# NAACOS Analysis of the Final 2021 Medicare Physician Fee Schedule

**Executive Summary**

In early December, the Centers for Medicare & Medicaid Services (CMS) released the final 2021 Medicare Physician Fee Schedule (MPFS) rule and related MPFS factsheet. NAACOS commented on the proposed 2021 MPFS, and that letter is available here. The final regulation includes a number of policies affecting Medicare physician payment, quality measure changes for Medicare Shared Savings Program (MSSP) ACOs, and Quality Payment Program (QPP) requirements for 2021. There is a separate QPP factsheet, available here. The key policies affecting ACOs are outlined below and further detailed in this analysis.

Actions by CMS include that the agency did the following:

**Medicare Shared Savings Program**

- Finalized a significant overhaul to MSSP quality, including:
  - Finalized adjustments to Web Interface quality measures effective for 2021, as well as adjustments to ACO administrative claims measures
  - Removed the Web Interface reporting mechanism with a delayed effective date of Jan. 1, 2022
  - Finalized a new quality assessment structure, the alternative payment model (APM) Performance Pathway (APP) which includes:
    - New scoring methodology for ACO quality
    - New policies for how quality performance contributes to shared savings/loss rates
  - Providing ACOs with full credit automatically for CAHPS measures for 2020 due to COVID-19
  - Introducing a new MSSP ACO quality measure set, effective Jan. 1, 2022 which relies on reporting electronic clinical quality measures (eCQMs)
  - Making the CAHPS for MIPS survey mandatory for ACOs effective Jan. 1, 2021
- Amended the list of primary care services used in ACO assignment by adding 11 more codes
- Revised the policy for determining the amount of repayment mechanism arrangements for certain renewing and re-entering ACOs to allow a decrease of the repayment mechanism amount

**Medicare Physician Payment and Quality Payment Program**

- Decreased the Medicare conversion factor to $32.41, which is a drop of roughly 10 percent from $36.09 finalized in the 2020 MPFS Rule
- Continuing implementation of significantly revising payment and coding for office/outpatient Evaluation and Management (E/M) services
- Revalued code sets that include, rely upon, or are analogous to office/outpatient E/M visits commensurate with the increased values finalized for office/outpatient E/M visits for 2021, and finalized a new code G2212 for prolonged office/outpatient E/M visits and another, G2211 for complex E/M

- Permanently added nine codes to the list of those eligible to be delivered via telehealth and temporarily added 60 codes through the calendar year for which the COVID-19 Public Health Emergency (PHE) ends
- Created HCPCS code G2252, which describes a 11-to-20 minute phone visit (i.e., virtual check-in) to an established patient with payment directly cross walked to CPT code 99442
- Clarified and finalized a number of polices related to remote patient monitoring (RPM), including allowing patient consent to be obtained at the time services are delivered, allowing RPM for patients with acute conditions, as well as chronic conditions, among others
- Changed the methodology for addressing prospectively aligned beneficiaries for Qualifying APM Participant (QP) score calculations and established a targeted review process
- Replaced the MIPS APM Scoring Standard with the new APM Performance Pathway to score all APMs in MIPS, including ACOs

## MEDICARE SHARED SAVINGS PROGRAM

**Quality Changes**

Despite extensive advocacy efforts by NAACOS and others, CMS finalized major structural changes to the way MSSP ACOs are measured and assessed on quality. Fortunately, due to NAACOS advocacy, CMS delayed retiring the Web Interface reporting mechanism and measures for ACOs for one additional year. Therefore, beginning with 2022 and future performance years, CMS will no longer offer the Web Interface as a means of reporting quality data and instead will transition to electronic clinical quality measure (eCQM) reporting and a new measure set included in the newly created APM Performance Pathway (APP). CMS finalized moving forward with changes to quality assessments to better align with the Quality Payment Program (QPP). The changes included in the new APP are detailed below. Finally, due to NAACOS advocacy, CMS retained a pay-for-reporting year for ACOs in the first performance year of their first agreement period, beginning January 1, 2022, and thereafter.

Unfortunately, CMS did not retain the policy to provide newly introduced measures and/or measures that undergo significant changes during the performance year with a pay-for-reporting year. Instead, these measures may be suppressed in the quality scoring for ACOs.

Table 39 on page 674 of the final rule summarizes final policies for ACOs related to quality assessments. More details on these changes are provided in the analysis below.

**TABLE 39: Summary of Final Policies on Applying the APP to Shared Savings Program ACOs Beginning PY 2021**

| | PY 2021 (Reporting in CY 2022) | PY 2022 (Reporting in CY 2023) | PY 2023 (Reporting in CY 2024) and Subsequent PYs |
|---|---|---|---|
| Quality Reporting requirements | ACOs will be required to report the 10 measures under the CMS Web Interface **or** the 3 eCQM/MIPS CQM measures. ACOs will be required to field the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10* measures will be included in calculating the ACO's quality performance score. | ACOs will be required to actively report on the 3 eCQM/CQM MIPS measures and field the CAHPS for MIPS survey. CMS will calculate the HWR and MCC measures using administrative claims data. All 6 measures will be included in calculating the ACO's quality performance score. | Same as PY 2022 |

| | | | |
|---|---|---|---|
| Quality Performance Standard | A quality performance score that is equivalent to or higher than the **30th** percentile across all MIPS Quality performance category scores.<br><br>Quality performance standard met: ACOs are eligible to share in savings at the maximum sharing rate; ACOs in two-sided models share in losses based on their quality score or at a fixed percentage based on track. | Same as PY 2021 | A quality performance score that is equivalent to or higher than the **40th** percentile across all MIPS Quality performance category scores. |
| | Quality performance standard not met: ACOs are ineligible to share savings and owe the maximum amount of shared losses, if applicable. | Shared savings and shared losses determinations same as PY 2021 | Shared savings and shared losses determinations same as PY 2021 |

* For PY 2021, if ACOs choose to report via the CMS Web Interface, they will be required to report all 10 measures, but will be scored on only seven of those measures.

*APP Measure Set*

Starting in 2022, CMS finalized proposals to dramatically decrease the number of measures ACOs are evaluated on for purposes of MSSP quality assessments. Table 46 on page 1119 of the final rule outlines the new APP measure set for MSSP ACOs. Note, this measure set is optional for reporting in 2021 but will be required for reporting among all MSSP ACOs starting in 2022.

**TABLE 46: APM Performance Pathway Quality Measure Set**

| 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 | Mgt. of Chronic Conditions |
| Quality ID: 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | 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 | Mgt. 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 |

The new measure set includes three clinical quality measures, the CAHPS for MIPS survey measures (counted as one measure), and two administrative claims measures. Note that CMS currently counts each CAHPS for ACOs survey measure as an individual measure under the current program structure (totaling 10 measures), while the APP measure set will count all CAHPS for MIPS survey measures as one measure. The readmission measure is specified for MIPS and is therefore slightly different from the readmission measure currently used to assess ACOs. Finally, CMS noted the agency may include a new "Days at Home" measure that is currently under development for future program years.

*Administrative Claims Based Measures*

The APP's claims-based measures are risk-adjusted with beneficiary demographic characteristics and a range of clinical comorbidities. These measures use a number of Hierarchical Condition Category (HCC) comorbidity categories that account for many high-risk conditions among beneficiaries to adjust for differences in patient populations between ACOs. Note the All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs (MCC) measure has an additional risk adjustment not present in the MCC measure in the current Shared Savings Program measure set. The revised APP measure adjusts for two area level social risk factors: (1) Agency for Healthcare Research and Quality socio-economic status index and (2) specialist density. The original MCC measure does not contain any social risk factors in the risk adjustment.

The Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure is a re-specified version of NQF #1789 (Hospital-Wide All-Cause Unplanned Readmission Measure), and an adapted version of NQF #1789 that is currently being used successfully to assess ACO quality performance (ACO-8: Risk-standardized, All Condition Readmission (ACR)). CMS noted the MIPS HWR is clinically aligned to the ACO ACR measure with the same cohort inclusion and exclusion criteria, outcome, measurement period, and risk adjustment variables; however, the attribution and risk-standardized readmission rate calculation methodologies differ between the two measures. The ACO ACR measure attributes beneficiaries to ACOs prior to measurement, whereas the MIPS HWR measure is attributed to three clinician groups — primary inpatient provider, discharge clinician, and primary outpatient provider — based on measure specifications and care utilization data. In addition, the ACO ACR uses hierarchical logistic regression modeling to calculate risk adjustment while the MIPS HWR cannot use hierarchical logistic regression modeling because of attribution to multiple providers. CMS will use the MIPS HWR three clinician group attribution method to attribute episodes at the ACO level. However, CMS will monitor and evaluate the ACO's performance on the MIPS HWR measure to ensure compatibility including evaluating attribution at the ACO level, as well as refinements to risk adjustment and risk stratification and may revisit the decision to include this measure in the APP measure set for Shared Savings Program ACOs in future rulemaking. NAACOS advises ACOs closely watch their performance on this measure beginning in 2021.

*CAHPS for MIPS Survey*

Starting in 2021, CMS will require ACOs to be measured on the CAHPS for MIPS survey. CMS will utilize the benchmarking and scoring methodology used for CAHPS for MIPS; a single set of benchmarks will be calculated using data from all applicable CAHPS for MIPS reporters. Additionally, CMS will continue to draw the CAHPS survey samples for MSSP ACOs administering the CAHPS for MIPS Survey at the Shared Savings Program ACO level with a target sample size of 860 going forward.

The CAHPS for MIPS Survey uses the same survey instrument to assess the same patient experience domains as the CAHPS for ACO Survey that is currently used by ACOs. In 2019, the two programs used identical survey instruments. CMS conducted an analysis to examine the impact of alignment with the MIPS survey methods. The results of these analyses indicate that scoring ACOs using the MIPS methodology resulted in ACOs having a similar distribution of quality points as MIPS groups, which is wider than the distribution of quality points using the ACO scoring methodology. CMS notes the analysis shows the wider score distribution is largely due to the differences across the two programs in the approach to benchmarking; CAHPS for ACOs uses flat percentage benchmarks for summary survey measures for which the 60$^{th}$ percentile of scores is greater than or equal to 80, or for which the 90$^{th}$ percentile of scores is greater than or equal to 95. CAHPS for MIPS does not use a flat percentage approach. Therefore, the shift away from flat percentage benchmarks may have the effect of creating larger differences in quality scores across MSSP ACOs. CMS believes that the scores will better reflect

small differences in quality performance and will support the goal to increase the MSSP quality standard over time. ACOs should carefully consider the impact this change may have on their CAHPS scores.

*Web Interface Changes for 2021*

As discussed above, as a result of NAACOS advocacy CMS finalized a policy to provide an option for ACOs to continue to report quality measures via the Web Interface for 2021 as well as the measures included in the Web Interface measure set. However, this reporting mechanism will sunset in 2022, and, therefore, beginning with performance year (PY) 2022, ACOs will be required to report via other methods specified in the new APP as described in this analysis. NAACOS will continue to advocate for CMS to maintain this reporting mechanism as an option for ACOs in future performance years.

If an ACO opts to report via the CMS Web Interface in 2021, the requirements for which patients must be included for purposes of quality reporting would remain unchanged; therefore, ACOs would report on the provided beneficiary sample as is currently the case. For the measures reported under the CMS Web Interface for performance year 2021, CMS will continue to use MSSP benchmarks developed for the CMS Web Interface for PY 2020. These MSSP benchmarks are based on data reported by ACOs, physicians, and groups through the CMS Web Interface from 2016, 2017, and 2018.

CMS noted that three of the CMS Web Interface measures (Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134)) do not have benchmarks, and, therefore, will not be scored in 2021. However, these measures are required to be reported in order to complete the CMS Web Interface dataset. Therefore, for ACOs who opt to continue to use the Web Interface reporting mechanism in 2021, the quality score will be based on seven of the 10 Web Interface measures, though the ACO must still report on all 10 measures to meet minimum reporting requirements. Finally, Table Group D, found on page 1850, lists measure specifications with substantive changes, including several Web Interface measures that have added exclusions for frailty as advocated for by NAACOS.

Table 40 on page 704 of the final rule lists the Web Interface and optional APP measures available to ACOs in 2021.

**TABLE 40: Measures included in the Final APM Performance Pathway Measure Set[1]**

| 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 |
| Measure # 479 | 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 |
| | | | | |
| Quality ID#: 001 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control | eCQM/MIPS CQM/CMS Web Interface* | APM Entity/Third Party Intermediary | Mgt. of Chronic Conditions |
| Quality ID#: 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | eCQM/MIPS CQM/CMS Web Interface* | APM Entity/Third Party Intermediary | Treatment of Mental Health |
| Quality ID#:236 | Controlling High Blood Pressure | eCQM/MIPS CQM/CMS Web Interface* | APM Entity/Third Party Intermediary | Mgt. of Chronic Conditions |
| Quality ID#: 318 | Falls: Screening for Future Fall Risk | CMS Web Interface* | APM Entity/Third Party Intermediary | Preventable Healthcare Harm |
| Quality ID#: 110 | Preventive Care and Screening: Influenza Immunization | CMS Web Interface* | APM Entity/Third Party Intermediary | Preventive Care |
| Quality ID#: 226 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | CMS Web Interface* | APM Entity/Third Party Intermediary | Prevention and Treatment of Opioid and Substance Use Disorders |
| Quality ID#: 113 | Colorectal Cancer Screening | CMS Web Interface* | APM Entity/Third Party Intermediary | Preventive Care |
| Quality ID#: 112 | Breast Cancer Screening | CMS Web Interface* | APM Entity/Third Party Intermediary | Preventive Care |
| Quality ID#: 438 | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | CMS Web Interface* | APM Entity/Third Party Intermediary | Mgt. of Chronic Conditions |
| Quality ID#: 370 | Depression Remission at Twelve Months | CMS Web Interface* | APM Entity/Third Party Intermediary | Treatment of Mental Health |

[1] We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) do not have benchmarks and are therefore not scored; they are, however, required to be reported in order to complete the Web Interface dataset.

* ACOs will have the option to report via Web Interface for the 2021 MIPS Performance year only.

*2021 MSSP Quality Benchmarks*

CMS will continue to use historical benchmarks for quality measures for the CY 2021 MIPS performance period. For the measures reported under the CMS Web Interface for performance year 2021, CMS will continue to use MSSP benchmarks developed for the CMS Web Interface for PY 2020. These MSSP benchmarks are based on data reported by ACOs, physicians, and groups through the CMS Web Interface from 2016, 2017, and 2018.

For ACOs who voluntarily choose to report eCQM measures in the APP for 2021, CMS will also continue to rely on historical benchmarks for 2021, looking at 2019 data to develop benchmarks for 2021 specifically. Historical benchmarks based on 2019 data will be available prior to the start of the 2021 performance period at qpp.cms.gov. CMS noted they will continue to monitor the impact of the COVID-19 Public Health Emergency (PHE) on data in 2020 and 2021.

*Newly Introduced Measures and Those Undergoing Significant Changes During the Performance Year*
Despite NAACOS advocacy efforts, CMS finalized a new policy for addressing quality measures that undergo significant changes during the performance year, as well as newly introduced measures. Instead of providing a pay-for-reporting year for newly introduced measures and those undergoing significant changes mid-year as is done currently in the MSSP, CMS will reduce the total available measure achievement points by 10 points under the APP per MIPS scoring policies. CMS made these changes to align with MIPS scoring methods and requirements.

*MSSP Quality Reporting Mechanism Changes Under the APP*
CMS finalized a change to eliminate the Web Interface as a reporting method for ACOs and all MIPS reporters, but delays this policy's effective date to January 1, 2022. In place of the Web Interface, the APP will require ACOs to actively report on three clinical quality measures (see table 46 above), which could be reported using a registry or direct via electronic health records (EHRs) using electronic clinical quality measure (eCQM) standards. Note that eCQMs must be reported for all patients, regardless of payer. This is a very significant change, and ACOs should consider the operational changes that may be necessary to make these adjustments.

According to CMS, the ACO will report data in the aggregate on behalf of its ACO participants using the relevant measure specifications and could submit data via the following MIPS submission types using either direct login, such as application program interface, or sign in and upload. CMS notes the ACO could, on behalf of its ACO participants combine the results from all the ACO participant TIN QRDA3 files, by adding numerators, denominators, etc. and create an aggregate QRDA3 file (or other compliant format) to submit as an ACO to CMS. ACOs could also contract with a third-party intermediary, such as a registry, to submit data on behalf of the ACO.

*MSSP Quality Scoring Methodology Under the APP*
CMS finalized changes to alter the scoring methodology currently used to assess MSSP ACO quality. Currently, ACOs are scored within four equally weighted domains. An ACO earns quality points for each measure on a sliding scale based on level of performance. For measures that are pay-for-reporting, ACOs receive full points if the ACO completely and accurately reports for that measure. These points roll up to the maximum points allowed for each domain. CMS also provides up to four points per domain for significant improvement. CMS calculates a percent score for each domain (i.e., the sum of points earned and improvement points divided by the total available quality points for that domain). ACOs receive an overall quality score (i.e., sum of all domain percent scores divided by four domains). See the CMS website (refer to quality measurement section) for the sliding scale and points currently used for these domains. Finally, the current minimum attainment standard requires ACOs to meet or exceed the 30$^{th}$ percentile among all Web Interface reporters on at least one measure in each of the four quality domains.

Under the finalized new APP approach, CMS will instead award a score of three-to-ten points for each measure in the APP that meets the data completeness and case minimum requirements, which would be determined by comparing measure performance to established MIPS benchmarks. Note that benchmarks will no longer be determined by looking at all Web Interface reporters, but rather, benchmarks will be established based on all MIPS reporters. Benchmarks will also vary based on the reporting method chosen by the ACO. CMS also finalized policies to change the minimum attainment standard, now requiring ACOs to meet or exceed the 30$^{th}$ percentile among all MIPS reporters in 2021 and 2022, and the 40$^{th}$ percentile among all MIPS reporters each year thereafter. Finally, as is currently the case, ACOs must also report on all measures in order to meet the minimum attainment standard. All measures will be summed, and the final total score must exceed the minimum attainment standard threshold prescribed.

As stated above for PY 2022 and subsequent performance years, for the first performance year of an ACO's first agreement period under the MSSP, if the ACO meets the data completeness requirement and case minimum requirement on the three measures that it is actively required to report and fields a CAHPS for MIPS survey via the APP, then the ACO will meet the quality performance standard.

**NAACOS Summary of New APP Scoring Approach for MSSP Quality Scores**

| **APP measures (Required starting in 2022)** | **3-10 points earned per measure based on performance compared to MIPS benchmarks per reporting mechanism used** | **Final score must meet or exceed the 30th percentile MIPS score in 2021 and 2022, and the 40th percentile in 2023 and subsequent years** |
|---|---|---|
| CAHPS for MIPS | 10 maximum points | 60 total points available<br><br>NOTE: CMS will suppress measures that undergo significant changes mid-year as well as newly introduced measures, and as a result remove 10 points per affected measure from the total measure points available for the year |
| Diabetes HbA1c Poor Control | 10 maximum points | |
| Controlling High Blood Pressure | 10 maximum points | |
| Screening for Depression & Follow Up | 10 maximum points | |
| HWR Administrative Claims Measure | 10 maximum points | |
| MCC Administrative Claims Measure | 10 maximum points | |
| *ACOs in their first year of their first agreement period are given full points for complete and accurate reporting for one year | | |

*Minimum Quality Performance/Attainment Standard*

Currently, ACOs must meet the minimum attainment standard to be eligible to share in any savings earned by the ACO. Once the minimum attainment standard is met, the ACO's final quality score determines an ACO's shared savings or loss rate. The better the score, the more savings earned; the better the score, the less an ACO must repay — if losses are owed.

Under the new finalized policy, ACOs must meet the minimum attainment standard to be eligible to share in any savings earned. Once the minimum standard is met, an ACO will receive the maximum shared savings rate automatically, regardless of the ACO's final quality score. If an ACO does not meet the minimum attainment standard, the ACO will not be eligible for shared savings. To determine shared loss rates, CMS will use an approach that awards ACOs with higher quality scores a lower shared loss rate (and vice versa), as described in more detail in the section below. Finally, CMS noted that ACOs failing to meet the minimum attainment standard and responsible for shared losses would owe the maximum shared loss rate.

Below is a summary of the finalized MSSP minimum performance standards required in 2021 and beyond:

- For PYs 2021 and 2022, CMS designates the quality performance standard for all ACOs, with the exception of ACOs in the first performance year of their first agreement period, as the ACO reporting quality data via the APP established under §414.1367 and achieving a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality Performance Category scores, *excluding entities/providers eligible for facility-based scoring.*

- For PY 2021, if an ACO does not report any of the 10 CMS Web Interface measures or any of the three measures it is actively required to report and does not field a CAHPS for MIPS survey via the APP, the ACO will not meet the quality performance standard.
- For PY 2023 and subsequent years, CMS designates the quality performance standard for all ACOs, with the exception of ACOs in the first performance year of their first agreement period, as the ACO reporting quality data via the APP established under §414.1367, achieving a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, *excluding entities/providers eligible for facility-based scoring.*

*Quality Scores and Shared Savings/Loss Rates*

For performance years beginning on or after January 1, 2021, CMS finalized a policy that if an ACO that is otherwise eligible to share in savings meets the quality minimum performance attainment standard established under §425.512, the ACO will share in savings at the maximum sharing rate according to the applicable financial model up to the performance payment limit. If the ACO fails to meet the quality minimum performance attainment standard, the ACO will be ineligible to share in savings.

As finalized, to determine the shared loss rate under Track 2 and the Enhanced Track for performance years beginning on or after January 1, 2021, CMS will determine the shared loss rate as follows:

- Step 1: Calculate the quotient of the MIPS quality performance category points earned divided by the total MIPS quality performance category points available.
- Step 2: Calculate the product of the quotient described in Step 1 and the sharing rate for the relevant track, either 60 percent for Track 2 or 75 percent for the Enhanced Track.
- Step 3: Calculate the shared loss rate as 1 minus the product determined in Step 2. Consistent with the existing structure of the financial models: under Track 2, the shared loss rate may not exceed 60 percent and may not be less than 40 percent; under the Enhanced Track, the shared loss rate may not exceed 75 percent and may not be less than 40 percent. If the ACO fails to meet the quality performance standard, the shared loss rate will be 60 percent under Track 2 or 75 percent under the Enhanced Track.

For Basic Track Levels C, D and E as well as Track 1+ CMS will continue to apply a fixed 30 percent loss sharing rate. ACOs are ineligible to share savings and will owe the maximum amount of shared losses if the minimum quality performance attainment standard is not met.

*Quality Compliance*

CMS finalized policies to strengthen compliance within the quality performance standard for MSSP by broadening the conditions for which CMS may terminate an ACO's participation agreement, beginning on or after January 1, 2021. Specifically, CMS will have the ability to terminate an ACO's participation agreement when the ACO fails to meet the quality performance standard for three consecutive performance years within an agreement period or fails to meet the quality performance standard for any four non-consecutive performance years within an agreement period. CMS also finalized a change to modify the Data Validation and Audit process to align with MIPS. Note CMS retains the right to audit and validate quality data reported by an ACO via the APP according to the MIPS data validation process for performance years beginning on or after January 1, 2021.

Finally, as part of evaluating a renewing or re-entering ACO's application to participate in the MSSP, CMS will consider whether the ACO has demonstrated a pattern of failure to meet the quality performance standards or met any of the criteria for termination under § 425.316(c)(1)(ii) or (c)(2)(ii).

*Quality and the MSSP ACO Extreme and Uncontrollable Circumstances Policy*

CMS finalized changes to the quality portion of the MSSP Extreme and Uncontrollable Circumstances policy for ACOs to align with the changes introduced in the new APP for ACOs and to align with MIPS. For PY 2021 and 2022, CMS will provide an ACO affected by an extreme and uncontrollable circumstance with the higher of its own quality score or a score equal to the 30th percentile MIPS quality performance category score. For PY 2023 and subsequent years, CMS will provide an ACO affected by an extreme and uncontrollable circumstance with the higher of its own quality score or a score equal to the 40th percentile MIPS quality performance category score. CMS will use the quarter four list of assigned beneficiaries to determine the portion of patients affected by the extreme and uncontrollable circumstance.

*Modifications to 2020 Quality Reporting Requirements and Extreme and Uncontrollable Circumstances Policy Due to COVID-19*

Due to the negative impacts of COVID-19 on sample size and performance scores, CMS finalized a policy to remove the requirement for MSSP ACOs to field a CAHPS for ACOs Survey for PY 2020. Instead, CMS will provide automatic full points for each of the CAHPS Survey Measures within the patient/caregiver experience domain for PY 2020. The Next Gen Model has made the same accommodations for Next Gen ACOs in 2020.

However, CMS did not move forward with an approach discussed in the proposed rule to alter the MSSP 2020 Extreme and Uncontrollable Circumstances Policy for ACOs to award ACOs the higher of their 2019 or 2020 quality scores, so long as the ACO fully reports quality in PY 2020. NAACOS has advocated since March for CMS to make accommodations to quality reporting requirements for 2020 given the COVID-19 pandemic, and we will continue to advocate for CMS to make additional accommodations for ACOs who may not be able to report quality data for PY 2020 due to COVID-19. As it stands, the existing extreme and uncontrollable circumstances policy for MSSP will award ACOs with the mean MSSP quality score if they are unable to report quality data due to the COVID-19 PHE. The mean quality score for 2020 is expected to be lower than in previous years due to the fact that many patients are delaying routine preventive care and screenings as a result of the pandemic. Please note that CMS indicates all ACOs will be given the higher of the mean score or their own 2020 quality score for PY 2020, regardless of whether the ACO is able to fully and accurately report quality data.

The Next Gen Model has made accommodations to provide the higher of the Next Gen ACO's 2019 or 2020 quality score in 2020 due to the impacts of COVID-19 on quality improvement efforts.

**Beneficiary Assignment**

Following NAACOS advocacy, CMS finalized updates to the list of primary care services it uses to assign beneficiaries to ACOs, adding 11 more codes and making technical changes to existing codes used in assignment starting in PY 2021. The newly added codes include:

- 99421, 99422, and 99423 (online digital evaluation and management, also known as "e-visits")
- 99483 (assessment of and care planning for patients with cognitive impairment)
- 99491 (chronic care management)
- G2058/99439 (non-complex chronic care management)
- G2064 and G2065 (principal care management)
- G2214 (psychiatric collaborative care model)
- G2010 and G2012 (remote evaluation of patient video/images and virtual check-ins)

The additional codes are similar to those currently used in beneficiary assignment, CMS states, therefore, making it logical to add these services. The principal care management and non-complex chronic care management codes were added to the fee schedule last year. E-visits, which were added in 2019, are non-face-to-face, patient-initiated communications using online patient portals with established patients. Elsewhere in this regulation, CMS finalized the addition of G2214, which would pay for 30 minutes of behavioral health manager time in the Psychiatric Collaborative Care Model. NAACOS was supportive of the additions, which create a more accurate reflection of where patients receive their primary care services.

G2010 (remote evaluation of patient video/images) and G2012 (virtual check-ins) were not originally proposed to be added to the list of codes used in assignment, but CMS is including them in the final rule since these telehealth codes are likely to continue to be widely used after the COVID-19 PHE. Earlier this year in rulemaking related to the COVID-19 PHE, CMS temporarily added G2010, G2012, and other codes to the list of those used in assignment for PY 2020 and any subsequent performance year that starts during the COVID-19 PHE.

CMS also finalized the exclusion of advance care planning (99497 and 99498) when billed in an inpatient setting from being used to determine beneficiary assignment starting in PY 2021. CMS believes not placing any exceptions on the place of service or provider type may result in patients being assigned to ACOs because of inpatient care rather than primary care services by their regular health providers. CMS found that more than 13 percent of the 1.6 million claims in 2019 for advance care planning took place in an inpatient setting. CMS will adjust ACOs' historical benchmarks to account for these assignment changes.

CMS also finalized excluding professional services furnished by Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs) when those services are delivered in a SNF. In the 2019 MPFS, CMS finalized a policy to exclude CPT codes 99304 through 99318 when delivered in a SNF, effective starting in 2019. Previously, CMS excluded claims with a place of service code 31, signifying the service was delivered in a SNF. However, because FQHC and RHC claims are submitted using institutional claim forms, CMS doesn't exclude CPT codes 99304 through 99318 from ACO assignment when provided in a SNF. Effective beginning with PY 2021, CMS will exclude from ACO assignment CPT codes 99304 through 99318 with dates of service that overlap with dates Medicare receives from SNF facility claims. CMS will adjust ACOs' historical benchmarks to account for any changes to ACO beneficiary assignment it makes.

**Repayment Mechanism Requirements**

CMS finalized repayment mechanism requirement changes in an effort to correct unintended consequences and burdens associated with the previous rules. Therefore, an ACO that wishes to use its existing repayment mechanism to establish its ability to repay any shared losses incurred during a new agreement period will be required to have a repayment mechanism amount equal to the lesser of the following: (1) 1 percent of the total per capita Medicare Parts A and B fee-for-service (FFS) expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available; or (2) 2 percent of the total Medicare Parts A and B FFS revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available. CMS removed the previous requirement to maintain a higher repayment amount that was in place under a previous agreement period if the newer amount were to be lower.

The revised policy applies to agreement periods starting on January 1, 2022, and in subsequent years. This policy applies to both renewing ACOs and re-entering ACOs, if the latter are the same legal entity as an ACO that previously participated in the program and that wishes to use its existing repayment

mechanism for a new agreement. CMS will allow a one-time opportunity for ACOs that renewed agreements on July 1, 2019, or January 1, 2020, to elect to decrease the amount of their existing repayment mechanisms if the amount calculated under the revised methodology is less. CMS notes the agency will notify eligible ACOs of their opportunity to reduce repayment mechanism amounts.

**COVID-19 and Financial Reconciliation**
The final rule includes a summary of clarifications CMS has made recently regarding policies to adjust financial reconciliation for MSSP ACOs due to the COVID-19 PHE. These clarifications have also been issued throughout the year by CMS through COVID-19 Frequently Asked Questions (refer to the MSSP section). NAACOS has a webpage dedicated to our COVID-19 education and resources which include summaries of the two Interim Final Rules with Comment issued in 2020 to address COVID-19 adjustments for ACOs.

The PHE for COVID-19 has been renewed with an effective date of October 23, 2020 and unless terminated early, will remain in effect for 90 days from the effective date. Shared losses will be mitigated for all ACOs participating in a risk-based track for the duration of the PHE. Therefore, unless the PHE is terminated early, any shared losses an ACO incurs for 2020 would be reduced completely and the ACO would not owe any shared losses. Additionally, CMS will adjust certain MSSP financial calculations including the determination of benchmark and performance year expenditures, to remove payment amounts for episodes of care for treatment of COVID-19 triggered by an inpatient service. In this regulation, CMS makes an additional clarification to specify that CMS also identifies episodes of care for treatment of COVID-19 based on discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the Inpatient Prospective Payment System such as Critical Access Hospitals, when the date of discharge occurs within the PHE.

**Track 1+**
CMS clarifies that the finalized MSSP policies in this rule would apply to Track 1+ ACOs in the same way they apply to Track 1 ACOs as long as the applicable regulation has not been waived under the Track 1+ Model. Therefore, policies detailed above, such as changes to MSSP quality and assignment, apply to Track 1+ ACOs. A specific list is available on page 873.

## PHYSICIAN PAYMENT AND POLICY CHANGES

**Overview**
As is typical in the MPFS, CMS outlines 2021 relative value units (RVUs), which include work, malpractice, and practice expense (PE) RVU updates. These building blocks of the MPFS are adjusted over time to reflect new developments and services as well as shifts in payments within the fee schedule. The agency also identifies payment changes through its process to update what it determines are misvalued services. Geographic Practice Cost Indices (GPCIs) are another essential component of MPFS payments and, following a scheduled three-year update in 2020, CMS did not make notable GPCI updates for 2021.

With the budget neutrality adjustment to account for changes in RVUs, as required by law, the Calendar Year (CY) 2021 MPFS conversion factor is $32.41, a notable decrease from the CY 2020 MPFS conversion factor of $36.09. This decrease is in part due to a 0 percent automatic conversion factor update from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and reflects the overall payment increases for outpatient/office Evaluation and Management (E/M) services, which lead to payment decreases in other areas of the MPFS to maintain budget neutrality. More detail on specific payment changes and shifts among specialties can be found in TABLE 106: CY 2021 PFS Estimated Impact on Total

Allowed Charges by Specialty, on page 1660 of the rule, and the full RVU files are available on this CMS webpage.

**Evaluation and Management Services (E/M)**
In total, E/M visits comprise approximately 40 percent of allowed charges for MPFS services; and office/outpatient E/M visits, in particular, comprise approximately 20 percent of allowed charges for MPFS services. CMS has long acknowledged the need to revise payment, guidelines, and documentation requirements for billing E/M services and has taken notable steps in recent years to do so. In the final 2020 MPFS Rule, summarized in this NAACOS resource, the agency finalized significant changes to generally adopt the new coding, prefatory language, and interpretive guidance framework issued by the American Medical Association Current Procedural Terminology (AMA CPT) Workgroup on E/M, which will be effective January 1, 2021. The 2021 MPFS Rule continues the approach finalized in last year's rule. The combined effect of E/M payment revisions along with valuation changes for codes related to E/M, results in more considerable payment shifts among different providers within the MPFS than what has been typical in the last few years. These payment shifts can be seen in Table 106 on page 1660.

To maintain relativity with the increased office/outpatient E/M values, CMS is revaluing certain services and code sets that include, rely upon, or are analogous to office/outpatient E/M visits. Among the codes and codes sets with values closely tied to the those for office/outpatient E/M visit codes are: transitional care management (TCM) services; cognitive impairment assessment and care planning; certain end-stage renal disease (ESRD) services; and the annual wellness visit (AWV) and initial preventive physical exam (IPPE), among others. Many of these services were valued via a building block methodology and have office/outpatient E/M visits explicitly built into their definition or valuation. CMS updated the valuation of these codes, including RVU and input changes.

CMS finalized two add-on codes to be used in conjunction with the revised E/M code set. Specifically, the agency finalized the following codes which go into effect in 2021:

- **G2211**, for complex E/M, which CMS says it believes reflects the time, intensity and PE when practitioners furnish services that enable them to build longitudinal relationships with patients.
    - Code descriptor: *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 condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).*
- **G2212,** for prolonged E/M, which agency is introducing in place of a similar CPT code, 99417, to address concerns about lack of clarity in the CPT code descriptor and the potential for double counting time under that code. CMS notes the valuation of G22122 is equal to that of 99417.
    - Code descriptor: *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services*) *"(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))*.

**Care Management Services**
As part of evaluating payment for Medicare services, CMS considers updates to care management services that many ACOs use as part of their overall care coordination strategy. Table 17 on page 203 provides a summary of care management codes. In last year's PFS, CMS finalized a new an add-on code,

G2058, for chronic care management services. Effective for 2021, the agency finalized replacing G2058 with CPT code 99439, which has the following code descriptor, *Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month*). For 2021, CMS is also updating billing policies for Transitional Care Management (TCM) codes 99495 and 99496. to remove 14 ESRD codes from the list of codes that may not be billed concurrently with TCM. CMS also finalized its proposal to allow G2058 (replaced by 99439 starting in 2021) to be billed concurrently with TCM when reasonable and necessary. The codes are shown in Table 18 on page 220.

Under another care management proposal, related to expanding use of Psychiatric Collaborative Care Model services, CMS established a new G-code to describe 30 minutes of behavioral health care manager time. The final code is effective in 2021 and is HCPCS code G2214, with the following code descriptor: *Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*. Finally, CMS finalized its proposal to add Principal Care Management (PCM) Services, HCPCS codes G2064 and G2065, to the existing comprehensive care management service for Rural Health Clinics and Federally Qualified Health Centers, G0511, starting January 1, 2021. The PCM codes will also be factored into the calculation of the G0511 payment rate.

**Telehealth and Other Services Involving Communications Technology**

*Additions to the Medicare Telehealth List*

CMS finalized permanently adding nine codes to the list of those eligible to be delivered via telehealth. CMS will also keep an additional 60 codes on the Medicare telehealth list through the calendar year for which the COVID-19 PHE ends so that more evidence can be collected on their use. During the COVID-19 PHE, CMS has temporarily added more than 100 codes to the Medicare telehealth list. In drafting the 2021 MPFS, CMS states that it reviewed those temporary additions to see if they met the agency's criteria to be added permanently to the telehealth list. Services must have a demonstrated clinical value when delivered via telehealth to be added to the permanent list.

Compared to what it originally proposed, CMS expanded the list of codes temporarily added to the list in the final rule, responding to public comments. CMS states that collection of information on use of these codes through telehealth would be difficult during the PHE, so allowing them to be used after the PHE expires will enhance data collection and give CMS more information on which to base future decisions about expanding the telehealth eligibility list.

However, there are nearly 30 other codes that were added to the Medicare telehealth list during the PHE for which CMS is declining to permanently add to the eligible list. These include initial visits for nursing facilities, hospital care, and neonatal intensive care units, home visits for new patients, observation and discharge day management visits, and others. CMS believes many of these services can and should be performed in-person given the frailty of patients. A full list of codes is included on Table 16 of the final rule, which is copied below.

**Summary of CY 2021 Services Added to the Medicare Telehealth Services List**

| Type of Service | Specific Services and CPT Codes |
|---|---|
| Services CMS is finalizing for permanent addition as Medicare Telehealth Services | • Group psychotherapy (CPT code 90853)<br>• Domiciliary, rest home, or custodial care services, established patients (CPT codes 99334–99335)<br>• Home visits, established patient (CPT codes 99347–99348)<br>• Cognitive assessment and care planning services (CPT code 99483)<br>• Visit complexity inherent to certain office/outpatient E/Ms (HCPCS code G2211)<br>• Prolonged services (CPT code G2212)<br>• Psychological and neuropsychological testing (CPT code 96121) |
| Services CMS is finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the COVID-19 PHE ends | • Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336–99337)<br>• Home Visits, Established Patient (CPT 99349–99350)<br>• Emergency Department Visits, Levels 1-5 (CPT 99281–99285)*<br>• Nursing facilities discharge day management (CPT 99315–99316)<br>• Psychological and Neuropsychological Testing (CPT 96130–96133; CPT 96136–96139)<br>• Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161–97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521–92524, 92507)*<br>• and Hospital discharge day management (CPT 99238–99239)*<br>• Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)*<br>• Continuing Neonatal Intensive Care Services (CPT 99478–99480)*<br>• Critical Care Services (CPT 99291–99292)*<br>• End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)*<br>• Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224–99226)* |
| Services CMS is not adding to the Medicare telehealth list either permanently or temporarily | • Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) (CPT 99304–99306)<br>• Initial hospital care (CPT 99221–99223)<br>• Radiation Treatment Management Services (CPT 77427)<br>• Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324–99328)<br>• Home Visits, New Patient, all levels (CPT 99341–99345)<br>• Inpatient Neonatal and Pediatric Critical Care, Initial (CPT 99468, 99471, 99475, 99477)<br>• Initial Neonatal Intensive Care Services (CPT 99477)<br>• Initial Observation and Observation Discharge Day Management (CPT 99218–99220; CPT 99234–99236)<br>• Medical Nutrition Therapy (CPT G0271) |

* Services that were not proposed to be kept on the Medicare telehealth list through the year in which the COVID-19 PHE ends but are being finalized as such.

While two-sided risk ACOs who use prospective assignment have an exception through the MSSP telehealth waiver, CMS notes that patients' homes are not generally a permissible telehealth originating site. An exception, however, was added by the SUPPORT Act of 2018, which made telehealth allowable in patients' homes for the purposes of treating substance use disorder or a co-occurring mental health

disorder to an individual with a substance use disorder diagnosis. Therefore, unless provided to prospectively assigned patients in a two-sided ACO model, the domiciliary/home visits codes either permanently or temporarily added to the Medicare telehealth list could be billed via telehealth for services to treat substance use disorder or cooccurring mental health disorder.

*Continuation of Payment for Audio-only Visits*

Following NAACOS advocacy, CMS finalized the creation of HCPCS code G2252, which describes a 11-to-20 minute phone visit (i.e., virtual check-in) to an established patient. Like with G2012, this longer virtual check-in must not be related to an E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours. Payment will be a direct crosswalk to CPT code 99442, which CMS feels most accurately reflects the resources associated with a longer service delivered via synchronous communication technology, which can include audio-only communication.

Federal law generally defines telehealth as a live, interactive audio-video visit. During the COVID-19 PHE, CMS moved to allow certain services to be delivered through audio-only technology, such as simple phone calls. While CMS recognizes that federal law will prohibit Medicare from covering audio-only visits once the PHE ends, it does appreciate the need to pay for these audio-only services after the PHE ends, which NAACOS supported in its comments. A rundown of CMS's allowances during the PHE can be found in this NAACOS resource.

*Furnishing Telehealth Visits in Skilled Nursing Settings*

Following NAACOS advocacy, CMS finalized a policy to allow subsequent nursing visits to be furnished via telehealth once every 14 days in the nursing facility setting but opted not to finalize any revisions to the frequency limitations on inpatient visits or critical care consultations provided via telehealth. Currently, telehealth visits might be conducted in nursing homes once every 30 days. CMS stated that allowing telehealth visits as often as once every three days, as it proposed, would provide too little incentive for needed in-person care. Fourteen days, in the agency's view, strikes an appropriate balance. CMS will still require initial visits to be in-person, a requirement it has waived during the COVID-19 PHE.

*Changes to Supervision Requirements Through Telehealth*

CMS finalized its decision to allow direct supervision to include the virtual presence of a supervising physician or clinician using interactive, real-time audio-video technology through at least 2021. This allowance was made during the COVID-19 PHE. CMS also finalized its proposed clarification that telehealth services may be billed when provided incident to a distant site physicians' service under the direct supervision of the billing professional provided through virtual presence.

*Creation of More Communication Technology-Based Services*

CMS finalized the establishment two new codes that can be billed by non-physician practitioners and others who cannot independently bill for E/M services. G2250 and G2251 cover the remote assessment of recorded video and/or images submitted by established patients and brief, 5-to-10 minute telephone calls with established patients. These codes are analogous to Medicare's "virtual check-in" codes created in the 2019 fee schedule, but those 2019 codes are only billable by practitioners who can furnish E/M services.

*Clarification of Allowable Telehealth Technology*

Lastly, CMS finalized its proposal to remove from the regulatory definition of allowable technology "[t]elephones, facsimile machines, and electronic mail systems that do not meet the definition of an interactive telecommunications system" to eliminate confusion whether smartphones may be permissible technology. Medicare still requires technology provide "at a minimum, audio and video

equipment permitting two-way, real-time interactive communication" which may include modern smartphones.

**Remote Physiologic Monitoring Services**

CMS attempted to clarify how it pays for the remote monitoring of patients' physiologic condition, care for which it has greatly expanded upon in recent years. Also, during the COVID-19 PHE, CMS has created several policies that seek to increase use of remote physiologic monitoring (RPM) during the pandemic in an effort to reduce in-person office visits. In the final rule, CMS goes to great lengths to clarify how to correctly deliver and bill for RPM services. Among the clarifications and finalizations made:

- Auxiliary personnel, including contracted employees, may furnish RPM services 99453 and 99454 under the general supervision of the billing physician or practitioner;
- Patient consent may be obtained at the time services are furnished;
- Practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions;
- "Interactive communication" for purposes of CPT codes 99457 and 99458 involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission;
- When the COVID-19 PHE ends, CMS will not be extending the PHE policy that allows RPM services to be furnished to new patients; an established patient relationship is required;
- Medical devices that deliver RPM must be approved by the Food and Drug Administration, which means data must be electronically and automatically collected and transmitted rather than self-reported; and
- When COVID-19 PHE ends, CMS will once again require that data be collected for 16 days within a 30-day period to bill for 99453 and 99454, which pay for RPM set-up, patient education and monitoring.

## QUALITY PAYMENT PROGRAM (QPP)

**Advanced APMs**

*Predicted Number of Qualifying APM Participants (QPs)*

As required under MACRA, QP thresholds rise over time, making it more challenging to earn the Advanced APM bonus. In PY 2021, which corresponds to Payment Year 2023, the QP payment amount threshold increases from 50 percent to 75 percent, and the QP patient count threshold increases from 35 percent to 50 percent. Despite a growing number of Advanced APMs, CMS predicts that the number of QPs will go down slightly in PY 2021 as compared to 2019 and 2020. Specifically, the agency estimates that there will be between 196,000 and 252,000 QPs for PY 2021 with total bonuses of between $700 and $900 million. NAACOS has repeatedly advocated to modify QP calculations, and we have worked with our congressional champions to introduce the Value in Health Care Act, summarized here, which would prevent the QP thresholds from rising in 2021. We urge ACOs to use our Take Action page to contact their members of Congress to request swift action on this issue.

*Advanced APM Incentive Payment*

Despite NAACOS objections and previous CMS guidance to the contrary, CMS finalized its clarification that the Advanced APM incentive amount is calculated based on the paid amount, not the allowed amount, of the applicable claims for covered professional services that are aggregated to calculate the estimated payments. This clarification comes after NAACOS pointed out previous regulations and language from the agency initially indicating the bonus would be based on the allowed amount. NAACOS

has advocated that the agency's implementation reflect its initial language, and we are disappointed to see this clarification.

CMS acknowledges the complexity of distributing Advanced APM bonuses when clinicians are no longer practicing at TINs associated with earning their bonuses. Therefore, the agency is revising the process for distributing Advanced APM bonuses when a QP is no longer affiliated with the TIN through which they earned the QP status. CMS notes that its main goal when this occurs is to identify and pay the TIN(s) with which the QP is affiliated at the time the APM incentive payment is made. CMS finalized its proposed eight-step hierarchy, shown on page 1529, for identifying where to pay the bonus, starting with a TIN tied to where the clinician earned QP status and ending with a public list of QPs for whom the agency could not identify a TIN to which to make the payment. CMS requires those QPs to contact the agency and provide payment information by the later of 60 days after the distribution of the APM incentive payment or by November 1 of the payment year. CMS finalized its proposal to include QPs on the list of those for whom the agency can't identify payment information if the QP had no claims in the incentive payment base year and its only qualifying Medicare payments were for supplemental services, which could be the case for ECs who retire following the performance year.

*QPs and Partial QP Determinations*

Under CMS rules for QP calculations, a beneficiary may be counted only once in the numerator and denominator for a particular ACO or APM Entity but that a beneficiary may be counted multiple times across the numerators and denominators for different ACOs or other APM Entities. In this rule, CMS acknowledges that when a beneficiary is prospectively assigned to an ACO or other APM Entity, and therefore could not possibly be assigned to other ACOs or APM Entities, it is unfair to include that beneficiary in those QP calculations. Therefore, CMS finalized a policy to exclude prospectively assigned beneficiaries from the denominators of other ACO/APM Entity QP calculations when that beneficiary is ineligible to be added to the ACO/APM Entity's list of assigned beneficiaries.

This decreases the QP denominator, thus increasing the overall QP score. In response to NAACOS comments, in the final rule CMS clarified that the prospectively assigned beneficiaries will be removed from the denominator of other ACOs regardless of whether those other ACOs have retrospective or prospective assignment.

*QP Targeted Review*

CMS finalized its policy to establish a targeted review process for limited circumstances surrounding QP determinations, such as to review CMS clerical errors like omitting a clinician from a Participation List used for QP determinations. The agency responded to numerous comments requesting expansion of the proposed review process by keeping the review opportunity narrow and citing statutory restraints on administrative or judicial review for QP determinations. If CMS determines a clinician was missing due to CMS clerical error, the agency will assign the ACO or APM Entity's most favorable QP score from that performance year. A review can be submitted by an eligible clinician or APM Entity during a 60-day review period announced by CMS, and the QP review period will align with the same 60-day period used for the MIPS targeted review process.

**MIPS**

CMS finalized very minor updates to MIPS for 2021 overall. However, an important change is that the agency has postponed moving forward with the MIPS Value Pathways (MVP) approach for 2021 due to the strains placed on the health care system related to the COVID-19 pandemic. Notably for ACOs, CMS finalized a policy to sunset the MIPS APM Scoring Standard, the scoring method currently used for ACOs

in MIPS, starting in 2021. Instead CMS replaces the MIPS APM Scoring Standard with the new APM Performance Pathway (APP) that will also be used to score MSSP ACOs quality for purposes of the MSSP.

*ACO Scoring in MIPS under the APP*

ACOs must submit quality data via the APP established under §414.1367 to satisfactorily report on behalf of the eligible clinicians who bill under the Tax Identification Number (TIN) of an ACO participant for purposes of the MIPS quality performance category.

CMS finalized policies to score ACOs subject to MIPS using the APP framework. This framework is similar to, but not the same as the current MIPS APM Scoring Standard. Note the APP will be used for all MIPS APMs that select this option. For MSSP ACOs specifically, reporting under the APP is required for purposes of the MSSP quality assessments. That information will also be used for scoring a quality performance category score in MIPS.

**Overview of Changes for ACOs Under the APP for MIPS Assessments**

| Performance Category | Weights | Notable Changes Finalized |
|---|---|---|
| **Quality** | 50% | Moves to APP structure and measure set as well as scoring approach. |
| **Cost** | 0% | No changes for ACOs. ACOs will not be given a cost score in MIPS. |
| **Improvement Activities** | 20% | No changes for ACOs. ACOs continue to be awarded full points automatically for improvement activities. |
| **Promoting Interoperability** | 30% | No changes for ACOs. All individual and group scores would continue to be averaged, using a weighted average based on the number of clinicians in a group to determine one average ACO Promoting Interoperability score. |

In this final rule, CMS clarified the agency will allow individual clinicians and groups (TINs) the option of choosing to report outside the ACO for purposes of MIPS analysis only in cases where the ACO fails to report data via the APP on behalf of its participant TINs. Should a practice or clinician choose this option, it would be required to select the appropriate measures and reporting method and report separately from the ACO for purposes of MIPS scoring. In this case, these clinicians/groups would only be provided with 50 percent automatic credit for improvement activities (while ACOs are awarded with full points automatically for this performance category). CMS would award the clinician or practice with the higher of its own quality score or the ACO's score for MIPS.

Another key change finalized by CMS is regarding how CMS awards a MIPS score when a clinician has multiple final scores associated with a single TIN/National Provider Identifier combination. CMS finalized a policy to use the following hierarchy to assign a final score in these instances:

1. Virtual group final score
2. Highest available score from an APM Entity (such as an ACO), group and/or individual clinician

Currently, CMS uses the following hierarchy:

1. APM Entity score (highest score if multiple exist)
2. Virtual group final score
3. Group or individual clinician score (whichever is higher)

Finally, CMS notes the MIPS quality measure scoring cap for topped out measures will not apply to clinicians, groups or APM Entities (such as an ACO) reporting through the APP. Instead should an APP measure be determined to be topped out, CMS will amend the measure set as appropriate through rulemaking.

*APM Entity Groups in MIPS*

CMS finalized a policy to end the full-TIN APM requirement given the removal of the APM Scoring Standard. Given this, MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the three snapshot dates (March 31, June 30, August 31), as well as December 31 during a performance period, would be considered participants in an APM Entity group. This will allow ACOs to capture all clinicians added to the ACO at any time in the performance year for purposes of determining the ACO final MIPS score and resulting payment adjustment.

*MIPS Promoting Interoperability Changes*

CMS finalized minimal changes to the scoring and measures used for the Promoting Interoperability performance category for 2021. These changes are outlined in Table 42 on page 990 in the final rule.

*CEHRT Changes Required by the 21st Century Cures Act*

CMS finalized a modified timeline to update the definitions of Certified EHR Technology (CEHRT) for the Promoting Interoperability Program and performance category of MIPS. Providers participating in the QPP may use technology certified to either the existing or updated 2015 Edition certification criteria, with the December 31, 2022 date established in the Office of the National Coordinator for Health IT (ONC) interim final rule for health IT developers to make updated certified health IT available.

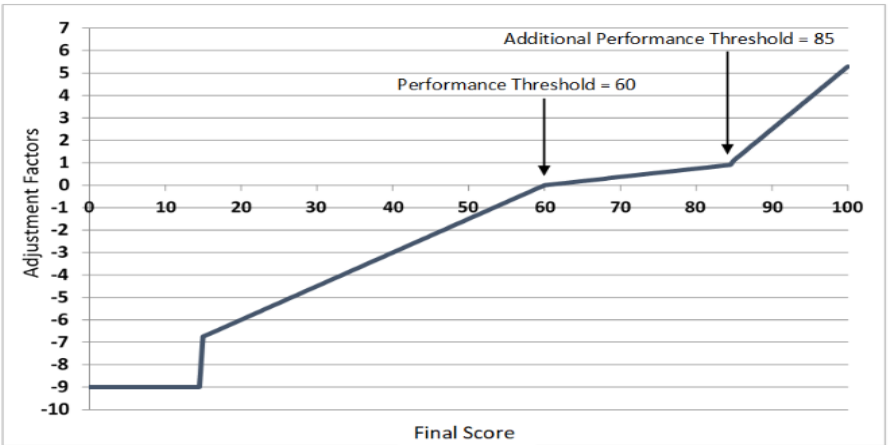
*MIPS Final Scoring and Projected MIPS Scores for 2021*

CMS finalized that final scoring for APMs reporting through the APP would follow the same methodology currently established for the MIPS APM Scoring Standard. Specifically, CMS will continue to score each performance category and multiply each performance category score by the applicable performance category weight, and then calculate the sum of each weighted performance category score and apply any applicable adjustments to those appearing on the APM Participation List or Affiliated Practitioner List.

For 2021, CMS did not finalize policies to reduce the generally applicable (non-ACO) MIPS performance threshold given challenges related to COVID-19. Therefore, the MIPS performance threshold for 2021 will be 60 points; this is the minimum required points necessary to avoid a penalty in MIPS for the corresponding 2023 payment year. The exceptional performance threshold will remain at 85 points for PY 2021 and corresponding 2023 payment year. Given these established thresholds, CMS projects approximately 5 percent as the maximum available bonus for a score of 100 points in 2021 and a

maximum negative penalty of 9 percent. CMS's projections are outlined in Figure A on page 1320 of the proposed rule.

**Figure A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2023 MIPS Payment Year**




*Reweighting/Exceptions for COVID-19 for APM Entities Subject to MIPS*

CMS finalized a policy to allow an APM Entity to submit a hardship exception on behalf of all of its participants beginning with PY 2020. The request for reweighting would apply for all four MIPS performance categories and for all clinicians in the APM Entity subject to MIPS. If an APM Entity, such as an ACO, submits a hardship exception, CMS would not use any data submitted and the APM Entity would receive a neutral MIPS score and payment adjustment for the performance year. Additionally, APM Entities must demonstrate in their application to CMS that greater than 75 percent of their participant MIPS eligible clinicians would be eligible for reweighting the Promoting Interoperability performance category for the applicable performance period. MIPS hardship exceptions are due by February 1, 2021, for PY 2020 and may be submitted through the QPP website.