the definition of this service is unclear as well as concerns about the agency's utilization assumptions. The agency is requesting comments on additional, more specific information regarding what aspects of the definition of HCPCS add-on code GPC1X are unclear, how those concerns might be addressed, and how the utilization assumptions for the code might be refined.

PROLONGED OUTPATIENT E/M VISITS (CPT CODE 99XXX): CPT code 99XXX is only reported when the time of the physician or qualified healthcare professional time is used to select the visit level. CMS interpreted the revised CPT prefatory language and reporting instructions would mean that CPT code 99XXX could be reported when the physician's (or NPP's) time is used for code level selection and the time for a level 5 office/outpatient E/M visit (the floor of the level 5 time range) is exceeded by 15 minutes or more on the date of service in the 2020 PFS.

The agency believes the intent of the CPT Editorial Panel is unclear because of the use of the terms "total time" and "usual service" in the CPT code descriptor ("*requiring total time with or without direct patient contact beyond the usual service."*). The term "total time" is unclear because office/outpatient E/M visits now represent a range of time, and "total" time could be interpreted as including prolonged time. There is no longer a typical time in the code descriptor that could be used as point of reference for when the "usual time" is exceeded for all practitioners, and there would be variation (as well as potential double counting of time) if applied at the individual practitioner level.

Now CMS believes allowing reporting CPT code 99XXX after the minimum time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. To avoid this, the agency is proposing that CPT code 99XXX could only be reported when the maximum time for the level 5 visit is exceeded by at least 15 minutes on the date of service. In Table 23, CMS provides the time requirements for billing this service with level 5 visits.

TABLE 23: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99XXX x 1	69-83 minutes
99215 x 1 and 99XXX x 2	84- 98 minutes
99215 x 1 and 99XXX x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

<u>Telehealth and Other Services Involving Communications Technology (p. 74)</u>

In this rule, CMS is proposing to add a number of services to the Medicare telehealth list permanently and others temporarily. The agency also discusses a number of services on the list temporarily during the PHE that are not proposed to be on the list permanently. A more detailed summary of the discussion of these categories follow. Table 12 from the rule summaries the agency's proposals by code.

TABLE 12: Summary of CY 2021 Proposals for Addition of Services to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
1. Services we are proposing for permanent addition to the Medicare telehealth services list	• 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)
2. Services we are proposing as Category 3, temporary additions to the Medicare telehealth services list.	• 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)
3. Services we are not proposing to add to the Medicare telehealth services list but are seeking comment on whether they should be added on either a Category 3 basis or permanently.	• Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Psychological and Neuropsychological Testing (CPT codes 96136-96139) • Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507) • Initial hospital care and hospital discharge day management (CPT 99221-99223; CPT 99238- 99239) • Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT 99468- 99472; CPT 99475- 99476) • Initial and Continuing Neonatal Intensive Care Services (CPT 99477-99480) • Critical Care Services (CPT 99291-99292) • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962) • Radiation Treatment Management Services (CPT 77427) • Emergency Department Visits, Levels 4-5 (CPT 99284-99285) • Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324-99328) • Home Visits, New Patient, all levels (CPT 99341- 99345) • Initial and Subsequent Observation and Observation Discharge Day Management (CPT 99217- 99220; CPT 99224- 99226; CPT 99234-99236)

Permanent Addition of Services to the Telehealth List

Services may be added to the list of permanent Medicare telehealth services if they meet CMS' Category 1 or 2 criteria which are:

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on Medicare telehealth services list. In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. The agency also looks for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.

- Category 2: Services that are not similar to those on the current Medicare telehealth services list. The review of these requests includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. The evidentiary standard of clinical benefit does not include minor or incidental benefits.

CMS is proposing to add 8 services to the Medicare telehealth services list permanently as the agency believes these services are similar to those already included on the list. Some domiciliary and rest home visits are on this list. While a patient's home is statutorily prohibited from serving as an originating site for most telehealth services, the domiciliary/home visits contain the same elements and have similar descriptors to the outpatient E/M visits for which the home can serve as an originating site under authority granted under the SUPPORT Act for the purposes of treatment of a substance abuse disorder or a co-occurring mental health disorder. Therefore, CPT codes 99334-99335 and 99347-99348 would only be furnished via telehealth for the treatment of these conditions if this proposal is finalized.

Proposed Temporary Addition of Services to the Medicare Telehealth List
CMS is proposing to create a new category of services (Category 3) added to the telehealth list during the PHE and will remain there on a temporary basis through the end of the year the PHE ends. This would include services that were added during the PHE for which there is likely to be a clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to adding the service permanently under existing criteria. The categories of services on this list include domiciliary, rest home, or custodial care services for established patients; home visits for established patients; emergency department visits; nursing facilities discharge day management; and psychological and neuropsychological testing.

Comment Solicitation on Medicare Telehealth Services Added on an Interim Basis during the PHE that CMS is not Proposing to Retain after the PHE Ends
Outside of the PHE, CMS does not believe that certain services added to the telehealth list during the PHE could be provided fully and effectively via telehealth. However, CMS is requesting comment on whether some of these services should be added to the list on a temporary basis and is seeking comment on whether they should be added permanently or the agency is correct to add them on a temporary basis. The categories of services on which the agency is specifically requesting comments on their concerns include initial and final/discharge interactions; higher level emergency department visits; and hospital, intensive care unit, emergency care, observation stays.

Proposed Technical Amendment to Remove References to Specific Technology
The final sentence of CMS' regulation at § 410.78(a)(3) prohibits the use of telephones, fax machines, and email systems for purposes of furnishing Medicare telehealth services. The first COVID interim final rule suspended the application of this sentence during the PHE, but in this rule, CMS is proposing to eliminate this sentence.

Communication Technology-Based Services (CTBS)
CMS has previously finalized separate payment for a number of services that could be furnished via telecommunications technology, but are not considered telehealth services, including HCPCS codes G2010 and G2012, remote evaluation of recorded video and or images and the virtual check-in respectively. In the first COVID interim final rule, CMS finalized policy to allow PTs, OTs, and SLPs who bill Medicare directly to bill G2061 and G2063, the qualified nonphysician healthcare professional online assessment and management services, during the PHE, and is now proposing to adopt this policy on a permanent basis. The agency is also proposing to allow certain nonphysician practitioners to bill CTBS consistent with the scope of their benefit categories through two new G codes:

- 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)

Comment Solicitation on Continuation of Payment for Audio-only Visits
CMS added the audio-only telephone E/M services to the telehealth services list during the PHE and is not proposing to continue payment for these services once the PHE concludes because the agency does not regularly have the authority to waive the requirement that telehealth services be delivered using an interactive telecommunications system that includes two-way audio and visual communications technology. The agency considered these services as telehealth services during the PHE because they were being delivered in place of outpatient E/M visits. However, the agency recognizes there may be circumstances where a longer telephone conversation may be necessary to determine whether an in-person visit is necessary. CMS is seeking comment on whether a code should be developed and valued to describe a longer virtual check-in. Specifically, CMS requests comment on the appropriate duration interval for such services and the work and PE resources required as well as whether this should be a permanent policy or temporary until a year or some other period after the PHE concludes.

Coding and Payment for Virtual Services
There are a number of services, like chronic care management and remote physiologic monitoring, that are inherently non face-to-face services and are not telehealth services, falling outside the restrictions on telehealth services. CMS is seeking comment on whether there are additional services that fall outside of telehealth services under section 1834(m) where it would be helpful to clarify these services do not need to be on the telehealth list in order to be billed and paid when furnished using telecommunications technology rather than in person with the patient present. The agency also requests comments on physicians' services that use involving technology that may not be fully recognized by current fee schedule coding and payment as well as any comments on any impediments that contribute to health care provider burden and would make providers reluctant to bill for communications technology based services.

Proposed Clarification of Existing PFS Policies for Telehealth Services
CMS believes that services provided incident to the professional services of an eligible distant site physician or practitioner could be reported when they meet direct supervision requirements at both the originating and distant site through the virtual presence of the billing physician or practitioner. Therefore,

the agency proposes to clarify that services that may be billed incident-to may be provided via telehealth incident to a physicians' service and under the direct supervision of the billing professional.

Direct Supervision by Interactive Telecommunications Technology
CMS proposes to allow direct supervision to be provided using real-time, interactive audio and video technology through the later end of the calendar year in which the PHE ends or December 31, 2021. This requires the supervising physician to be immediately available to engage via audio/video technology (excluding audio-only) and would not require real-time presence or observation of the service via interactive audio and video technology through the performance of the procedure. The agency is concerned that direct supervision through virtual presence may not be sufficient to support payment on permanent basis because of patient safety issues. CMS is seeking comment as to whether there should be any additional "guardrails" or limitations to sure patient safety/clinical appropriateness beyond typical clinical standards, as well as restrictions to prevent fraud or inappropriate use if this policy is finalized on a temporary basis.

Practice Expense (PE) - Market-Based Supply and Equipment Pricing Update (p. 50)
The Protecting Access to Medicare Act (PAMA) of 2014 provided for the Secretary to collect or obtain information from any eligible professional or any other source on the resources directly or indirectly related to delivering MPFS services. The information collected may include the time involved in furnishing services; the amounts, types and prices of PE inputs; overhead and accounting information for practices of physicians and other supplies; and any other elements under the PFS. Under this PAMA authority, CMS hired a contractor to conduct a market research study to update the direct PE inputs. These changes are being phased in over a four year period that begin in CY 2019. For CY 2021, the agency received invoice submissions for a dozen supply and equipment codes from stakeholders as part of the third year of this update and are proposing to update the a number of supply and equipment codes. The proposed updated included in Table 7 were calculated based on averaging together the prices of the submitted invoices.

TABLE 7: Proposed CY 2021 Market-Based Supply and Equipment Pricing Updates

CMS CODE	Description	CMS 2020 Price	Prior CMS 2022 Price	Prior CMS 2021 Price	Updated CMS 2022 Price	Updated CMS 2021 Price
SA105	UroVysion test kit	$153.040	$129.280	$141.160	$187.490	$170.265
SD089	guidewire, hydrophilic	$39.435	$43.370	$41.403	$13.350	$26.393
SD136	vascular sheath	$36.650	$52.800	$44.725	$24.444	$30.547
SD155	catheter, RF endovenous occlusion	$637.500	$550.000	$593.750	$382.500	$510.000
EQ041	Vmax 22d and 62j (PFT equip, autobox, computer system)	$47,930.000	$47,930.000	$47,930.000	$47,406.540	$47,668.270
ER044	nuclide rod source set	$1,783.167	$2,171.333	$1,977.250	$2,081.167	$1,932.167

Practice Expense - Update on Technical Expert Panel Related to Practice Expense (p. 64)
CMS contracted with the RAND Corporation to study potential improvements to CMS' PE allocation methodology and the data that underlie it. Currently, the PE RVUs are based in part in the Physician Practice Information Survey administered by the American Medical Association in 2007 and 2008. RAND has concluded that the PPIS data are outdated. Their study found that practice ownership was strongly associated with indirect PE, with physician-owned practices requiring 190% higher indirect PE compared to facility-owned practices. It also found that aggregating Medicare provider specialties into broader

categories resulted in small specialty-level impacts relative to the current system, suggesting that specialty-specific inputs may not be required to accurately reflect resource codes.

Earlier this year, RAND convened a technical expert panel (TEP) to obtain stakeholder input on issues ranging from identifying issues with the current system; changes in medicine that have affected PE; how PE inputs could be updated; how to best aggregate PE categories in a new survey instrument; ways to maximize response rates in a potential survey; and using existing data to inform MPFS PE rates.

Based on the results of the TEP and RAND's ongoing research, CMS is interest in potentially refining the PE methodology and updating the data used to make MPFS payments. The agency is considering how to best incorporate market-based information and how to update the clinical labor data. Specifically, CMS is interested in whether the data from the Bureau of Labor Statistics is the best source for this data. The agency will be holding a Town Hall meeting to discuss this topic.

Care Management Services and Remote Physiologic Monitoring Services (p. 129)

CMS proposes a number of code refinements related to remote physiologic monitoring (RPM), transitional care management (TCM), and psychiatric collaborative care model (CoCM) services to improve payment for care management services.

Digitally Stored Data Services/Remote Physiologic Monitoring/Treatment Management Services (RPM)

For CY 2021, CMS clarifies how they read CPT code descriptors and instructions associated with CPT codes 99453, 99454, 99091, and 99457 (and the add-on code, CPT code 99458) and their use to describe remote monitoring of physiologic parameters of a patient's health. CPT codes 99453 and 99454 are PE only codes. For the latter code, the agency clarifies that the medical device or devices that are supplied to the patient to collect the data are considered equipment and are direct PE inputs for the code.

The devices included in these codes must be a device as defined the Food and Drug Administration (FDA) but is not required to be cleared by the agency. There is also no requirement that the device be prescribed by a physician. CMS does clarify that the medical device in CPT code 99454 should digitally upload patient physiologic data; be reasonable and necessary for the diagnosis or treatment of the patient; and be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient's health status to develop and manage a plan of treatment.

The whole family can only be billed by physicians or nonphysician practitioners who are eligible to bill Medicare for E/M services. CMS further clarifies that these services may be furnished to remotely collect and analyze physiologic data from patients with acute as well as chronic conditions.

CPT code 99091 includes only professional work and has no direct PE input, therefore, this service can only be those providers who can bill Medicare directly, not clinical staff. CPT codes 99457 and 99458 describe the treatment and management services associated with RPM.

CMS proposes to make two of its interim RPM policies – to allow consent to be obtained at the time the RPM service is furnished and to allow auxiliary personnel to furnish the services described by CPT codes 99453 and 99454 under the general supervision of the billing practitioner – permanent. However, only established patients will be eligible to receive these services once the PHE ends.

In the response to the executive order titled "Regulatory Relief to Support Economic Recovery," CMS is seeking comment 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, specifically whether they should consider establishing coding and payment rules that would allow practitioners to bill for RPM services with shorter monitoring periods. The agency is interested in 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.

Transitional Care Management (TCM)
CMS is proposing to remove 14 additional actively priced HCPCS codes from the list of remaining HCPCS codes that cannot be billed concurrently with TCM as well as to allow the new Chronic Care Management HCPCS code G2058 to be billed concurrently with TCM when reasonable and necessary. The minutes counted for the TCM services cannot also be counted towards other services. See Table 15 for the full list of services CMS is proposing that can be billed concurrently with TCM services.

TABLE 14: 15 Additional Codes That Could Be Billed Concurrently with TCM

Code Family	CPT Code	Descriptor
End Stage Renal Disease Services (for ages less than 2 months through 20+ years)	90951	ESRD related services with 4 or more face-to-face visits per month; for patients <2 months of age
	90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2-11 years
	90955	ESRD related services with 2-3 face-to-face visits per month; for patients 2-11 years
	90956	ESRD related services with 1 face-to-face visit per month; for patients 2-11 years
	90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12-19 years
	90958	ESRD related services with 2-3 face-to-face visits per month; for patients 12-19 years
	90959	ESRD related services with 1 face-to-face visit per month; for patients 12-19 years
	90963	ESRD related services for home dialysis per full month; for patients <2 years of age
	90964	ESRD related services for home dialysis per full month; for patients 2-11 years
	90965	ESRD related services for home dialysis per full month; for patients 12-19 years
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90967	ESRD related services for dialysis less than a full month of service; per day; for patients <2 years of age
	90968	ESRD related services for dialysis less than a full month of service; per day; for patients 2-11 years
	90969	ESRD related services for dialysis less than a full month of service; per day; for patients 12-19 years
Complex Chronic Care Management Services	G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month

Scope of Practice and Related Issues (p. 181)
CMS believes the proposed policies outlined in this section will ensure that health professionals are able to provide services to beneficiaries in accordance with their scope of practice and state licensure, and may help to address physician shortage issues in the country, as well as help to alleviate the opioid crisis.

Teaching Physician and Resident Moonlighting Policies
CMS is considering whether the following policies, implemented in the March 31 and May 1 IFCs, should be extended on a temporary basis, until December 31, 2021, or be made permanent once the PHE concludes. CMS is seeking public comment on how this would support patient safety; ensure burden reduction without creating risks to patient care or increasing fraud; avoid duplicative payment between the PFS and the IPPS for GME programs; and support emergency preparedness. CMS asked specifically for stakeholders to share data and experiences with these policies during the PHE.

- Supervision of Residents in Teaching Settings through Audio/Video Real-Time Communications Technology

CMS finalized that for the duration of the PHE, the teaching physician could be present virtually through audio/video real-time communication technology, during a portion of the patient visit or interpretation of diagnostic radiology or test. This policy requires the teaching physician to observe through audio and video technology, not audio-only technology. Under the Primary Care Exception (PCE), CMS finalized that the teaching physician could review the services furnished by the resident during or immediately following the visit using audio/video real-time communications technology. CMS asked for specific clinical scenarios under which residents could furnish certain types of services under the supervision of a teaching physician using communications technology.

- Virtual Teaching Physician Presence during Medicare Telehealth Services

CMS finalized, on a temporary basis, policy which allows Medicare to make payment under the PFS for teaching physician services when a resident furnishes Medicare telehealth services to beneficiaries while a teaching physician is present using audio/video real-time communications technology.

- Resident Moonlighting in the Inpatient Setting

CMS finalized that, for the duration of the PHE, the services performed by residents that are not related to their approved Graduate Medical Education (GME) programs and are furnished to inpatients of a hospital in which they have their training program are separately billable physicians' services for which payment can be made under the PFS. CMS specified that these services must be separately identified from the services that are required as part of the approved GME program. CMS is concerned that there may be risks to program integrity, such as duplicate Medicare payment for the resident's services under the Inpatient Prospective Payment System for GME and the MPFS.

Pharmacists Providing Services Incident to Physicians' Services
In this proposed rule, CMS is clarifying that pharmacists may provide services "incident to" the services of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit. CMS believes this clarification may relieve burden on physicians and NPPs and increase access to medication management services for beneficiaries with chronic conditions. CMS also noted that this clarifies the ability of pharmacies to enroll as laboratories and work with physicians in the assessment of clinical information, specimen collection and reporting results of COVID-19 clinical diagnostic laboratory tests (CDLTs).

Medical Record Documentation
CMS is clarifying that physicians and NPPs, 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 MPFS. Residents and students working under a physician or practitioner who furnishes and bills directly for their services to the Medicare program, may also document in the record as long as it is reviewed and verified by the billing physician, practitioner, or therapist.

Updates to Certified Electronic Health Record Technology (CEHRT) due to the 21st Century Cures Act Final Rule (p. 558)
The American Recovery and Reinvestment Act of 2009 (ARRA) authorized incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs), and Medicare Advantage (MA)

organizations to promote the adoption and meaningful use of CEHRT. Since ARRA's enactment, the Office of the National Coordinator for Health Information Technology (ONC) launched the Health IT Certification Program (Certification Program) to provide for the certification of health IT and in May 2020, the 21st Century Cures Act final rule finalized a number of updates to the 2015 Edition of health IT certification criterion to enhance interoperability and patients' access to their electronic health information.

In this proposed rule, CMS is proposing to require that technology used to meet the CEHRT definitions must be certified in accordance with the updated certification criteria in the 21st Century Cures Act final rule. CMS also proposes that healthcare providers participating in the Promoting Interoperability Programs and the QPP would be required to use only technology that is considered certified under the ONC Health IT Certification Program according to the timelines finalized in the 21st Century Cures Act final rule. Specifically, program participants and health providers have until August 2, 2022 (27 months from May 2020) to work with their health IT developers to plan for implementing CEHRT that meets the 2015 Edition Cures Update, as soon as health IT developers make updated technology available.

Quality Payment Program (QPP) (p. 592)

Overview
CMS is continuing a transition period of building on the first years of implementation of the QPP to better focus measurement efforts and to reduce barriers to entry into advanced APMs. The agency continues to develop QPP policies that more effectively reward high-quality treatment of patients and increase opportunities for advanced APM participation. CMS is moving forward with the MIPS Value Pathways (MVPs) policy development, which was proposed in last year's rule. Due to the COVID-19 PHE, the proposal for initial MVPs will be delayed until at least the 2022 performance year.

MIPS Program Details---MIPS Value Pathways (p. 604)
CMS proposes updates to the MVP guiding principles to incorporate feedback from last year's proposed rule. The first guiding principle will be modified by adding wording to further emphasize that MVP measures and activities are linked collectively; specifically, by adding the words "connected, complementary" to describe the MVP "sets of measures and activities that are meaningful to clinicians." The phrase "simplify scoring" will change to "align scoring" to better express the intent of the MVPs. The second guiding principle will be revised to specify allowing the option of subgroup reporting to MVPs, which would permit subgroups of clinicians to select relevant MVPs to report measures and activities that are meaningful to their practice. This would allow for multispecialty practices to better participate in MVPs. The third guiding principle will be revised to say that MVP measures should be selected to include the patient voice whenever possible. A reference to the Meaningful Measures framework to inform MVP measure selection will also be added.

The agency proposes to add a fifth guiding principle on the use of digital performance measure data submission technologies to reduce provider burden. It would state, "MVPs should support the transition to digital quality measures."

CMS requests feedback on the following proposed criteria to develop and select MVPs with stakeholder input:

- Utilization of measures and activities across performance categories:
    - MVPs should include measures and activities from the Quality, Cost, and Improvement Activities performance categories.
    - MVPs should include the entire set of Promoting Interoperability (PI) measures.

- Intent of measurement:
    - What is the intent of the MVP?
    - Is the intent of the MVP the same at the individual clinician and group level?
    - Are there opportunities to improve the quality of care and value in the area being measured?
    - Why is the topic of measurement meaningful to clinicians?
    - Does the MVP act as a vehicle to incrementally phase clinicians into APMs? How?
    - Is the MVP reportable by small and rural practices? Does the MVP consider reporting burden to those small and rural practices?
    - Which Meaningful Measure Domain(s) does the MVP address?
- Measure and activity linkages with the MVP:
    - How do the measures and activities within the proposed MVP link to one another? (For example, do the measures and activities assess different dimensions of care provided by the clinician?)
    - Are the measures and activities related or a part of the care cycle or continuum of care offered by the clinicians?
    - Why are the measures and activities most meaningful to the specialty?
- Appropriateness:
    - Is the MVP reportable by multiple specialties? If so, has the MVP been developed collaboratively across specialties?
    - Are the measures clinically appropriate for the clinicians being measured?
    - Do the measures capture a clinically definable population of clinicians and patients?
    - Do the measures capture the care settings of the clinicians being measured?
    - Prior to incorporating a measure in an MVP, is the measure specification evaluated, to ensure that the measure is inclusive of the specialty or sub-specialty?
- Comprehensibility:
    - Is the MVP comprehensive and understandable by the clinician or group?
    - Is the MVP comprehensive and understandable by patients?
- Incorporation of the patient voice:
    - Does the MVP take into consideration the patient voice? How?
    - Does the MVP take into consideration patients in rural and underserved areas?
    - How are patients involved in the MVP development process?
    - To the extent feasible, does the MVP include patient-reported outcome measures, patient experience measures, and/or patient satisfaction measures?
- Measures and improvement activities considerations: MIPS quality measures
    - CMS is not being prescriptive on the number of quality measures that are included in an MVP. In selecting quality measures, consideration should be given to the following:
        - Do the quality measures included in the MVP meet the existing quality measure inclusion criteria? (For example, does the measure demonstrate a performance gap?)
        - Have the quality measure denominators been evaluated to ensure the eligible population is consistent across the measures and activities within the MVP?
        - Have the quality measure numerators been assessed to ensure the measure is applicable to the MVP topic?

        - To the extent feasible, does the MVP include outcome measures, or high priority measures in instances where outcome measures are not available or applicable?
        - To the extent feasible, does the MVP include electronically specified clinical quality measures?
        - To the extent feasible, does the MVP avoid including quality measures that are topped out?
        - What collection types are the measures available through?
        - What role does each quality measure play in driving quality care and improving value within the MVP? Provide a rationale as to why each quality measure was selected.
        - How do the selected quality measures relate to other measures and activities in the other performance categories?
        - To the extent feasible, specialty and sub-specialty specific quality measures are incorporated into the MVP. Broadly applicable (cross-cutting) quality measures may be incorporated if relevant to the clinicians being measured.
- Measures and improvement activities considerations: cost measures
    - What role does the cost measure(s) play in driving quality care and improving value within the MVP? Provide a rationale as to why each cost measure was selected.
    - How does the selected cost measure(s) relate to other measures and activities in other performance categories?
    - If there are not relevant cost measures for specific types of care being provided (for example, conditions or procedures), does the MVP include broadly applicable cost measures that are applicable to the type of clinician?
    - What additional cost measures should be prioritized for future development and inclusion in the MVP?
- Measures and improvement activities considerations: improvement activities
    - What role does the improvement activity play in driving quality care and improving value within the MVP? Provide a rationale as to why each improvement activity was included.
    - Describe how the improvement activity can be used to improve the quality of performance in clinical practices for those clinicians who would report this MVP.
    - Does the improvement activity complement and/or supplement the quality action of the measures in the MVP, rather than duplicate it?
    - To the extent feasible, does the MVP include improvement activities that can be conducted using CEHRT functions? The use of improvement activities that specify the use of technologies will help to further align with the CEHRT requirement under the Promoting Interoperability performance category.
    - If there are not relevant specialty or sub-specialty specific improvement activities, does the MVP includes broadly applicable improvement activities (that is applicable to the clinician type) are used?
- Measures and improvement activities considerations: promoting interoperability measures
    - Must include the full set of PI measures.

CMS proposes that stakeholders developing MVPs are required to include patients as part of the candidate MVP development process. This can be done through advisory committees, technical expert panels, focus groups, or other methods to incorporate the patient perspective. CMS requests comments on this proposal.

The agency believes it is important to implement a streamlined approach to receive and evaluate potential MVPs. To do this, CMS proposes that stakeholders should formally submit their MVP candidates using a standardized template, including information on how the candidate MVP fits the development criteria and rationales for choosing specific measures and activities. The agency will host a public MVP develop webinar each year to continue to engage stakeholders. If a candidate MVP is selected as feasible, the agency will schedule follow-up discussions with the stakeholders who submitted the MVP and will work together to develop the MVP. All MVPs must be established through rulemaking. CMS requests comment on this process, and suggestions to increase transparency.

CMS is still considering how to best include population health measures calculated from administrative claims-based data as part of the foundational layer of MVPs. The agency proposes that only qualified clinical data registry (QCDR) measures that were approved in the prior year may be considered for inclusion with candidate MVPs, and must meet the existing criteria for QCDRs in MIPS. The agency will allow third party intermediaries who support other quality reporting programs to support MVPs, since this will allow clinicians and groups additional reporting methods.

Due to the COVID-19 PHE, CMS is delaying the implementation of MVPs and will revisit potential MVP implementation through future rulemaking, potentially beginning with the 2022 performance period.

APM Performance Pathway (p. 627)
In order to reduce reporting burden and encourage continued APM participation, CMS proposes to establish an APM Performance Pathway (APP) under MIPS beginning in the 2021 MIPS performance year. The APP would be an optional MIPS reporting and scoring pathway for MIPS eligible clinicians identified on the APM's Participation List or Affiliated Practitioner List of an APM Entity that is participating in any MIPS APM. Individual eligible clinicians who are participants in MIPS APMs would be able to report through the APP at the individual level. Groups and APM Entities may report through the APP on behalf of their constituent MIPS eligible clinicians, but the final score earned by the group will only apply to eligible clinicians. The final score applied to each individual MIPS eligible clinician will be the highest available final score for that clinician (TIN/NPI) or a Virtual Group score, if applicable. CMS requests comment on this proposal.

The agency proposes to amend the definition of MIPS APM, and to codify the following criteria. Two existing criteria will be maintained, that an APM Entity participates in the APM under an agreement with CMS or through a law or regulation; and that the APM bases payment on quality measures and cost/utilization. CMS proposes to expand the definition to include those APMs that use only an Affiliated Practitioner List and meet the other criteria. CMS request comment on this proposal.

The following reporting and scoring rules would only apply to individuals or entities reporting through the APP. CMS proposes that beginning in the 2021 performance year (PY), MIPS eligible clinicians scored under the APP would be scored on the quality measure set finalized for that performance period. For PY 2021, the proposed measures are listed in the below table.

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience

Quality ID: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Management of Chronic Conditions
Quality ID: 134	Preventive Care and Screening for Depression and Follow-up	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID: 236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Management of Chronic Conditions
Measure # TBD	Hospital-Wide 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions

CMS proposes to remove any measure that is unavailable to MIPS eligible clinicians, groups, or Entities due to the size of the patient population or inability to meet the minimum case threshold. The agency proposes to not apply the quality measure scoring cap in the event that a measure in the APP measure set is topped out, as the measure set is fixed and will only be changed through future rulemaking.

CMS proposes to waive the cost performance category for the APP, which is aligned with the approach taken with CMS Innovation Center APMs and the Medicare Shared Savings Program.

CMS proposes to align a score for the Improvement Activities performance category for each MIPS APM, and that score will be applied to participant MIPS eligible clinicians reporting through the APP. The agency proposes to assign a baseline score for each MIPS APM based on the improvement activity requirements of the particular MIPS APM. CMS would review the MIPS APM's requirements in relationship to activities specified under the generally applicable MIPS improvement activities performance category and assign a score that is applicable to all clinicians reporting through the APP who are participants in the MIPS APMs. The agency would publish the assigned improvement activities scores for each MIPS APM on the CMS website prior to the start of the MIPS performance period.

CMS proposes that the Promoting Interoperability performance category score would be reported and calculated in the same manner as under the MIPS program. The agency seeks comment on the proposals related to each category.

CMS proposes to continue to waive the requirement to weight each MIPS performance category in the same manner as MIPS, as is done for the Innovation Center APMs and the Shared Savings Program. The agency proposes to reweight the performance categories for the APP to:

Quality	50 percent
Cost	0 percent
Promoting Interoperability	30 percent
Improvement Activities	20 percent

In certain circumstances, it may be necessary to reweight a performance category. If the Promoting Interoperability category is reweighted to 0, then the Quality category would be reweighted to 75 percent and the Improvement Activities category to 25 percent. If the Quality category is reweighted to 25 percent, the Promoting Interoperability category would be reweighted to 75 percent and the Improvement Activities category to 25 percent.

CMS proposes to use the same methodology as established for MIPS generally to determine final scores for the APP. The agency would continue to score each performance category and multiple the score by the applicable category weight, then calculate the sum of each weighted category score and apply any applicable adjustments. The agency also proposes to make performance feedback available to all APP participants in the same manner as applies to all MIPS eligible clinicians.

MIPS Performance Category Measures and Activities (p. 638)
CMS proposes the following policies for the Quality performance category:

- Weigh the quality performance category at 40 percent for the 2023 MIPS payment year and 30 percent for the 2024 MIPS payment year;
- Sunset the CMS Web Interface measure as a collection type for groups and virtual groups with 25 or more eligible clinicians starting with the 2021 performance period;
- Make changes to the MIPS quality measure set as described in Appendix I, including additions of new measures, updates to specialty sets, removal of existing measures, and substantive changes to existing measures;
- Establish separate performance periods specific to administrative claims;
- Make changes to the CAHPS for MIPS survey to address the increased use of telehealth by integrating one telehealth item into the CAHPS for MIPS survey that assesses patient-reported usage of telehealth services; and
- Expand telehealth codes used in beneficiary assignment for the CAHPS for MIPS beginning with the 2021 survey.

CMS proposes to weight the Cost performance category at 20 percent for MIPS payment year 2023 and 30 percent for MIPS payment year 2024 and all subsequent years. The agency considered maintaining the Cost performance category weight at 15 percent for the 2023 payment year and then increasing it to 30 percent for the 2024 payment year. The agency requests comment on the proposal and other options to consider. For the 2021 performance period, CMS proposes to add costs associated with telehealth services to the previously established cost measures. The telehealth services that the agency proposes to add are directly relevant to the intent of each cost measure, so they are not considered a new category of costs.

For the Improvement Activities performance category, beginning in the CY 2021 performance period, CMS proposes the following:

- Changes to the Annual Call for Activities, including an exception to the nomination period timeframe during a PHE and a new criterion for nominating new improvement activities;

- Creation of a process for HHS-nominated improvement activities; and
- Modifications to two existing improvement activities, as seen in Appendix B.

For the 2024 MIPS payment year, CMS proposes to establish a performance period for the Promoting Interoperability performance category of a minimum of a continuous 90-day period within the calendar year that occurs two years prior to the applicable payment year. This would align with the proposed EHR reporting period for the CY 2022 Medicare Promoting Interoperability Program. The agency also proposes for the performance period in CY 2021 to maintain the Electronic Prescribing objective's Query of PDMP measure as an optional measure, and to increase the amount of bonus points associated with the measure from 5 points to 10 points.

CMS makes several proposals related to the Health Information Exchange (HIE) objective of the Promoting Interoperability performance category. The agency proposes to rename the "Support Electronic Referral Loops by Receiving and Incorporating Health Information measure" to "Support Electronic Referral Loops by Receiving and *Reconciling* Health Information measure." CMS also proposes an alternative measure for bidirectional exchange through a HIE under the HIE objective. The Bi-Directional Exchange measure would replace two existing measures, would be worth 40 points, and would be reported by attestation. The agency requests comments on these proposals, and whether the new optional measure will incentivize eligible clinicians to participate in HIE's while establishing a high-performance standard for sharing information with other clinicians.

The below table sets out the proposed scoring methodology for the performance period in CY 2021 for the Promoting Interoperability performance category.

Objective	Measure	Maximum Points
Electronic Prescribing	e-prescribing	10 points
	Bonus: Query of PDMP	10 points (bonus)
Health Information Exchange OR	Support electronic referral loops by sending health information	20 points
	Support electronic referral loops by receiving and reconciling health information	20 points
Health Information Exchange (alternative)	HIE Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide patients electronic access to their health information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reopening	10 points

APM Entity Groups and APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs (p.694)

Due to feedback on the complexity of the APM scoring standard and its inflexibility in adopting to changes in APM participation and design, CMS proposes to terminate the APM scoring standard effective January

1, 2021. The APP discussed earlier and its scoring rules will replace the APM scoring standard. The agency proposes to retain certain APM Entity group reporting policies established for reporting and scoring. CMS will also allow MIPS eligible clinicians to move into or out of APM Entities late in the performance year, which will end the use of the full-TIN APM policy.

MIPS Final Score Methodology (p. 701)
For the 2023 performance year, CMS will build on the existing scoring methodology, which allows for accountability and alignment across the performance categories and minimizes burden on clinicians. The agency is maintaining many existing scoring policies, with the following proposed changes:

- Implement scoring flexibility for quality measures with specification or coding changes during the PY;
- Implement benchmark and topped out scoring policies that are responsive to potential low reporting rates for the 2019 PY due to the COVID-19 PHE;
- Implement scoring for all administrative claims-based measures;
- Continue policies for scoring quality measures based on achievement as well as policies for measures that do not meet case minimum, data completeness requirements, or have a benchmark;
- Continue bonuses in the quality performance category; and
- Continue improvement scoring of the quality performance category comparing clinicians to a 30 percent baseline score if clinicians scored 30 percent or less.

CMS is not proposing changes to scoring polices for the cost, improvement activities and promoting interoperability performance categories. The agency is maintaining the approach that MIPS eligible clinicians are scored against performance standards for each performance category and receive a final score, comprised of their performance category scores and calculated with the final score methodology. The below table summarizes the proposed policies for the CY 2021 MIPS Performance Period for the Quality performance category:

Measure Type	Description	Scoring rule for Traditional MIPS
Class 1	Measures that can be scored based on performance. Measures that are submitted or calculated that meet all the following criteria: 1. Has a benchmark; 2. Meets case minimum; and 3. Meets the data completeness standard (generally 70 percent for 2021)	For the 2021 MIPS performance period: 3 to 10 measure achievement points based on performance compared to the benchmark.
Class 2	For the 2020 MIPS performance period: Measures that are submitted and meet data completeness, but do not have either of the following: 1. A benchmark; and 2. Meets case minimum.	For the 2021 MIPS performance period, 3 measure achievement points.
Class 3	Measures that are submitted but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum.	Beginning with the 2020 MIPS performance period: MIPS eligible clinicians other than small practices will receive zero points for this

		measure. Small practices will continue to receive 3 points.

CMS proposes to continue the complex patient bonus for the 2023 MIPS payment year, and to modify the complex patient bonus for the 2022 MIPS payment year due to the COVID-19 PHE. The agency also proposes performance category redistribution policies for the 2023, 2024 and future payment years. The below table summarizes the proposed weights for each performance category:

Performance Category	2023 MIPS Payment Year	2024 and Future MIPS Payment Years
Quality	40%	30%
Cost	20%	30%
Improvement Activities	15%	15%
Promoting Interoperability	25%	25%

The below table summarizes the proposed redistribution policies for the 2023 MIPS payment year:

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
-Scores for all four performance categories	40%	20%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	65%	20%	15%	0%
-No Quality	0%	20%	15%	65%
-No Improvement Activities	55%	20%	0%	25%
Reweight Two Performance Categories				
-No Cost and No Promoting Interoperability	85%	0%	15%	0%
-No Cost and No Quality	0%	0%	15%	85%
-No Cost and No Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and No Quality	0%	50%	50%	0%
-No Promoting Interoperability and No Improvement Activities	80%	20%	0%	0%
-No Quality and No Improvement Activities	0%	20%	0%	80%

MIPS Payment Adjustments (p. 732)

CMS proposes to make several revisions to policies regarding the final score hierarchy used to determine MIPS payment adjustments:

- To reflect the discontinuation of the APM scoring standard and the addition of the APP;
- To reduce the performance threshold from 60 points to 50 points for the 2023 MIPS payment year; and
- To potentially revisit the prior estimate of the performance threshold for the 2024 MIPS payment year due to the impact of the COVID-19 PHE.

Review and Correction of MIPS Final Score (p. 744)

Due to the COVID-19 PHE, CMS may provide performance feedback after July 1, 2020. The agency aims to provide performance feedback on or around July 1 of each year, but this year will more likely provide feedback by late July or early August.

Third Party Intermediaries (p. 745)
For third party intermediaries generally, CMS proposes to clarify requirements of QCDRs, qualified registries, and health IT vendors with regards to submitting data for MIPS, particularly for third party intermediaries who are interested in supporting MVPs in the future. The agency will also consider past failure to comply with program requirements or provision of inaccurate information when determining if a third-party intermediary may participate in the MIPS program.

For QCDRs, CMS proposes policies on data validation audits and targeted audits, and measure requirements.

Public Reporting on Physician Compare (p. 781)
In order to more completely and accurately reference the website for which CMS will post information available for public reporting, CMS proposes to define Physician Compare at §414.1305 to mean the Physician Compare Internet website of CMS, or a successor website.

APM Incentive Payment (p. 782)
Under the QPP, Qualifying APM participants (QPs) receive a 5 percent APM Incentive Payment in years 2019 through 2024. CMS proposes to clarify that the APM Incentive Payment amount is calculated based on the paid amount of the applicable claims for covered professional services that are subsequently aggregated to calculate the estimated aggregate payments. This does not include amounts that were allowed but not actually paid by Medicare. Certain payments and adjustments, including the MIPS payment adjustments, are excluded when calculating the Incentive payment amount.

CMS proposes to establish a revised approach to identifying the TIN(s) to which the agency makes the APM Incentive payment. This approach would involve looking at a QP's relationship with their TIN(s) over time, as well as considering the relationship the TIN(s) have with the APM Entity or Entities through which the eligible clinician earned QP status, or other Entities the QP may have joined in the interim. The agency also proposes to introduce a cutoff date of November 1 of each payment year, or 60 days from the day when CMS makes the initial round of APM Incentive payments (whichever is later) after which the agency will no longer accept new helpdesk requests from QPs or their representatives who have not received their payments. This change is intended to give CMS sufficient time to make disbursements of the APM Incentive payments.

For QP and partial QP determinations, CMS proposes to:

- Update the methodology for addressing prospectively assigned beneficiaries for Threshold Score calculations and QP determinations; and
- Establish a Targeted Review process for QP Determinations.

CMS provides clarification on policies on Advanced APM determinations and QP determinations in light of questions on the effect of the COVID-19 PHE. The agency is exercising its enforcement discretion to not reconsider the Advanced APM determinations of APMs which have already been evaluated and determined to meet the Advanced APM criteria for CY 2020. Furthermore, CMS will evaluate all APMs in future years with the understanding that any provisions of the Participating Agreement designed in response to the COVID-19 PHE will not be considered if they would prevent the APM from meeting the Advanced APM criteria for a year.

The following APMs are considered Advanced APMs for 2020:

- Bundled Payments for Care Improvement Advanced Model;

- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track);
- Comprehensive Primary Care Plus Model;
- Comprehensive ESRD Care Model;
- Maryland Total Cost of Care Model;
- Medicare Shared Savings Program;
- Medicare Accountable Care Organization (ACO) Track 1 + Model;
- Next Generation ACO Model;
- Oncology Care Model; and
- Vermont All-Payer ACO Model.

The agency seeks comment on whether to allow an APM Entity to make the Partial QP election on behalf of all of the APM Entity's participating eligible clinicians.

APPENDIX A

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%
Otolamgology	$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.

APPENDIX B

MIPS Measures

Each year CMS proposes changes to the MIPS measures set. The changes below apply to insert specialty members.

New Quality Measures Proposed for the 2023 MIPS Payment Year and Future Payment Years

- Hospital-wide, 30-day, All-Cause Unplanned Readmissions (HWR) Rate for the Merit-Based Incentive Program System (MIPS) Groups

Proposed Changes to Specialty Measure Sets for 2023 MIPS Payment Year and Future Payment Years

Allergy/Immunology --- Proposed for Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse): Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.	Process/Efficiency and Cost Reduction	American Academy of Otolaryngology—Head and Neck Foundation
Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use): Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.	Process/Efficiency and Cost Reduction	American Academy of Otolaryngology—Head and Neck Foundation
Optimal Asthma Control: Composite measure of the percentage of pediatric and adult patients whose asthma is well controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.	Outcome/Effective Clinical Care	Minnesota Community Measurement
Medication Management for People with Asthma: The percentage of patients 5-64 years of age during the performance period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	Process/Efficiency and Cost Reduction	National Committee for Quality Assurance

Otolaryngology—Proposed for Removal		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse): Percentage of patients aged 18 and older with a diagnosis of acute sinusitis who had a CT scan of the paranasal	Efficiency/Efficiency and Cost Reduction	American Academy of Otolaryngology

sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis.		

Quality Measure Proposed for Removal for the 2023 MIPS Payment Year and Future Payment Years

- All-Cause Hospital Readmission