

High-level Summary of the Combined 2021 Medicare Physician Fee Schedule (PFS) and MACRA Quality Payment Program (QPP) Final Rule

On December 1, 2020, the Centers for Medicare & Medicaid Services (CMS) [released](#) a Medicare annual payment rule for calendar year (CY) 2021 that impacts payments for physicians and other health care practitioners. The final rule combines policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program—the quality performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). CMS had issued a [proposed rule](#) in August, which ACEP responded to with a robust set of comments. Highlights of ACEP’s response are found [here](#). Below is a high-level summary of key final policies.

Physician Fee Schedule

- **Conversion Factor:** The Centers for Medicare & Medicaid Services (CMS) is finalizing a policy to increase the office and outpatient evaluation and management (E/M) services and add a new add-on code for complexity for these services in 2021. This decision, as well as some other technical refinements, results in a significant “budget neutrality” adjustment to the conversion factor. The budget neutrality requirement forces CMS to make an overarching negative adjustment to physician payments in order to offset any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare “conversion factor”—which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount. To preserve budget neutrality, CMS is reducing the conversion factor by **10.2 percent** in 2021 from \$36.09 to \$32.41—a slightly lower reduction that CMS estimated in the proposed rule (a 10.6 percent cut).
- **Emergency Medicine Reimbursement and Emergency Department (ED) E/M services:** The cut to the conversion factor will reduce reimbursement levels for all physicians and other health care practitioners. However, the actual impact of the cut on reimbursement depends on the codes that the physicians and other health care practitioners typically bill. As seen below, the total payment clinicians receive for a service depends on both the amount of RVUs for the service (which include work, practice expense, and malpractice RVUs) and the size of the conversion factor (as well as a geographic adjustment).

Total payment under the PFS = total RVUs x geographic adjustment x conversion factor

Therefore, for specialties that primarily bill the office and outpatient E/M codes, the magnitude of the increase in these code values outweighs the cut to the conversion factor—so overall these clinicians will expect to see an increase to their reimbursement in 2021. Most emergency physicians however do not bill office and outpatient E/M codes. Rather, they bill ED E/M services (CPT codes 99281 to 99285). Therefore, we would expect to see an overall cut to reimbursement for emergency physicians.

ACEP knew that the office and outpatient E/M policy would cause a significant across the board reduction in payment in 2021 and therefore made it a priority to offset some of that cut for emergency medicine. ACEP strongly advocated for CMS to increase the value of the ED E/M codes to appropriately align with the revised office and outpatient E/M code levels for new patients. **In the final rule, CMS is accepting our recommendation, and increasing ED E/M codes to match the values that we had specifically advocated for (found below).**

Work RVU Changes

Code	2021 RVWs	2020 RVWs	% chg.
99283	1.60	1.48	+12.68%
99284	2.74	2.60	+5.38%
99285	4.00	3.80	+5.26%

According to CMS, the increase in the value of these codes will cause your payments to bump up by approximately 2 percent (slightly lower than the 3 percent increase CMS estimated in the proposed rule). After taking into account this increase and other adjustments, **the overall reduction to emergency medicine is 6 percent, significantly less than the 10.2 percent cut to the conversion factor.** This is the same overall reduction to emergency medicine reimbursement that CMS initially estimated in the proposed rule.

ACEP is extremely disappointed that CMS is finalizing these cuts to emergency medicine reimbursement. In our [comments](#) on the proposed rule, we had outlined the effects that such a reduction would have on access to care—especially during the pandemic. We had also made specific recommendations to CMS on how it could eliminate or at least mitigate the reduction to emergency medicine reimbursement—none of which were incorporated into the final rule.

Now that the final rule has been released, the only way to prevent these devastating cuts from taking place is for Congress to act by passing legislation that holds physicians harmless. ACEP, along with a coalition of organizations representing more than 1 million physicians and allied health professionals, [support](#) including the “[Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020](#)” in any forthcoming year-end legislative package. The bill—introduced by Representatives Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN)—would temporarily maintain for the next two years physicians’ reimbursement in Medicare at 2020 levels if they were otherwise scheduled to receive a payment cut.

- **Telehealth:** In the rule, CMS examines which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 public health emergency (PHE) will remain on the list permanently. CMS breaks out the codes that it temporarily added to the list of approved telehealth services into three buckets:
 - BUCKET 1: Codes that CMS is proposing to be included on the list of approved telehealth services permanently.
 - BUCKET 2: Codes that CMS is proposing to be included on the list of approved telehealth services for the remainder of the calendar year in which the PHE ends (i.e. until December 31, 2021).
 - BUCKET 3: Codes that CMS is proposing to be removed from the list of approved telehealth services once the PHE ends.

CMS is finalizing its proposal to keep ED E/M code levels 1-3 (CPT codes 99281-99283) on the approved telehealth list for the remainder of the year after the PHE expires (i.e. Bucket 2).

In addition, based on our comments, CMS is ALSO including ED E/M levels 4 and 5

(CPT codes 99284 and 99285), critical care codes, and observation codes in Bucket 2 as well. CMS had initially proposed to eliminate these codes from the list of approved telehealth services once the PHE ends.

CMS does note that it still needs to see more data and evidence about the benefits of providing ED E/M, critical care, and observation services via telehealth in order to permanently add these codes to the list of approved telehealth services.

CMS is also extending some telehealth policies that are currently being implemented during the pandemic. For example, during the PHE, CMS has temporarily modified the direct supervision requirement to allow for the virtual presence of the supervising physician using interactive audio/ video real-time communications technology. In the rule, CMS is extending this policy until the end of the calendar year in which the PHE ends (December 31, 2021).

- **Payment for Medication Assisted Treatment (MAT) in the ED:** Due to ACEP's advocacy, CMS is finalizing a proposal to pay for MAT delivered in the ED starting in 2021. Specifically, CMS is creating an add-on code to be billed with E/M visit codes used in the ED setting. This code will include payment for assessment, referral to ongoing care, follow-up after treatment begins, and arranging access to supportive services. The add on code will have a work RVU value of 1.30, which is between a 99282 and 99283 (ED E/M code levels 2 and 3).
- **Scope of Practice:** CMS is finalizing a proposal to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians. CMS granted this flexibility during the COVID-19 PHE and now will be extending it permanently.
- **PFS Payment for Services of Teaching Physicians:** CMS is permanently extending a policy instituted during the COVID-19 PHE that allows teaching physicians to supervise residents remotely using telehealth (audio-visual) equipment. However, CMS is limiting this policy to residency training sites of a teaching setting that are outside of a metropolitan statistical area (MSA).

Further, CMS permanently expanded the settings in which residents may moonlight to include the services of residents that are not related to their approved graduate medical education programs and which are furnished to inpatients of a hospital in which they have their training program.

- **Electronic Prescribing of Controlled Substances:** CMS is implementing a provision of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires electronic prescribing of controlled substances (EPCS) under Medicare Part D. To help inform CMS's implementation of this requirement, the agency issued a Request for Information, which ACEP responded to (see our comments [here](#).) CMS had proposed to require EPCS by January 1, 2022 (a delay of one year from the statutorily required date of January 1, 2021) to allow for sufficient time to implement feedback from the Request for Information and to help ensure that the agency is not burdening clinicians during the COVID-19 pandemic. **However, based on comments received, CMS is finalizing the program with an effective date of January 1, 2021 and a compliance date of January 1, 2022 to encourage prescribers to implement EPCS as soon as possible.**

- **Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs):** In last year’s rule, CMS implemented a new Medicare benefit for the treatment of opioid use disorder (OUD) furnished by Opioid Treatment Programs (OTPs). In doing so, CMS established new codes describing the bundled payments for certain episodes of care that include methadone, oral buprenorphine, implantable buprenorphine, injectable buprenorphine or naltrexone, and non-drug episodes of care, as well as add-on codes for intake and periodic assessments, take-home dosages for methadone and oral buprenorphine, and additional counseling. In this year’s rule, CMS is finalizing several refinements to the new benefit. One of the new policies is to expand the definition of OUD treatment services to include opioid antagonist medications, such as naloxone. It is important to remember that this benefit only applies to services delivered by OTPs. ACEP continues to believe that at least some of these services should also be paid for when delivered in the ED, such as the administration of naloxone.
- **Medicare Shared Savings Program:** The Medicare Shared Savings Program (MSSP) is the national accountable care organization (ACO) program. CMS is finalizing changes to the MSSP quality performance standard as well as to its quality reporting requirements to align with CMS’ Meaningful Measures initiative and reduce reporting burden. Further, CMS is finalizing refinements to the list of codes that are used to assign beneficiaries to ACOs and altering the methodology for determining shared savings and shared losses based on ACO quality performance.

Quality Payment Program

CMS finalizes policies that impact the fifth performance year (2021) of the Quality Payment Program (QPP). The QPP includes two tracks: [the Merit-based Incentive Payment System \(MIPS\)](#) and Advanced Alternative Payment Models (APMs).

MIPS Policies

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2021 will impact Medicare payments in 2023).

The first five years of MIPS include some flexibilities that allow for a transition into the Program. In this year’s rule, CMS is delaying the new MIPS Values Pathway (MVP) framework that CMS originally intended to begin in 2021. Further, CMS finalizes numerous other changes to MIPS, including to the four performance categories and their associated weights, the overall performance threshold, and reporting requirements for qualified clinical data registries (QCDR)—which directly affect ACEP’s QCDR the [Clinical Emergency Data Registry \(CEDR\)](#).

- **2020 Reporting Exemptions Due to COVID-19:** As described [here](#), CMS is granting hardship exemptions on a case-by-case basis due to COVID-19. It is therefore possible for a clinician or group to request to be exempted from all four performance categories in 2020. If clinicians submit a hardship exception application for all four MIPS performance categories, and their application is approved, they will be held harmless from a payment adjustment in 2022—meaning that they will not be eligible for a bonus or potentially face a penalty based on their MIPS performance in 2020. **CMS will also be extending this hardship exception policy into 2021 as well.**

To account for the additional complexity of treating patients due to COVID-19, CMS is finalizing a proposal to double the complex patient bonus for the 2020 performance period only. Clinicians would be able to earn up to 10 bonus points instead of 5 bonus points.

- **MIPS Value Pathways (MVP) Delay:** CMS has heard feedback, including from ACEP, that MIPS reporting should be streamlined and more meaningful to clinicians. Therefore, CMS proposed in last year's rule to create the MIPS Value Pathways (MVPs), an approach that would allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. CMS previously indicated that it would propose the first set of MVPs in this rule, so that some MVPs could be implemented in 2021.

However, due to the COVID-19 pandemic, CMS is not implementing any MVPs for 2021 in this year's rule. Rather, CMS is postponing MVPs to at least 2022 and finalizes some revisions to the MVP guiding principles that CMS established in last year's rule. ACEP is working on developing an emergency-medicine focused MVP.

- **APM Performance Pathway:** CMS is finalizing its proposal to create a new, complementary pathway to MVPs that will be available for clinicians who participate in APMs and who must still report in MIPS. The APM Performance Pathway (APP) will be required for participants in the MSSP. The APP, like an MVP, is comprised of a fixed set of measures for each performance category. The Cost performance category will be weighted at 0 percent and the Improvement Activity performance category score will be automatically assigned to the APM. All APM participants reporting the APP will earn a score of 100 percent for the 2021 performance period. The Promoting Interoperability performance category will be reported and scored as required for the rest of MIPS. The Quality performance category will be comprised of 6 measures designed specifically focused on population health and believed to be widely available to all MIPS APM participants.

CMS is NOT finalizing its proposal to eliminate the CMS Web Interface as a collection type submission type beginning with the 2021 performance period. Instead, CMS will keep the CMS Web Interface as a collection type submission type through 2021.

- **Performance Category Weighting in Final Score:** As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. Under current law, CMS has the flexibility to keep the Cost category percentage less than 30 percent until 2022, when this category is required to have a 30 percent weight. In the rule, CMS is finalizing its performance cost weighting proposals.

General Performance Category Weights Finalized for 2021:

- **Quality: 40% (down from 45% in 2020)**
- **Cost: 20% (up from 15% in 2020)**
- Promoting Interoperability (EHR): 25% (same as 2020)
- Improvement Activities: 15% (same as 2020)

General Performance Category Weights Finalized for 2022:

- **Quality: 30%**
- **Cost: 30%**
- Promoting Interoperability (EHR): 25%
- Improvement Activities: 15%

- **Performance Threshold:** The performance threshold is the point total a clinician must surpass to be eligible for an upward payment adjustment (bonus). CMS is increasing the performance threshold from 45 points in 2020 to **60 points** in 2021. CMS had initially proposed to increase it to 50 points, but ultimately decided to finalize a higher threshold. CMS recognizes that not all practices have been impacted by COVID-19 to the same extent and many clinicians have been able to successfully participate in MIPS.

There is also an additional performance threshold that is applied to reward clinicians for exceptional performance. Clinicians who surpass this threshold can receive an additional bonus on top of their upward payment adjustment. CMS is will be maintaining the exceptional bonus threshold at **85 points** in 2021.

As required by statute, the maximum negative payment adjustment in 2023 (based on performance in 2021) is -9%, and the positive payment adjustment can be up to 9% (before any exceptional performance bonus). Since MIPS is a budget neutral program, the size of the positive payment adjustments is ultimately controlled by the amount of money available through the pool of negative payment adjustments. In other words, the 9% positive payment adjustment can be scaled up or down (capped at a factor of + 3%). Likewise, the exceptional performance bonus is capped at \$500 million across all eligible Medicare providers, so the more providers who qualify for the bonus, the smaller it is. In the first three years of the program, most clinicians qualified for a positive payment adjustment, so the size of the adjustment was relatively small. For example, if a clinician received a perfect score of 100 in 2019, the clinician will only receive a positive adjustment of 1.79 percent in 2021 (much less than the 7 percent permissible under law).

- **Quality Performance Category:** CMS is finalizing a total of 209 quality measures for the 2021 performance period. This includes substantive changes to 113 existing MIPS quality measures, changes to specialty sets, the removal of 11 quality measures, and the addition of two new administrative claims outcome quality measures.

Due to the COVID-19 pandemic, CMS had proposed to change how it establishes quality benchmarks. Since CMS held clinicians harmless if they were unable to report data from 2019, CMS had thought that 2019 data may be unreliable. Therefore, CMS had proposed to develop performance period benchmarks for the CY 2021 MIPS performance period using the data submitted during the CY 2021 performance period rather than historic data from 2019. **However, CMS is NOT finalizing that proposal. CMS has determined that sufficient data were submitted for the 2019 performance period to allow the agency to calculate historical benchmarks for the 2021 performance period.**

Finally, CMS is increasing flexibility in the Quality category scoring methodology by expanding the list of reasons that a quality measure may be impacted during the performance period, and revising when CMS would allow scoring of the measure with clinicians are unable to report a full 12 months-worth of data.

- **Cost Category:** CMS is not finalizing any new cost measures this year but is including telehealth services in the current cost measure calculations, as applicable.

- **Improvement Activities:** CMS is finalizing its proposals to modify two existing improvement activities and add the following new criterion for nominating new improvement activities: “include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible.” CMS is also removing one improvement activity that is obsolete.
- **Promoting Interoperability:** CMS is finalizing its proposal to keep the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and propose to make it worth 10 bonus points. CMS is also changing the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to “Electronic Referral Loops by Receiving *and Reconciling* Health Information.” Finally, CMS is adding an optional Health Information Exchange (HIE) exchange measure.
- **Qualified Clinical Data Registries (QCDRs):** QCDRs are third-party intermediaries that help clinicians report under MIPS. As stated above, ACEP has its own QCDR called the Clinical Emergency Data Registry (CEDR). CMS has separate policies governing QCDRs and the approval of QCDR measures.

Due to the COVID-19 pandemic, CMS has delayed two new requirements finalized in last year’s rule:

- The QCDR measure testing requirement is delayed until the 2022 performance period; and
- The QCDR measure data collection requirement is delayed until the 2022 performance period. QCDRs are required to collect data on a QCDR measure prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

In the rule, CMS is finalizing its proposal to allow QCDRs to develop measures that can be used in MVPs, as long as the measures are fully tested at the clinician level prior to being submitted for consideration.

CMS is also finalizing other QCDR-related proposals including requiring that QCDRs conduct data validation audits, with specific obligations, on an annual basis.

Alternative Payment Model (APM) Policies

- **Qualifying APM Participant (QP) determinations:** Clinicians who have a certain proportion of their revenue or patient population tied to an Advanced APM (known as the revenue or patient threshold) is classified as a Qualifying APM Participant (QP) and is eligible for a five percent bonus. In the rule, CMS makes a technical modification to how it determines whether clinicians reach this threshold. CMS will also be accepting targeted review requests for QP determinations under limited circumstances where a clinician believes in good faith CMS made a clerical error.