



Medicare Physician Fee Schedule Final Rule for Calendar Year 2021 Detailed Summary of the Payment and Quality Payment Program Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of final changes to the payment provisions of the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2021. This summary also includes policies for implementation of the fifth year for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Changes will be effective Jan. 1, 2021.

Conversion Factor (page 1657*)

The Centers for Medicare and Medicaid Services (CMS) finalized a CY 2021 conversion factor of \$32.4085, which reflects a 10.20 percent decrease from the current conversion factor of \$36.0896.

CMS estimates an overall impact of the final MPFS changes to radiology to be a 10 percent decrease, while interventional radiology would see an aggregate decrease of an 8 percent, nuclear medicine an 8 percent decrease and radiation oncology and radiation therapy centers a 5 percent decrease. Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in relative value units (RVUs) may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality. This year's budget neutrality adjustment is largely a result of increased RVUs for office/outpatient evaluation and management services (E/M).

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

CMS did not address the appropriate use criteria (AUC)/clinical decision support (CDS) mandate for all advanced diagnostic imaging services in the MPFS rule. However, CMS did update its website Monday, August 10th, to indicate that the current educational and operations testing period will be extended through December 31, 2021.

Evaluation and Management (E/M) Services (page 225)

Background and Previous Rulemaking

CMS finalized to move forward with adoption of a new coding structure for the office/outpatient E/M codes as recommended by the American Medical Association (AMA) and the associated increased valuations of these E/M services starting January 1, 2021.

In the CY 2020 MPFS final rule, for the office/outpatient E/M visit code set (CPT codes 99201 through 99215), CMS finalized a policy to generally adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA's CPT Editorial Panel (see <https://www.ama-assn.org/practice-management/cpt/cptevaluation-and-management>) and will be effective January 1, 2021. Under this new CPT coding framework, history and exam will

*Page numbers are from the display version of the MPFS final rule released on December 1st.

no longer be used to select the level of code for office/outpatient E/M visits. Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent, reasonable and necessary, and clinically appropriate.

The changes also include deletion of CPT code 99201 (*Level 1 office/outpatient visit, new patient*), which the CPT Editorial Panel decided to eliminate because CPT codes 99201 and 99202 are both straightforward medical decision making (MDM) and currently largely differentiated by history and exam elements.

For levels 2 through 5 office/outpatient E/M visits, selection of the code level to report will be based on either the level of MDM or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). CMS continues to believe these policies will further its ongoing effort to reduce administrative burden, improve payment accuracy, and update the office/outpatient E/M visit code set to better reflect the current practice of medicine.

In the CY 2020 MPFS final rule, CMS also addressed and responded to the AMA RUC recommendations. The agency finalized new values for CPT codes 99202 through 99215 and assigned RVUs to the new office/outpatient E/M prolonged visit code G2212, as well as the new code G2211. These valuations were finalized with an effective date of January 1, 2021. Table 20 below provides a summary of the codes and work RVUs finalized in the CY 2020 MPFS final rule for CY 2021.

TABLE 20: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

*Page numbers are from the display version of the MPFS final rule released on December 1st.

Time Values for Levels 2-5 Office/Outpatient E/M Visit Codes

In the CY 2020 MPFS proposed rule, CMS sought comment on the times associated with the office/outpatient E/M visits as recommended by the AMA RUC. When surveying these services for purposes of valuation, the AMA RUC requested that survey respondents consider the total time spent on the day of the visit, as well as any pre- and post-service time occurring within a timeframe of 3 days prior to the visit and 7 days after, respectively. In developing its recommendations to CMS, the AMA RUC then separately averaged the survey results for pre-service, day of service, and post-service times, and the survey results for total time, with the result that, for some of the codes, the sum of the times associated with the three service periods does not match the RUC-recommended total time. The approach used by the AMA RUC to develop recommendations sometimes resulted in two conflicting sets of times: the component times as surveyed and the total time as surveyed.

CMS finalized to adopt the actual total times (defined as the sum of the component times) rather than the total times recommended by the RUC for CPT codes 99202 through 99215 beginning CY 2021.

Add-On Codes

Code G2211 (formerly GPC1X)

CMS finalized to adopt add-on code G2211 describing the “visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex condition.” To better define the service and clarify that the code applies to a single condition that is serious, rather than any single condition, CMS is revising the CPT descriptor to include the word “condition” after “single, serious.” The revised descriptor will be “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 complex condition.” (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

CMS believes that the typical visit described by the revised and revalued office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. CMS also believes the work reflected in this code is inherently distinct from existing coding that describes preventive and care management services. CMS stated that they were not restricting billing based on specialty, but that they did assume that certain specialties furnished these types of visits more than others.

CMS continues to believe that the time, intensity, and PE involved in furnishing services to patients on an ongoing basis that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape, are not adequately described by the revised office/outpatient E/M visit code set.

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CMS believes code G2211 reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time.

For 2021, CMS is assuming that utilization for G2211 will be 90 percent of office/outpatient E/M visits. CMS plans to monitor utilization for appropriate use of the code, which could inform additional efforts to refine the code descriptor and/or provide further guidance.

Prolonged Office/Outpatient E/M Visits (CPT code 99417/HCPSC code G2212)

CMS frequently receives questions about the required time and what time may be counted toward the required time to report prolonged office/outpatient E/M visits. To better address this issue, lack of clarity in the CPT code descriptor, and prevent the potential for double-counting time, CMS created code G2212 "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)" to be used when billing Medicare instead of code 99417 (formerly 99XXX) starting in 2021. The valuation for code G2212 will be the same as for CPT code 99417.

Global Surgical Packages (Page 242)

In the CY 2020 MPFS final rule, CMS decided not to make changes to the valuation of 10- and 90- day global surgical packages to reflect changes made to values for the office/outpatient E/M visit codes while the agency continues to collect and analyze the data on the number and level of office/outpatient E/M visits that are actually being performed as part of these services.

Revaluing Services that are Analogous to Office/Outpatient E/M Visits (Page 232)

CMS finalized its proposal to revalue a group of code sets that include or rely upon office/outpatient E/M visit valuation, consistent with the increases in values finalized for E/M visits for 2021. These code sets include:

- End-stage renal disease monthly capitation payment services
- Transitional care management services
- Maternity services
- Cognitive impairment assessment and care planning
- Annual wellness visits and initial preventive physical examination
- Emergency department visits
- Therapy evaluations
- Certain behavioral healthcare services

Practice Expense

Equipment Life Duration (Page 41)

CMS received input from stakeholders including the RUC, specialty societies, and other commenters suggesting a useful life of less than 1 year for several of the new equipment items for CY 2021, and as low as three months in one case. CMS has rarely received requests for equipment useful life of less than one year in duration and notes that these very short useful life durations are significantly lower than anything in the current equipment database, and if finalized would represent major outliers when compared to the rest of the equipment.

CMS believes that equipment items with very low useful life durations represent outlier cases that are not handled appropriately by the current equipment methodology. The current equipment formula is not designed to address cases in which equipment is replaced multiple times per year, and CMS believes that applying a multi-year depreciation in these situations would not be reflective of market pricing. CMS finalized its proposal **to treat equipment life durations of less than 1 year as having a duration of 1 year for the purpose of our equipment price per minute formula. In the rare cases where items are replaced every few months, CMS believes that it is more accurate to treat these items as disposable supplies with a fractional supply quantity as opposed to equipment items with very short equipment life durations.**

Equipment Maintenance (Page 44)

CMS notes that they continue to investigate potential avenues for determining equipment maintenance costs.

Equipment Utilization Rate (Page 40)

CMS disagrees with the commenters that utilization assumptions for equipment should be revisited as part of the public health emergency. CMS states that while many services had a reduced volume of Medicare beneficiaries at times during the 2020 calendar year, CMS notes that equipment costs under the PFS are amortized across the full useful life of the equipment which in the vast majority of cases is 5-10 years. CMS believes that it would distort relativity to apply a temporary decrease in utilization caused by the public health emergency to the pricing structure of the equipment's full useful life duration. CMS also notes that they do not have statutory authority to exempt any modifications to the equipment utilization assumptions from budget neutrality calculations.

Interest Rates (Page 45)

CMS does not make any proposed changes to the interest rates used in developing the equipment cost per minute calculation for CY 2021.

Update on Technical Expert Panel Related to Practice Expense (Page 88)

CMS has contracted with the RAND Corporation to research potential improvements to CMS' Practice Expense (PE) allocation methodology and data. CMS currently uses a system for setting PE RVUs that relies on data collected in the Physician Practice Information Survey (PPIS) administered by the AMA in 2007-2008. RAND has published its first Research Report on the topic:

https://www.rand.org/pubs/research_reports/RR2166.html

In its first report, RAND found that PPIS data are outdated and may no longer reflect the resource allocation, staffing, and cost structures that describe practitioners' requirements. For example, the PPIS preceded widespread adoption of EHR technology, quality reporting programs, team-based billing codes, and hospital acquisition of physician practices. In their report, RAND also found that practice ownership is strongly associated with indirect PE, with physician-owned practices requiring 190% higher indirect PE compared to facility-owned practices. RAND found that aggregating specialties into broader categories resulted in small specialty-level impacts relative to the current system. RAND recommends 1) considering ways to improve the allocation of PE RVUs by shifting more to the physician office setting, 2) establishing a new PE survey that can be repeated on an ongoing basis to ensure that PE RVUs reflect future changes, and 3) identifying codes with potentially misvalued PE using OPPS information. RAND also convened a Technical Expert Panel (TEP) in January 2020. RAND has published a Summary of its Technical Expert Panel (TEP) on PE: https://www.rand.org/pubs/working_papers/WR1334.html

Based on results of the TEP and RAND's research, CMS is interested in potentially refining PE methodology and updating the data used to make payments under the PFS. CMS' goal is to obtain the data as soon as practicable and in a way that would allow stakeholders and CMS to examine. CMS remains interested in holding a Town Hall meeting for stakeholders (date TBD) to provide an open forum for discussion. Stakeholders are encouraged to submit comments outside the public comment period via email to CMS at PE_Price_Input_Update@cms.hhs.gov. In response to the RAND Report, during the public comment period CMS received comments that encouraged the Agency working with stakeholders on any new PE data collection effort. CMS responded that they would want to engage with stakeholders in any new PE data collection effort and will do so through their public notice and comment rulemaking process for any future proposals.

Equipment Recommendations for Scope Systems (Page 50)

In the 2021 proposed rule, CMS shared that they still lacked invoices for seven scope equipment items and also requested feedback on the scope equipment that had updated pricing.

Following the proposed rule, CMS did receive invoice submissions for three of the seven scope equipment items they were missing. CMS will be finalizing the prices for these equipment.

Market-Based Supply and Equipment Pricing Update (Page 65)

For CY 2019, CMS contracted with StrategyGen to review and update the pricing for direct practice expense supply and equipment inputs. The updated prices are to be phased in over a four-year period, with the final prices to be fully implemented in CY 2022.

In the proposed rule, CMS included updated pricing for 6 items, 4 of which pertain to radiology: guidewire, hydrophilic (SD089), vascular sheath (SD136), catheter, RF endovenous occlusion (SD155), and nuclide rod source set (ER044).

CMS received invoice(s) for several radiology-pertinent supply and equipment items following the proposed rule.

- radiofrequency introducer kit (SA026) - The updated 2021 pricing for SA026 will be \$32.83, with a final price of \$28.575 in CY 2022.

- hydrophilic guidewire (SD089) - The updated 2021 pricing for SD089 will be \$29.995, with a final price of \$20.555 in CY 2022.
- endovascular laser treatment kit (SA074) – The updated 2021 pricing for SA074 will be \$429.88, with a final price of \$438.60 in CY 2022.
- RF endovenous occlusion catheter (SD155) - The updated 2021 pricing for SD155 will be \$562.71, with a final price of \$487.92 in CY 2022.
- Vascular sheath (SD136) – While CMS received comments regarding the inaccuracy of the \$24.44 price for this item, no invoice(s) were actually submitted.
- HDR Afterload System, Nucletron – Oldelft (ER003), SRS System, SBRT, Six Systems (ER083) – CMS received comments that the pricing for these two items were inaccurate and requested that CMS conduct additional market pricing research for these equipment. However, no invoices were submitted.

CMS received comments from stakeholders expressing their desire for CMS to be more transparent about the decision-making process regarding supply and equipment pricing. CMS agrees the need to explain why they choose (or not choose) to accept an invoice for pricing.

CMS accepts invoices at this email address: PE_Price_Input_Update@cms.hhs.gov

Medical Physics Dose Evaluation (CPT code 76145)/HOPPS Cap List (Page 467)

CMS proposed to replace new CPT code 76145 (formerly 7615X) (Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report) on the Deficit Reduction Act (DRA) OPSS cap list. Based on comments received, **CMS finalized the direct PE inputs for CPT code 76145 as proposed and is removing this code from the OPSS Cap List.**

Potentially Misvalued Services Under the PFS (Page 92)

No Radiology codes were identified as potentially misvalued, either by CMS or through the public nominations process in the proposed rule.

In the final rule, several commenters proposed additional codes as potentially misvalued for CMS consideration. However, none of the proposed codes pertain to radiology.

Proposed Valuation of Specific Codes for CY 2021 (Page 390)

Fine Needle Aspiration (CPT codes 10021, 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, and 10012) (Page 390)

The Fine Needle Aspiration (FNA) code family was finalized for CY 2019, with CMS accepting the RUC-recommended values for seven of the ten codes. The AMA RUC provided comment that they believed CMS had double-counted the utilization for some of the new codes that had image guidance bundled, leading to the refinement of some of the code values. At the January 2020 meeting, the RUC reaffirmed the values previously recommended and resubmitted them to CMS for reconsideration. However, CMS still does not believe that utilization was erroneously double-counted for this family and states that the refined values are a result of changes in surveyed time and the relationship between the codes in the family.

Even following feedback from several commenters, CMS still maintains that they did not double-count the utilization for codes in the FNA family. Commenters pointed to the 2019 utilization for these codes compared to CMS' projected RVU pool and urged CMS to reconsider implementing the RUC-recommended values. However, CMS states that it is not their methodology to review utilization crosswalks against claims data, and insists that their valuation of CPT codes 10021, 10005, and 10009 are based on changes in surveyed work time and the relativity within the code family.

Commenters indicated that they believe CMS miscalculated some equipment time for CPT codes 10021, 10005, 10007, and 10009. However, CMS disagrees and will be reaffirming their previous times.

Lung Biopsy-CT Guidance Bundle (CPT code 32408) (Page 424)

CPT codes 32405 (*Biopsy, lung or mediastinum, percutaneous needle*) and 77012 (*Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation*) were identified on a screen for codes reported together 75% or more of the time. The CPT Editorial Panel then created a new code, 32408 (*Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed*), bundling these services.

CMS disagreed with the RUC-recommended 4.00 RVU for CPT code 32408, indicating that the value overstates the increase in intensity given the decrease in time. Instead, CMS proposed a value of 3.18 RVU.

Commenters disagreed with CMS time-based ratio to value CPT code 32408. They also believe that CMS overlooked compelling evidence rationale that would justify a higher valuation. However, CMS disagrees and are finalizing their proposed 3.18 RVU for CPT code 32408. Additionally, CMS is finalizing the PE inputs as proposed.

X-Ray of Eye (CPT code 70030) (Page 455)

CPT code 70030 (*Radiologic examination, eye, for detection of foreign body*) was identified on the CMS/Other screen for codes with Medicare utilization over 20,000. Following the supporting comments from stakeholders, CMS is finalizing the 0.18 RVU and PE inputs as proposed.

CT Head-Brain (CPT codes 70450, 70460, and 70470) (Page 455)

CPT code 70450 (*Computed tomography, head or brain; without contrast material*) was publicly nominated as potentially misvalued in the CY 2019 MPFS, citing GAO and MedPAC reports which indicate that the work RVUs were overstated for these type of procedures. The family was expanded during the survey process to include CPT codes 70460 (*Computed tomography, head or brain; with contrast material(s)*) and 70470 (*Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections*). Following supporting comments from stakeholders, CMS is finalizing the values of 0.85 RVU for CPT code 70450, 1.13 RVU for CPT code 70460, and 1.27 RVU for CPT code 70470, as well as the PE inputs, as proposed.

Screening CT of Thorax (CPT codes 71250, 71260, 71270, and 71271) (Page 457)

HCPCS code G0297 (*Low dose ct scan (ldct) for lung cancer screening*) was identified on a CMS/Other screen for codes with 2017 Medicare utilization over 30,000. The CPT Editorial Panel created a new CPT code for this procedure, 71271 (*Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)*). CT chest codes 71250 (*Computed tomography, thorax; without contrast material*), 71260 (*Computed tomography, thorax; with contrast material(s)*), and 71270 (*Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections*), were also addressed as part of the larger code family.

In the proposed rule, CMS applied intraservice time ratios to refine the values for the codes in the family. Commenters attributed the decreases in intraservice time to survey variation, but CMS believes that the changes in time yielded overestimations in value. CMS further defends their application of incremental differences between codes to maintain intra-family relativity.

CMS is finalizing the values of 1.08 RVU for CPT code 71250, 1.16 RVU for CPT code 71260, 1.25 RVU for CPT code 71270, and 1.08 for CPT code 71271 as proposed. The values for CPT codes 71250, 71260, and 71270 are decreases from the current value. However, the value for 71271 is an increase from the previous value for G0297.

CMS is finalizing the PE inputs as proposed.

X-Ray Bile Ducts (CPT codes 74300, 74328, 74329, and 74330) (Page 462)

CPT codes 74300 (*Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation*) and 74328 (*Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation*) were identified on a CMS/Other screen for codes with 2017 Medicare utilization over 30,000. The code family was expanded to include CPT codes 74329 (*Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation*) and 74330 (*Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation*), and all four codes were surveyed.

In the proposed rule, CMS agreed with the RUC-recommended 0.47 RVU for CPT code 74328, but refined the values for the remaining three codes. Commenters contested CMS's use of intraservice time-ratios to value the family as a valid methodology, with which CMS disagrees. In response to commenters' statement that CPT code 74329 is a more intense procedure than 74328 and should be valued higher, CMS stated that they do not have survey evidence to support that statement. Therefore, CMS is finalizing the values of 0.27 RVU for CPT code 74300, 0.47 RVU for CPT code 74328, 0.47 RVU for CPT code 74329, and 0.56 RVU for CPT code 74330 as proposed.

No direct PE inputs were recommended, as these codes are performed in the facility setting.

Venography (CPT codes 75820 and 75822) (Page 465)

CPT code 75820 (*Venography, extremity, unilateral, radiological supervision and interpretation*) was identified on a CMS/Other screen for codes with Medicare utilization over 20,000. CPT code 75822 (*Venography, extremity, bilateral, radiological supervision and interpretation*) was surveyed as part of the venography family.

Following support from commenters, CMS is finalizing the values of 1.05 RVU for CPT code 75820 and 1.48 RVU for CPT code 75822, as well as the PE inputs, as proposed.

Introduction of Catheter or Stent (CPT code 75984) (Page 466)

CPT code 75984 (*Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation*) was reviewed by the RUC during the April 2019 meeting. Following support from commenters, CMS is finalizing the value of 0.83 RVU for CPT code 758984, as well as the PE inputs, as proposed.

Medical Physics Dose Evaluation (CPT code 76145) (Page 467)

A practice expense (PE) survey was conducted to determine the appropriate direct inputs associated with CPT code 76145 (*Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report*). This is a new CPT code, and there are no analogous services for this stand-alone service. Following support from commenters, CMS is proposing to accept the proposed PE inputs without refinement.

CMS also received comments requesting the removal of this code from the Deficit Reduction Act (DRA) cap designation, since this is not an imaging service. CMS was persuaded by the comments and agreed that this procedure is more akin to a physics consultation service. CPT code 76145 will not be subject to the adjustment under the OPSS cap.

Radiation Treatment Delivery (CPT code 77401) (Page 473)

CPT code 77401 (*Radiation treatment delivery, superficial and/or ortho voltage, per day*) was identified on a high-volume growth screen for services with 2017 Medicare utilization over 10,000 that has increased by at least 100 percent from 2012 through 2017. This is a PE-only code.

CMS proposed reducing the “clean room/equipment by clinical staff” time from 5 minutes to the standard 3 minutes. Commenters indicated that the additional 2 minutes approved by the RUC is necessary to clean both the room and the equipment. CMS disagrees, stating that the standard 3 minutes allotted to “clean room” includes the time to clean both the room and the equipment.

Additionally, CMS requested information clarification on the new equipment item “Lead Room” (ER119), in order to determine whether it is a direct or indirect expense. Following comments that the lead-lined room may be used for other services outside of superficial radiation therapy (SRT), CMS believes this item to be an indirect expense akin to office rent expenses. CMS finalized the PE inputs as proposed.

Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) (Page 475)

CPT codes 77522 (*Proton treatment delivery; simple, with compensation*) and 77523 (*Proton treatment delivery; intermediate*) were identified as contractor-priced Category I codes with 2017 estimated Medicare utilization over 10,000. The code family was expanded to include CPT codes 77520 (*Proton treatment delivery; simple, without compensation*) and 77525 (*Proton treatment delivery; complex*), and a PE survey was performed.

In the proposed rule, CMS indicated that they had some difficulty with the two new equipment items, specifically due to their high prices. Based on submitted invoices used to help price the items, the Proton Treatment Vault (ER115) is \$19,001,914 and the Proton Treatment Delivery System (ER116) is \$30,400,000, significantly higher than the current highest priced PE item in the database, which is the “SRS system, Linac” (ER082), which is \$4,233,825. CMS expressed concern that adding the higher priced equipment into the database could distort relativity. Another concern is that the submitted invoices reflected some costs that could be considered direct expenses, such as building construction costs.

In light of the above concerns, CMS proposes that the code family remain contractor-priced. If CMS were to propose active pricing for this family, the construction costs would need to be removed, thus substantially lowering the equipment prices. CMS would also refine the equipment times to the standard formula for highly technical equipment, which would lower the times for each equipment item by 3 minutes.

CMS received mixed comments about their proposal to maintain contractor pricing for this family. One commenter urged CMS to implement the RUC recommendations, but CMS disagreed, stating that the associated equipment costs are problematic to their PE methodology. CMS is finalizing their decision to maintain contractor pricing for this code family, as proposed.

Telehealth (Page 104)

Several conditions must be met for services to be added to the Medicare telehealth list. Category 1 services are services that are similar to professional consultations, office visits, and office psychiatry visits that are currently on the Medicare telehealth services list. Category 2 services are services that are not similar to those currently on the Medicare telehealth services list. In response to the COVID-19 PHE, during emergency rulemaking CMS added services to the telehealth services list on an interim final basis. Through Waiver authority in response to the COVID-19 PHE, CMS has removed the geographic and site of service originating site restrictions as well as the restrictions on the types of practitioners who may furnish telehealth services, and has allowed certain telehealth services to be furnished using audio-only technology. At the conclusion of the PHE, these waivers and interim policies will expire, payment for Medicare telehealth services will again be limited by requirements in section 1834(m) of the Act, and CMS will return to the policies of the regular rulemaking process.

CMS finalized their proposal to add 9 services to the Medicare telehealth services list on a Category 1 basis for 2021. These include: G2211, previously described by placeholder code GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services), G2212, previously

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described by placeholder code 99XXX (Prolonged office or other outpatient evaluation and management services (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes), 90853 (Group psychotherapy, other than of a multiple-family group), 96121 (neurobehavioral status exam), 99483 (Cognitive Assessment and Care Planning Services), 99334 and 99335 (Domiciliary, Rest Home, or Custodial Care Services), and 99347 and 99348 (Home visits, established patients).

CMS finalized their proposal to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. Category 3 will include the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Any service in Category 3 will remain on the telehealth services list through the later of the end of the calendar year in which the PHE ends or December 31, 2021. CMS finalized over 60 services to the Medicare telehealth list under Category 3.

CMS finalized their proposal that when new codes are issued to replace codes that describe the same clinical services that are currently on the Medicare telehealth services list, CMS will consider those new codes to be successor codes. CMS sought comment on whether frequency limitations for telehealth are burdensome and limit access to care (ex. allowing one telehealth appt. every 30 days) when services are only available through telehealth. CMS finalized a policy to allow subsequent nursing visits to be furnished via Medicare telehealth once every 14 days in the nursing facility setting. In the March 31st COVID-19 IFC, CMS allowed non-physician providers such as clinical social workers, clinical psychologists, OTs, PTs, and SLPs who bill Medicare directly for their services to bill HCPCS codes G2061 through G2063. CMS finalized their proposal to adopt this PHE policy on a permanent basis. CMS also finalized their proposal to allow billing of other communication technology based services (CTBS) by certain NPPs, consistent with the scope of these practitioners' benefit categories through the creation of two additional HCPCS G codes (G2250, G2251) that can be billed by practitioners who cannot independently bill for E/M services.

During the PHE, CMS established a payment for audio-only telephone E/M services. Although CMS received broad support in comments for maintaining certain audio-only services after the duration of the PHE, CMS is unable to do so without PHE declaration as the audio-only assessment and management or E/M visits are by definition replacements for in-person office visits, and would be subject to the statutory restrictions outlined in section 1834(m) of the Act. Without the PHE declaration for COVID-19, CMS believes that their regulatory interpretation of "telecommunications system" precludes the use of audio-only technology for purposes of Medicare telehealth services. CMS finalized their proposal to clarify that telehealth services may be furnished and billed when provided incident to a distant site physicians' (or authorized NPP's) service under the direct supervision of the billing professional provided through virtual presence.

Telehealth and Supervision

During the PHE, CMS adopted an Interim Final Policy to revise the definition of direct supervision to include virtual presence of the supervising physician or practitioner using audio/video real-time communications technology. CMS finalized their proposal to extend this policy through the later of the calendar year in which the PHE for COVID-19 ends or December 31, 2021, to recognize

*Page numbers are from the display version of the MPFS final rule released on December 1st.

circumstances of communities that may continue after the PHE ends, and to allow time for public input.

During the PHE, CMS adopted a policy on an interim basis to allow Medicare to make payment under the PFS for teaching physicians when a resident furnishes Medicare telehealth services to beneficiaries while a teaching physician is present using interactive communication technology. **CMS is finalizing a permanent policy but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA).** CMS is not permanently extending this policy for any other areas, however the policy will remain in place for the duration of the COVID-19 PHE in all teaching settings.

Scope of Practice and Related Issues (Page 290)

CMS finalized several proposed policies consistent with the President’s Executive Order 13890 on “Protecting and Improving Medicare for Our Nation’s Seniors” to modify supervision and other requirements of the Medicare program that limit healthcare professionals from practicing at the top of their license (84 FR 53573, October 8, 2019, Executive Order #13890). CMS believes that physicians, NPPs, and other professionals should be able to furnish services to Medicare beneficiaries in accordance with their scope of practice and state licensure, including education and training, to the extent permitted under the Medicare statute, as long as it is not likely to result in fraud, waste or abuse. The agency believes these policies will also help ensure an adequate number of clinicians, in addition to physicians, who are able to furnish critical services including primary care services in areas where there is a shortage of physicians. Some of the policies may also help alleviate the opioid crisis.

Recognizing the wide variation in state laws CMS requested information about the number and names of states that have licensure or scope of practice laws in place, as well as any facility-specific policies, that would impact the ability of clinicians to exercise the flexibilities the agency proposed, to help assess the potential impact of, or challenges for, the proposed changes. CMS requested public comment on whether applicable state laws, scope of practice, and facility policies would permit practitioners to exercise the proposed flexibilities if CMS were to adopt the policies proposed in this section, and to what extent practitioners would be permitted to exercise these proposed flexibilities, such as for all diagnostic tests or only a subset.

Teaching Physician and Resident Moonlighting Policies (Page 292)

In the March 31st COVID-19 Interim Final Rule with Comment (IFC) and the May 1st COVID-19 IFC, CMS implemented several policies on an interim final basis related to MPFS payment for the services of teaching physicians involving residents and resident moonlighting regulations. CMS accepted comments for both of the IFCs and plans to address the IFC comments for issues in which there are proposals in this proposed rule when the MPFS final rule is published. **After consideration of comments received, CMS is finalizing extension of these policies for the duration of the COVID-19 PHE.**

Under current law, payment is made under the MPFS for services furnished in a teaching hospital setting if the services are personally furnished by a physician who is not a resident, or the services are furnished by a resident in the presence of a teaching physician, with exceptions as specified in

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subsequent regulatory provisions. If a resident participates in a service furnished in a teaching setting, MPFS payment is made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought. The regulation states that, for the interpretation of diagnostic radiology and other diagnostic tests, MPFS payment is made if the interpretation is performed or reviewed by a physician other than a resident.

CMS adopted a policy on an interim basis during the COVID-19 PHE that the requirement for the presence of a teaching physician during the key portion of the service furnished with the involvement of a resident can be met using audio/video real-time communications technology. This policy generally requires real-time observation (not mere availability) by the teaching physician through audio and video technology, and does not include audio-only technology (for example, telephone without video). CMS also adopted a policy on an interim basis for the duration of the COVID-19 PHE to allow MPFS payment to be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. A physician other than the resident must still review the resident's interpretation. **After reviewing comments, CMS is finalizing extension of these policies for the duration of the COVID-19 PHE.**

In the March 31st COVID-19 IFC CMS adopted a policy on an interim basis to allow Medicare to make payment under the MPFS for teaching physician services when a resident furnishes Medicare telehealth services to beneficiaries while a teaching physician is present using audio/video real-time communications technology. **CMS is finalizing extension of this policy for the duration of the COVID-19 PHE. CMS also clarified that the physician must be present using video communications technology, not audio only.**

Under the so-called "primary care exception," Medicare makes MPFS payment in certain teaching hospital primary care centers for certain services of lower and mid-level complexity furnished by a resident without the physical presence of a teaching physician. The regulation requires that the teaching physician must not direct the care of more than four residents at a time, and must direct the care from such proximity as to constitute immediate availability (that is, provide direct supervision) and must review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies. There is also a requirement that the teaching physician must have no other responsibilities at the time, assume management responsibility for the beneficiaries seen by the residents, and ensure that the services furnished are appropriate.

In the March 31st COVID-19 IFC, CMS amended its regulations to allow, during the PHE for COVID-19, all levels of office/outpatient E/M visits to be furnished by the resident and billed by the teaching physician under the primary care exception. In the May 1st COVID-19 IFC, CMS further expanded the list of services included in the primary care exception during the PHE for COVID-19. CMS also allowed MPFS payment to the teaching physician for services furnished by residents via telehealth under the primary care exception if the services were also on the list of Medicare telehealth services. **CMS finalizing extension of the policy for the duration of the COVID-19 PHE.**

CMS adopted a policy on an interim basis for the duration of the PHE for COVID-19 to allow MPFS payment for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is

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performed by a resident when the teaching physician is present through audio/video real-time communications technology. A physician other than the resident must still review the resident's interpretation.

After reviewing comments received, CMS believes that permitting the teaching physician to meet the requirements to bill under the PFS for their services through virtual presence when furnishing services involving residents in rural training settings could increase access to Medicare-covered services by preventing the beneficiary from potentially having to travel long distances to obtain care, particularly as rural areas have stretched and diminishing clinical workforces. Further, permitting the virtual presence of the teaching physician could facilitate expanded training opportunities for residents in rural settings, which have historically been in limited supply. As such, the need to improve rural access to care for patients and training for residents overshadows CMS's concerns about the ability for the teaching physician to render sufficient personal and identifiable physicians' services through virtual presence. Accordingly, CMS believes it would be appropriate to continue its policy to permit teaching physicians to meet the requirements to bill under the MPFS for their services through virtual presence when furnishing services involving residents in rural settings after the conclusion of the PHE for COVID-19. **Therefore, CMS is finalizing a permanent policy to permit teaching physicians to meet the requirements to bill for their services involving residents through virtual presence, but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA).** When a teaching physician, through virtual presence, furnishes services involving residents in a residency training site located outside of a MSA, the patient's medical record must clearly reflect how and when the teaching physician was present for the service in accordance with CMS regulations.

For all other settings, CMS is not permanently finalizing the teaching physician virtual presence policies; however, they will remain in place for the duration of the PHE to provide flexibility for communities that may experience resurgences in COVID-19 infections.

CMS believes that a policy to permit Medicare to make MPFS payment for teaching physician services when a resident located within a rural training setting furnishes Medicare telehealth services to beneficiaries while a teaching physician is present through interactive, audio/video real-time communications technology (excluding audio-only) could increase access to Medicare-covered services in rural areas by preventing the beneficiary from potentially having to travel long distances to obtain care, particularly as rural areas have stretched and diminishing clinical workforces. Increasing beneficiary access to care in rural areas is also consistent with CMS's longstanding interest in increasing beneficiary access to Medicare-covered services in rural areas; therefore, in order to allow for more widespread access to care for beneficiaries in rural areas, CMS believes it would be appropriate for a resident located within a rural training setting to furnish telehealth services to a beneficiary who is in a separate location within the same rural area as the resident or within a different rural area, while a teaching physician is present, through interactive, audio/video real time communications technology (excluding audio-only), in a third location, either within the same rural training setting as the resident or outside of that rural training setting. **Therefore, CMS is permanently finalizing its policy that Medicare may make payment under the MPFS for teaching physician services when a resident furnishes Medicare telehealth services in a residency training site located outside of a MSA to a beneficiary who is in a separate location outside the same MSA (that is, in the same rural area) as the residency training site or is within a rural area outside of a**

different MSA, while a teaching physician is present, through interactive, audio/video real-time communications technology (excluding audio only), in a third location, either within the same rural training site as the resident or outside of that rural training site. For all other settings, CMS is not permanently finalizing this policy; however, the policy will remain in place for the duration of the PHE for COVID-19 to provide flexibility for communities that may experience resurgences in COVID-19 infections.

Supervision of Diagnostic Tests by Certain Non-Physician Practitioners (NPPs) (Page 348)

In response to a previous request for comments, physician assistants (PAs) and nurse practitioners (NPs) recommended regulatory changes that would allow them to supervise the performance of diagnostic tests because they are currently authorized to do so under their state scope of practice rules in many states. **In the May 1st COVID-19 IFC, CMS established on an interim basis during the COVID-19 PHE, a policy to permit these and certain other NPPs to supervise diagnostic tests. Despite comments from the ACR opposing the proposal to make the changes permanent, CMS is finalizing the proposal.**

Prior to the COVID-19 PHE, physicians, NPs, CNSs, PAs, certified nurse-midwives (CNMs), clinical psychologists (CPs), and clinical social workers (CSWs) who are treating a beneficiary for a specific medical problem may order diagnostic tests when they use the results of the tests in the management of the beneficiary's specific medical problem. However, generally only physicians were permitted to supervise diagnostic tests.

In light of stakeholder feedback to CMS on identifying additional Medicare regulations that contain more restrictive supervision requirements than existing state scope of practice laws, or that limit health professionals from practicing at the top of their license, effective January 1, 2021, **CMS is finalizing its proposal to amend the rule to allow NPs, CNSs, PAs or CNMs to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice.** These NPPs have separately enumerated benefit categories under Medicare law that permit them to furnish services that would be physician's services if furnished by a physician, and are authorized to receive payment under Medicare Part B for the professional services they furnish either directly or "incident to" their own professional services, to the extent authorized under state law and scope of practice.

Medical Record Documentation

As CMS established in the CY 2020 PFS final rule, and expressed in the May 1st COVID-19 IFC, any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team.

In the final rule, CMS emphasizes that, while any member of the medical team may enter information into the medical record, only the reporting clinician may review and verify notes made in the record by others for the services the reporting clinician furnishes and bills. CMS wants to emphasize that information entered into the medical record must document that the furnished services are reasonable

and necessary.

Proposal to Remove Selected National Coverage Determinations (NCDs) (Page 997)

CMS finalized the proposal to use the rulemaking process to use the criterion established in 2013 to regularly identify and remove NCDs that no longer contain clinically pertinent and current information, those items and services that no longer reflect current medical practice, or that involve items or services that are used infrequently by beneficiaries. CMS proposed this change of vehicle because removing a NCD changes a substantive legal standard related to Medicare coverage and payment for items and services under section 1871(a)(2) of the Act. Eliminating an NCD for items and services that were previously covered means that the item or service will no longer be automatically covered by Medicare. Instead, the coverage determinations for those items and services will be made by Medicare Administrative Contractors (MACs). On the other hand, if the previous NCD barred coverage for an item or service under title XVIII (that is, national noncoverage NCD), a MAC would now be able to cover the item or service if the MAC determined that such action was appropriate under the statute. Removing a national non-coverage NCD may permit access to technologies that may now be beneficial for some uses. As the scientific community continues to conduct research that produces new evidence, the evidence base we previously reviewed may have evolved to support other policy conclusions.

Per the guidance issued in 2013, CMS may consider an older NCD for removal if, among other things, any of the following circumstances apply:

- CMS believes that allowing local contractor discretion to make a coverage decision better serves the needs of the Medicare program and its beneficiaries.
- The technology is generally acknowledged to be obsolete and is no longer marketed.
- In the case of a noncoverage NCD based on the experimental status of an item or service, the item or service in the NCD is no longer considered experimental.
- The NCD has been superseded by subsequent Medicare policy.
- The national policy does not meet the definition of an “NCD” as defined in sections 1862(l) or 1869(f) of the Act.
- The benefit category determination is no longer consistent with a category in the Act.

CMS requested public comments that may identify other reasons for proposing to remove NCDs. The agency was also interested in whether the time-based threshold of “older” which was designated as 10 years in the 2013 notice continues to be appropriate or whether stakeholders believe a shorter period of time or some other threshold criterion unrelated to time is more appropriate. The ACR recommended in our comment letter that the threshold be reduced to 7 years. CMS responded acknowledging the rapid pace of medical technology development and changes in standard of care and will consider those factors in the future when evaluating whether NCDs should be removed.

Some commenters suggested that CMS should have a process that is more nimble and flexible than rulemaking, such as an expedited subregulatory administrative process. CMS responded that given the importance of NCDs in notifying the public when particular items or services will (or will not) be covered, the agency believes that a public process is necessary to remove the policies. The agency did acknowledge that the rulemaking process is not required to establish or change NCDs. CMS also

believes that the rulemaking process is most efficient for removing multiple NCDs at once. Finally, CMS noted that they may consider using the rulemaking process in the future to remove and/or “wrap up” Coverage with Evidence Development (CEDs).

CMS proposed the below NCDs for removal. **CMS finalized the removal of all of the proposed NCDs except 110.14 Apheresis, 190.1 Histocompatibility Testing, and 190.3 Cytogenetic Studies.**

TABLE 37: Proposed NCDs for Removal

NCD Manual Citation	Name of NCD
20.5	Extracorporeal Immunoabsorption (ECI) using Protein A Columns (01/01/2001)
30.4	Electrosleep Therapy
100.9	Implantation of Gastroesophageal Reflux Device (06/22/1987)
110.14	Apheresis (Therapeutic Pheresis) (7/30/1992)
110.19	Abarelix for the Treatment of Prostate Cancer (3/15/2005)
190.1	Histocompatibility Testing
190.3	Cytogenetic Studies (7/16/1998)
220.2.1	Magnetic Resonance Spectroscopy (09/10/2004)
220.6.16	FDG PET for Inflammation and Infection (03/19/2008)

NCD #220.2.1 Magnetic Resonance Spectroscopy

MRS can determine the relative concentrations and physical properties of a variety of biochemicals and has the potential to probe a wide range of metabolic pathways in different human tissue. Although MRS is mostly used in assessing brain tissue, it also offers potential applicability to breast, prostate, hepatic, and other cancers. External stakeholders suggested this NCD might be outdated, noting the 2004 broad noncoverage determination for all indications was based on evidentiary review for one limited indication, the diagnosis of brain tumors. As the scientific evidence evolves and the clinical utility develops across various indications, the restrictive scope of the 2004 NCD may prohibit appropriate local coverage determinations.

CMS finalized removal of this policy.

NCD #220.6.16 FDG PET for Inflammation and Infection

The decision to use FDG PET for inflammation and infection is multifactorial and depends on: whether conventional diagnostics have been unsuccessful, the stage of the underlying pathophysiological condition in the affected tissues, and the sensitivity and specificity of FDG PET to inform the differential diagnosis or course of disease, among other factors. For some inflammatory and infectious conditions, there is no overall agreement in the current literature about the added value of FDG PET for this indication. Conversely, leaving such determinations to local contractor discretion builds in flexibility to tailor coverage decisions to the pertinent facts of a patient’s case and considering any added benefit of FDG PET in establishing a diagnosis and treatment plan that might link the PET imaging to an improved patient outcome.

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CMS finalized removal of this NCD as proposed and will modify the NCD manual to ensure that contractors have the authority to make a coverage determination when claims are submitted for PET for Inflammation and Infection.

CT Colonography

In comments on the proposed rule, the ACR requested removal of the outdated non-coverage NCD for screening CT colonography. CMS also received comments recommending removal of several other NCDs. CMS responded that they will take the suggestions under advisement for future review and will continue to communicate with interested stakeholders.

Medicare Shared Savings Program (Page 712)

Eligible groups of providers and suppliers may participate in the Shared Savings Program by forming or participating in an Accountable Care Organization (ACO). Under the Medicare Shared Savings Program (MSSP) participants in an ACO continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements. In the May 8th COVID-19 IFC, CMS modified MSSP policies to 1) allow ACOs whose current agreement period ends December 31st 2020 the option to extend one year and allow ACOs on the BASIC track the option to elect to maintain their current level of participation for performance year 2021; 2) adjust program calculations to remove payment amounts for episodes of care for treatment of COVID-19; 3) expand the definition of primary care services for purposes of determining beneficiary assignment; and 4) clarified the applicability of the program's extreme and uncontrollable circumstances policy to mitigate shared losses for the PHE beginning January 2020.

ACOs must meet a quality performance standard to qualify to share in savings, and the quality performance standard is currently based on an ACO's experience in the program rather than financial risk. The Alternative Payment Model Performance Pathway (APP) was designed for MIPS APMs, but also supports interests in aligning the Shared Savings Program with MIPS. The APP is designed to reduce burden, create new scoring opportunities for those in MIPS APMs and encourage participation in APMs. The APP requires fewer quality measures specifically intended for population health: 6 measures versus the current 23 required measures. CMS proposed revising the Shared Savings Program quality performance standard effective for PY 2021 and subsequent performance years to align the Shared Savings Program quality performance standard with the proposed APP under the QPP. Due to concerns from commenters in implementing the APP for MSSP ACOs starting in 2021, CMS is modifying the proposed quality performance standard to include a gradual phase-in of the increase in the level of quality performance that would be required for ACOs to meet the quality performance standard under the APP for Shared Savings Program ACOs. ACOs will only need to report one set of quality metrics via the APP that will satisfy quality reporting requirements under both MSSP and MIPS. The APP will replace the current MSSP quality measure set to streamline reporting requirements for ACOs and will be complementary to MVPs.

CMS proposed increasing the level of quality performance that would be required of all ACOs to meet the Shared Savings Program quality performance standard to the 40th percentile or above across all MIPS categories. Due to concern from commenters, CMS is finalizing a modified version of this policy to allow a gradual phase-in of the increase in the level of quality performance that would be

required for all ACOs to meet the Shared Savings Program quality performance standard. An ACO will meet the quality performance standard if: 1) for performance years 2021 and 2022, the ACO achieves a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores; 2) for performance year 2023 and subsequent performance years, the ACO achieves a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores.

CMS finalized their proposal to terminate an ACO's participation agreement when the ACO fails to meet the quality performance standard for 2 consecutive performance years or any 3 performance years. CMS finalized their proposed policy with modification to update the extreme and uncontrollable circumstances policy under MSSP consistent with the proposal to align quality reporting requirements with the APP. For performance years 2021 and 2022, CMS will set the minimum quality performance score for an ACO affected by extreme and uncontrollable circumstances during the performance year, to equal the 30th percentile to the MIPS quality performance score. CMS will use the higher of the ACO's MIPS quality performance category or the 30th percentile MIPS quality performance score. If unable to report quality data and meet data completeness, CMS will use the 30th percentile MIPS quality performance score. For PY 2023, CMS will follow this same policy, with the exception of increasing to the 40th percentile of the MIPS quality performance score.

CMS finalized two payment policy proposals that will allow lower repayment for ACOs. Under the first finalized policy, a renewing ACO that uses an existing repayment mechanism to establish its ability to repay any shared losses incurred for performance years in its new agreement period may reduce its existing repayment mechanism amount if the repayment mechanism amount calculated for the new agreement period is less than the amount of the existing repayment mechanism. Under the second finalized policy, CMS will permit ACOs whose agreements began July 1, 2019 or January 1, 2020 a one-time opportunity to reduce the amount of their repayment mechanisms. CMS will notify an eligible ACO in writing of this opportunity.

QUALITY PAYMENT PROGRAM

Of note, CMS is lowering the quality performance category's weight to 40 percent and raising the cost category to 20 percent of the overall performance score for performance year 2020. Several quality measures have also been proposed for removal, including *Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms*. CMS also finalizes their proposal to lower the performance threshold to 50 points (from the previously finalized 60 points). Small practices can claim the small practice bonus of 6 points to their quality score.

MIPS Program Details

Transforming MIPS: MIPS Value Pathways (Page 1146)

In the CY 2020 PFS final rule, CMS defined the framework for MIPS Value Pathways (MVPs) as "a subset of measures and activities established through rulemaking." In this final rule (CY 2021), **CMS finalizes the proposed updates to the MVP guiding principles that guide MVP implementation.** The updates include the incorporation of distinct characteristics of MVPs. For instance, within each MVP, measures and activities must complement each other, and scoring practices must align among the MVPs. Comparative performance data, valuable to patients and caregivers, should promote

subgroup reporting and comprehensively reflect multispecialty groups' services. MVP developers should implement CMS' Meaningful Measures framework and, when possible, include the patient voice. MVPs should transition to digital quality measures when feasible.

Although CMS stated in the CY 2020 PFS final rule that the MVP framework would start with the 2021 performance year, in this final rule, **CMS is delaying the implementation timeline to CY 2022 due to the COVID-19 pandemic national public health emergency.** CMS also intends to phase in MVPs until a comprehensive set of MVPs are available for all MIPS-eligible clinicians (ECs).

CMS asserts that the MVP framework is a vehicle for practices to participate in Advanced APMs. The final rule states that MVP performance measures will be reported for specific populations to encourage practices to implement an infrastructure that promotes population health data analysis, an essential capability when assuming and managing risk.

MVP development criteria (Page 1177)

In the CY 2021 proposed rule, CMS explained the importance of identifying connections between the MVP-specific measures and activities and demonstrating the relevance of measures and activities to the clinicians captured within the MVP. **CMS is finalizing, as proposed, the criteria for MVP developers to follow when forming candidate MVPs.** For instance, MVPs should include measures and activities from the four MIPS performance categories (quality, cost, improvement activities, and promoting interoperability), apply to rural and small practices, capture the patient voice, specify how measures and activities in a proposed MVP drive quality care and improve value, and demonstrate how a proposed MVP is practical for phasing clinicians into APMs.

Quality measures included within a candidate MVP should meet the existing quality measure inclusion criteria. In the final rule, CMS clarified the misconception that MVP developers are expected to propose quality measures with denominators consistent across their MVP's measures and activities by explaining that all quality measures are not required to capture the same denominator. However, they encourage MVP developers to consider the denominators across the measures proposed for MVP inclusion, particularly for the quality and cost components.

CMS acknowledges that when relevant cost measures do not exist for specific types of care provided (e.g., conditions or procedures), the proposed MVP should include broadly applicable cost measures particular to the clinician type. **CMS requests feedback from stakeholders on cost measure prioritization for future development and inclusion in a proposed MVP.**

The MVP Improvement Activities (IAs) should improve the quality of performance in clinical practices and confirm that the improvement activity complements and/or supplements the MVP measures' quality actions, rather than duplicate it. MVP developers should include broadly applicable IAs if specialty or sub-specialty specific IAs do not exist.

As proposed, CMS is finalizing that MVP developers must include the full CMS-defined set of Promoting Interoperability measures. **In response, stakeholder comments advocated that non-patient-facing clinicians should be permitted to report on the Promoting Interoperability measures that are meaningful and appropriate to this subset of ECs, as the patient-facing Promoting Interoperability measures would not be meaningful or applicable. CMS recognized**

this concern and acknowledged their plan to evaluate this issue after MVPs’ Promoting Interoperability measure scores for non-patient facing clinicians are generalizable across this EC subset.

Capturing the Patient Voice (Page 1192)

CMS is finalizing the proposal that a pre-requisite for approving proposed MVPs is the inclusion of patients and/or patient representatives in the MVP development process.

Candidate MVP Co-Development, Solicitation Process, and Evaluation (Page 1197)

Following the release of the CY 2020 PFS final rule, CMS conducted focus groups with stakeholders to understand preferences for MIPS participation simplification, burden reduction, and MVP intent. As a result, **CMS is finalizing its proposal that MVP developers formally submit proposed MVPs using a CMS-standardized template. The document titled “Stakeholder Submissions of MIPS Value Pathways (MVP) Candidates: Instructions and Template” will be published in the [QPP Resource Library](#).** CMS will take on responsibility for approving proposed MVPs and vet quality and cost measures to validate their technical specifications before rulemaking and engage with MVP developers to discuss feedback on proposed MVPs potentially approved for the coming performance year.

In the CY 2020 proposed rule, CMS sought comments on recommendations to develop a more transparent MVP approval process, including opportunities for MIPS stakeholders to participate in potential advisory committees or technical expert panels that would review MVP candidates (like that of the NQF-convened Measures Application Partnership (MAP), which assesses MIPS quality measures as a part of rulemaking). However, in this final rule, CMS omitted references and excluded comments from ACR and other commenters regarding this topic. **ACR is tracking the development of CMS’s plan for a transparent MVP approval process and will address it during participation in MVP-focused public meetings hosted by CMS.**

Implementing Meaningful Measures in MVPs (Page 1201)

Incorporating Population Health Measures into MVPs

To achieve the goal of implementing population health measures into MVPs, CMS finalizes that these measures, calculated from administrative claims-based data, serve as MVPs’ foundational layer. As such, **CMS anticipates that administrative claims-based population health measures will improve patient outcomes, reduce reporting burden and costs, align clinician quality improvement efforts, and increase alignment among APMs and other payer performance measurement programs.** For the 2021 MIPS performance year, CMS is finalizing their proposal to include the population health measure, *Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups*. Within the final rule, CMS states that this measure will incentivize collaborative care among primary care and other clinicians during a qualifying episode of care.

Incorporating QCDR measures into MVPs

CMS finalized the role of QCDR measures in MVPs as these measures are relevant, applicable, and meaningful to a specialty or sub-specialty. In addition to meeting CMS’ current QCDR measure standards, proposed QCDR measures must submit data with proposed MVPs that include empirical

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validity testing data at the clinician level. As such, beginning in the 2022 performance period, QCDR measures must be tested and used for more than one performance year before including them in a proposed MVP.

Reporting of MVPs through Third Party Intermediaries (Page 1212)

CMS is finalizing that QCDRs, other qualified registries, and Health IT vendors enable capabilities to support MIPS participation through MVPs.

Transition to MVPs (Page 1214)

Timeline for MVP implementation

CMS is finalizing the proposal to gradually implement individual MVPs through the now finalized development process and submission for rulemaking beginning in CY 2022.

APM Performance Pathway

Overview (Page 1216)

As explained in the CY 2021 proposed rule, there are different needs (e.g., reporting volume and measure accessibility) of MIPS-eligible clinicians (ECs) to join APMs. **CMS is finalizing the establishment of the APM Performance Pathway (APP) under MIPS in the 2021 MIPS performance year.** The APP is anticipated to provide predictable and consistent MIPS reporting standards to encourage APM participation.

Applicability

CMS is finalizing that the APP will be an optional MIPS reporting and scoring pathway for MIPS ECs. To report through the APP, ECs must appear on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM and appear on any of the CMS-delineated “snapshot dates” (March 31, June 30, August 31, and December 31) during a performance period.

Reporting through the APM Performance Pathway

Beginning in CY 2021, MIPS ECs participating in MIPS APMs may report through the APP at the individual level. However, groups and APM entities may report through the APP for their MIPS ECs, with the group’s final score limited to those MIPS ECs appearing on a MIPS APM’s Participation List or Affiliated Practitioner List on at least one snapshot date. The final score applied to each MIPS EC will be the highest available final score for that clinician (TIN/NPI). MIPS APM participants have the option of reporting through the APP or MIPS reporting mechanisms.

Under the final rule, ACOs participating in the Medicare Shared Savings Program are required (beginning CY 2021) to report quality measure data through the APP, while MIPS ECs participating in ACOs retain the option of reporting MIPS outside the APP at the individual or group level.

MIPS APMs (Page 1213)

CMS is finalizing their proposals to maintain MIPS APM criteria 1) the APM Entity participate in the APM under an agreement with CMS or through law or regulation and 2) APM bases payment on

quality measures and cost/utilization, and is **including a third criterion - APMs in which there is only an Affiliated Practitioner List.**

MIPS Performance Category Scoring in the APM Performance Pathway (Page 1219)

The following reporting and scoring rules apply to those MIPS ECs, groups, or APM entities reporting through the APP.

Quality Performance Category

When reporting under the APP, MIPS ECs' quality performance category scoring will be on the ECs' quality performance from the APP-specific measure set finalized for the particular MIPS performance period (e.g., measures for the performance year 2021, *Page 1230, Table 47*). CMS will remove specific measures from the quality performance category score's denominator if MIPS ECs, groups, or APM Entities participating in MIPS under the APP cannot report specific quality measures. Further, when an APP quality measure becomes topped out, CMS explains that the APP quality measure set will undergo revisions through future rulemaking.

Cost

CMS will continue to waive the Cost performance category for those reporting in the ACO Medicare Shared Savings Plan and APM Entities in MIPS APMs. APM entities in MIPS APMs are already subject to a cost-performance assessment under their APMs. The MIPS APM criteria include a cost-based evaluation of participants since MIPS APMs may measure cost performance differently from MIPS. For example, basing cost on the total cost of care measures demonstrates cost and resource use more broadly than the narrower claims-based accountability standard under MIPS. Also, to measure cost, MIPS APM attribution may assign beneficiaries differently from MIPS, leading to variable overlap between the beneficiaries for whom MIPS ECs would be responsible under their APM and MIPS.

APM Entities have limited resources to improve quality and lower costs for a specified beneficiary population under the APM. Therefore, the APM Entity should identify a single beneficiary population to prioritize its cost-saving efforts free of confounding factors. Participating through the APP, APM participants may indicate their intent to focus resources on the beneficiary population and services identified by the APM's terms, rather than the population and services they would have been responsible for under the MIPS Cost performance category.

Improvement Activities (IAs)

CMS is finalizing their proposal to assign a score for the IA performance category for each MIPS APM, applicable to MIPS ECs reporting through the APP. **CMS will assign baseline scores for each MIPS APM based on the particular MIPS APM's IA requirements.** CMS will review the MIPS APM's requirements regarding activities specified under the MIPS IA performance category. CMS will assign MIPS APMs an IA performance category score applicable to all MIPS ECs reporting through the APP, who are participants in the MIPS APM. To develop the IA score for MIPS APMs, CMS will compare the APM requirements with the IAs for the applicable year and score those activities as they would be scored in MIPS.

CMS will publish the assigned IA scores for each MIPS APM on the CMS website before the beginning of the MIPS performance period. If a MIPS APM does not represent the maximum IAs'

*Page numbers are from the display version of the MPFS final rule released on December 1st.

score, CMS further proposes that MIPS ECs reporting through the APP may indicate additional IAs to apply to their scores.

Promoting Interoperability (PI)

As proposed, CMS is finalizing the PI performance category scoring under APP participation, which means that PI measures will be reported and calculated in the same manner as suggested in the PI performance category under traditional MIPS.

APP Performance Category Weights (Page 1235)

CMS will waive the Cost performance category for MIPS ECs reporting to MIPS through the APP. The following are the finalized weights aligned with the performance category weights under MIPS and MVPs in cases where the cost performance category is reweighted to zero percent.

- Quality: 50 percent
- Cost: 0 percent
- PI: 30 percent
- IAs: 20 percent

Reweighting a performance category

Given the potential for circumstances preventing MIPS ECs, groups, or APM Entities from reporting to MIPS due to extreme and uncontrollable circumstances, hardship, or the unavailability of measures, CMS finalized reweighting one or more performance categories. When the PI performance category is reweighted to zero percent, CMS will reweight the Quality performance category to 75 percent and the IA performance category to 25 percent. Similarly, when the Quality performance category is reweighted to zero percent, CMS will reweight the PI performance category to 75 percent and the IA performance category to 25 percent. Such performance category weights contribute to an aligned performance category reweighting policy throughout MIPS in extreme and uncontrollable circumstances.

Scoring for APM Participants Reporting through the APP (Page 1236)

CMS finalizes, as proposed, aligning traditional MIPS scoring methods with APP scoring. As such, scores will be determined by applying the appropriate adjustments after scoring each performance category by multiplying each performance category score by the applicable performance category weight and summing each weighted performance category score.

Performance Feedback for APM Participants Reporting through the APP (Page 1237)

CMS finalized their proposal to make performance feedback available to MIPS ECs reporting through the APP, like those participating under APMs.

MIPS Performance Categories and Scoring

Quality (page 1408)

CMS is finalizing their proposal to lower the weight of the Quality performance category to 40 percent for 2021 and 30 percent for 2022. CMS will also end the CMS Web Interface measure collection type (which had been available for groups and virtual groups with 25 or more eligible clinicians) beginning in the 2021 performance year (page 1596). Removing this collection type results from decreased utilization of the CMS Web Interface in favor of other collection types, such as QCDRs.

*Page numbers are from the display version of the MPFS final rule released on December 1st.

Topped out Measures (page 1381)

CMS did not finalize their proposal to use 2021 performance period benchmarks, rather than historical benchmarks, for scoring quality measures in the 2021 performance year (page 1375). If approved, this proposal would have created difficulty determining whether a quality measure qualifies as "topped out" and therefore subject to a point reduction. Because this proposal was not finalized, the benchmarking and topped out measure designation processes will not change. CMS will continue to score measures based on historical benchmarks, and topped out measures will be capped at seven achievement points once they are designated as topped out for two consecutive years.

Measures Finalized for Removal (page 2000)

CMS is removing two measures which were previously reportable by radiologists and interventional radiologists:

- MIPS Quality ID 146: Inappropriate Use of 'Probably Benign' Assessment Category in Screening Mammograms (page 2003)
- MIPS Quality ID 437: Rate of Surgical Conversation from Lower Extremity Endovascular Revascularization Procedure (page 2012)

CMS finalizes these measures' removal because they were designated as extremely topped out due to high and unvarying performance rates for the two previous years.

Quality Measure Data Completeness Requirements (Page 1381)

CMS will maintain the data completeness requirements established in the 2020 final rule, which sets the data completeness requirement for quality measures at 70 percent.

Improvement Activities (page 1186)

In the final rule, CMS sustains the 15 percent weight for the Improvement Activities (IA) category for 2021. As proposed, they are finalizing flexibility for submitting new improvement activities to the Annual Call for Activities. The flexibilities allow stakeholders to submit new IAs outside of the established four-month timeframe, in the event of a PHE, like COVID-19. The Annual Call for Activities, occurring February 1st through June 30th, permits CMS to respond to clinicians' immediate needs. Similarly, **CMS is now allowing the Department of Health and Human Services (HHS) to submit new IAs for year-round consideration for inclusion into the IA inventory.**

CMS finalizes a new IA for 2020 and subsequent years. The IA, *COVID-19 Clinical Trials (IA_ERP_3)*, promotes clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat patients with COVID-19 infection. The final rule clarifies this IA's description, explaining that it includes clinicians participating in the care of a patient diagnosed with COVID-19 who simultaneously submit their clinical patient data to a clinical data registry for research. To earn credit for this activity, MIPS ECs or groups must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research.

The IA, *Partner in Patients Hospital Engagement Network (IA_CC_5)*, will be removed from the IA inventory for the 2021 performance year and subsequent years. This activity required membership and participation in a CMS Partnership for Patients Hospital Engagement Network, which ended on March 31st, 2020, rendering this IA obsolete.

As proposed, CMS is adopting an additional criterion for new IAs submitted in 2021 and subsequent years. As stated in the final rule, the requirements for IA submission and approval will "Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible."

Cost Category (page 1171)

CMS is maintaining the 20 percent Cost performance category weight during the 2021 performance year. As mandated by the statute, CMS will increase the Cost performance category weight to 30 percent for the 2022 performance year. Also, **for the 2021 performance period and beyond, CMS will include costs associated with telehealth services in the list of cost measures.** The telehealth service codes are relevant to each appropriate measure (e.g., E/M, follow-up consultation after hospital discharge). Some of these codes, new to the Medicare telehealth services, were finalized under the COVID-19 IFCs published in March 2020 and May 2020. Initially excluded from the episode-based cost measures, these codes were not billed widely enough to find in empirical claims-based data (CMS' method to determine clinically related services). CMS perceives that adding these cost codes will not alter the measures' intents or modify existing cost categories. Updated measure specifications with the telehealth codes are available on the [MACRA Feedback website](#).

Promoting Interoperability Category (Pages 1311)

For the 2024 MIPS payment year and each subsequent year, CMS finalizes its proposal to establish a Promoting Interoperability category performance period of a minimum of a continuous 90-day period within the calendar year that occurs two years before the applicable MIPS payment year, up to and including the full calendar year. This establishes a permanent 90-day performance period for the Promoting Interoperability category, thus circumventing CMS's administrative need to define performance periods annually.

CMS finalizes the proposal to add an optional, alternative measure for the "Health Information exchange" objective titled, "Health Information Exchange (HIE) Bi-Directional Exchange." To complete this measure, the clinician will participate in an HIE network to share data for every patient encounter, transition/referral, and record stored or maintained in the EHR during the performance period. While doing so, the clinician will use the corresponding certified functions of CEHRT. CMS modified its proposals regarding the wording of the related attestation statements. (Page 1319)

CMS finalizes minor modifications to certain objectives and measures. The "Query of Prescription Drug Monitoring Program (PDMP)" measure will remain optional in CY 2021, but the bonus points will increase from five to 10 points (page 1313). The name of the "Support Electronic Referral Loops by Receiving and Incorporating Health Information" measure under the "Health Information Exchange" objective will change from "incorporating" to "reconciling" (page 1317).

CMS finalizes their proposed alignment of the "certified electronic health record technology (CEHRT)" definition with May 1st, 2020 updates by the Office of the National Coordinator for Health IT (ONC) to the 2015 Edition health IT certification criteria. CEHRT used by QPP participants will need updated certification by December 31st, 2022, to continue utilizing for QPP compliance purposes, such as participation in the Promoting Interoperability performance category of MIPS (pages 1063-1108).

MIPS Performance Threshold (Page 1426)

The Bipartisan Budget Act of 2018 allows CMS flexibility to set performance thresholds until 2021. The statutorily required performance threshold is based on the mean or median of final scores from a prior performance period. However, CMS has not yet implemented a threshold based on historical scores. In the 2021 proposed rule, CMS considered lowering the threshold to 50 points for the 2021 performance year. **However, this was not finalized. Instead, CMS retains the MIPS performance threshold at 60 points as established in previous rules.** CMS is further maintaining the exceptional performance threshold of 85 points for 2021 set under the CY 2020 final rule. CMS previously set the payment adjustment of +/- 9 percent for performance years 2020 and beyond.

Low-Volume Threshold and Small Practice Considerations (page 1721)

As in previous MIPS performance years, the low-volume threshold allows Medicare clinicians the potential to be excluded from MIPS participation. CMS is not changing the low-volume threshold. To avoid participating in MIPS in 2021, clinicians or groups must meet at least one of the following criteria:

- Maintain \leq \$90,000 in allowed charges for covered professional services.
- Provide covered professional services to \leq 200 Medicare Part B-enrolled individuals.
- Provide \leq 200 covered professional services to Medicare Part B-enrolled individuals.

As established in the CY 2020 final rule, clinicians or groups who meet one (but not all) of the low-volume criteria will continue to have the ability to opt-in to the MIPS program and receive a MIPS payment adjustment.

CMS also maintains the six-point small practice bonus included in the Quality performance category score and continues to award small practices three points for submitting quality measures that do not meet data completeness requirements. Small practices may also still report quality measures through Medicare Part B claims.

Physician Compare (page 1397)

CMS finalizes the proposed new definition for Physician Compare. The website formerly called "Physician Compare" is now the "Physician Compare Internet Website of the Centers for Medicare and Medicaid Services." CMS states that the new definition more accurately references the site where CMS posts information available for public reporting.

Advanced Alternative Payment Models (page 1523)

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model. For payment years 2019 through 2024, Qualifying APM Participants (QPs) receive 5 percent APM Incentive Payment. Beginning in the CY 2021 QP Performance Period, the QP

payment amount threshold increases from 50 percent to 75 percent of Medicare payments, while the QP patient count threshold increases from 35 percent to 50 percent of Medicare patients.

QP Threshold Scores

Threshold scores used for QP determinations using patient count are calculated as a ratio of attributed Medicare patients whom the APM entity or eligible clinician furnished Part B services and attribution-eligible Medicare patients to whom the APM Entity or eligible clinician furnishes Medicare Part B covered professional services during the QP Performance Period. Threshold scores used for QP determinations using payment amount are calculated as a ratio of the aggregate of payments for Medicare Part B covered professional services furnished by the APM entity or eligible clinician during the QP performance period and the aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity or eligible clinician to attribution-eligible beneficiaries. CMS finalized their proposal for calculating the Threshold Scores used in making QP determinations, and beginning in the 2021 QP Performance Period, Medicare patients who have been prospectively attributed to an APM entity during a QP Performance period will not be included as attribution-eligible Medicare patients for any APM entity that is participating in an Advanced APM that does not allow such prospectively attributed patients to be attributed again.

This policy removes prospectively attributed Medicare patients from the denominators when calculating QP Threshold Scores for APM Entities or individual eligible clinicians in Advanced APMs that do not allow for attribution of Medicare patients that have already been prospectively attributed elsewhere. This prevents dilution of the QP Threshold Score for the APM Entity or individual eligible clinician in an Advanced APM that uses retrospective alignment.

Targeted Review

CMS finalized their proposal to establish a Targeted Review process for limited circumstances surrounding QP Determinations. Starting in the 2021 QP Performance Period, CMS will accept Targeted Review requests when an eligible clinician or APM Entity believes in good faith CMS has made a clerical error such that an eligible clinician(s) was not included on a Participation List of an APM Entity participating in an Advanced APM for purposes of QP or Partial QP determinations. CMS also finalized that after the conclusion date of the targeted review, there will be no further review of QP determination with respect to an eligible clinician during the relevant performance period. If CMS determines an error was made, CMS will assign the clinician the most favorable QP status at the APM entity level on any of the snapshot days for the relevant QP performance period.

Other Updates

CMS finalized their proposal to clarify that the APM Incentive Payment amount is calculated based on the paid amount of the applicable claims for covered professional services that are subsequently aggregated to calculate the estimated aggregate payments. CMS finalized their proposal to establish a revised approach to identifying the TIN(s) to which they make the APM Incentive Payment: this approach would involve looking at a QP's relationship with their TIN(s) over time, as well as considering the relationship the TIN(s) have with the APM Entity or Entities through which the eligible clinician earned QP status, or other APM Entities the QP may have joined in the interim. CMS believes that this approach will allow CMS to more accurately identify TINs with which QPs are currently receiving other Medicare payments, and through which they would receive an APM incentive payment. This will also prioritize when the QP is no longer affiliated with its original TIN through

which they attained QP status. CMS also finalized their proposal to introduce a cutoff date of November 1 of each payment year (or 60 days from the day on which CMS makes the initial round of APM Incentive Payments, whichever is later), as a point in time after which CMS will no longer accept new helpdesk requests from QPs or their representatives who have not received their payments. CMS believes this is necessary in order to achieve their goal of disbursing correct payments to QPs as quickly as possible.

Due to the impacts of COVID-19, CMS will not reconsider advanced APM determinations of APMs that have already met the criteria for CY 2020, even if they have undergone changes due to the Public Health Emergency. Additionally, CMS will evaluate all APMs in future years with the understanding that any provisions of the Participation Agreement or governing regulation designed in response to the COVID-19 PHE will not be considered to the extent they would prevent the APM from meeting the Advanced APM criteria for a year. Due to the impacts of the COVID-19 PHE, certain APMs may adopt earlier end dates. CMS will not consider this to be termination from an agreement and will not revoke QP status of eligible clinician participants. CMS clarified that they will continue to perform QP determinations at the established times for the 2020 QP performance period without modification for the PHE. CMS believes that Advanced APM participants benefit from timely and predictable QP determinations, and that making changes to the QP determination methodology would inadvertently pick winners and losers during the PHE.