Summary: Medicare Physician Fee Schedule (PFS) CY21 Proposed Rule (CMS-1734-P)

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the advance copy of its proposed 2021 Physician Fee Schedule rule that announces and solicits public comments on proposed policy changes for the Medicare Part B program effective on or after January 1, 2021. The Academy of Nutrition and Dietetics every year submits comments to CMS on any proposed annual changes that impact registered dietitian nutritionists (RDNs) who are Medicare providers.

The following information summarizes proposed policy changes relevant to RDNs. CMS will issue its final rule around December 1, 2020 taking into consideration public comments. Provisions in the final rule may differ from those described below. Members who are interested in helping inform the Academy’s comments should contact Marsha Schofield by August 21, 2020.

Medicare Telehealth and Related Services

During the COVID-19 public health emergency (PHE), Medicare beneficiaries have benefited from increased access to medical nutrition therapy (MNT) and diabetes self-management training (DSMT) services as Congress granted CMS authority to temporarily waive the geographic and site of service originating site restrictions for Medicare telehealth services, as well as allow certain telehealth services to be furnished via audio-only communication technology. Permanent changes to these restrictions will require Congressional action, hence CMS does not propose to permanently waive these restrictions in the proposed rules.

CMS does propose to permanently keep several codes that were temporarily added to the Medicare telehealth list. MNT and DSMT have always been on the list of Medicare approved telehealth services, so will continue to be eligible telehealth services after the end of the PHE. In the same way, RDNs have always been on the list of practitioners who may furnish telehealth services and will remain on that list after the end of the PHE. The list of proposed codes (see Table 12) to remain on the Medicare telehealth list (either permanently or through the calendar year in which the PHE ends) are primarily Evaluation/Management (E/M) codes and do not include any services provided by RDNs.

Continuation of Payment for Audio-only Visits (98966-8)

For these audio-only E/M services, CMS used their temporary waive authority to change these codes from a non-covered to covered status during the PHE. They are not proposing to continue to recognize these codes for payment under the PFS after conclusion of the PHE for the COVID-19 pandemic because, outside of the circumstances of the PHE, they are not able to waive the requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology. CMS views these services as a substitute for care that would otherwise be reported as an in-person or telehealth visit so were placed on the Medicare telehealth services list. They do not view them as CTBS as the latter are services that CMS considers not ordinarily furnished in person but rather routinely furnished using a telecommunication system. However, CMS recognize that the need for audio-only interaction could remain as beneficiaries continue to try to avoid sources of potential infection, such as a provider’s office; and in that circumstance, a longer phone conversation may be needed to determine if an in-person visit is necessary than what is described by the virtual check-in code. CMS is seeking comment on whether they should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with an accordingly higher value. They are also seeking comment on whether separate payment for such telephone-only services should be a provisional policy to remain in effect until a year or some other period after the end of the
PHE or if it should be PFS payment policy permanently. CMS considers these services are a substitute for care that would otherwise be reported as an in-person or telehealth visit (so placed on the Medicare telehealth services list for the duration of the PHE).

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

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Specific Services and CPT Codes</th>
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</table>
| 1. Services we are proposing for permanent addition to the Medicare telehealth services list | • Group Psychotherapy (CPT code 90833)  
• Domiciliary, Rest Home, or Custodial Care service, Established patient (CPT codes 99334-99335)  
• Home Visits, Established Patient (CPT codes 99347-99348)  
• Cognitive Assessment and Care Planning Services (CPT code 99483)  
• Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code G0410)  
• Prolonged Services (CPT code 993XX)  
• Psychological and Neuropsychological Testing (CPT code 96121) |

| 2. Services we are proposing as Category 3, temporary additions to the Medicare telehealth services list. | • Domiciliary, Rest Home, or Custodial Care service, Established patient (CPT codes 99336-99337)  
• Home Visits, Established Patient (CPT code 99349-99350)  
• Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)  
• Nursing Facilities Discharge Day Management (CPT codes 99315-99316)  
• Psychological and Neuropsychological Testing (CPT codes 96130-96133) |

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

**Communication Technology-Based Services (CTBS)**

CMS defines communication technology-based services (CTBS) as services that can be furnished via telecommunications technology but that are not considered Medicare telehealth services. Starting January 1, 2020, CMS added payment for G2061-G2063. They stated those codes may be billed by nonphysician practitioners consistent with the definition of their respective benefit category but did not provide specific examples. In the March 31 COVID-19 IFC they established on an interim basis for the duration of the PHE for the COVID-19 pandemic that these services could be billed for example, by licensed clinical social workers and clinical psychologists, as well as PTs, OTs, and SLPs who bill Medicare directly for their services when the service furnished falls within the scope of these practitioner’s benefit categories. CMS is proposing to adopt that policy on a permanent basis. They note that this is not an
exhaustive list and are seeking comment on other benefit categories into which these services fall. The Academy has been communicating with CMS regularly asking them to specifically include RDNs on the list of examples as the Academy believes RDNs have had access to use of these codes since January 1, 2020.

CMS is proposing to add another “virtual check-in” code that could be used by certain nonphysician practitioners, consistent with the scope of these practitioners’ benefit categories, who cannot independently bill for E/M services:

\[G20X2\text{ (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)}\]

**Direct Supervision by Interactive Telecommunications Technology**

CMS is proposing to allow direct supervision to be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021. Specifically, they propose to continue their current rule that “Direct supervision” in the office setting means the physician (or other supervising practitioner) must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician (or other supervising practitioner) must be present in the room when the procedure is performed. They propose to add that, until the later of the end of the calendar year in which the PHE ends or December 31, 2021, the presence of the physician (or other practitioner) may include virtual presence through audio/video real-time communications technology (excluding audio-only) subject to the clinical judgement of the supervising physician or (other supervising practitioner). They are also clarifying that, to the extent their policy allows direct supervision through virtual presence using audio/video real-time communications technology, the requirement could be met by the supervising physician (or other practitioner) being immediately available to engage via audio/video technology (excluding audio-only), and would not require real-time presence or observation of the service via interactive audio and video technology throughout the performance of the procedure.

**Remote Physiological Monitoring (RPM) Services**

RPM (CPT codes 99453, 99454, 99091, and 99457) involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. CMS has issued the following guidance (based on the CPT Codebook) on use of these codes based on ongoing requests from stakeholders, including the Academy, for more clarity:

- Following the PHE for the COVID-19 pandemic, CMS will again require that an established patient-physician relationship exist for RPM services to be furnished.
- Proposing as permanent policy to allow consent to be obtained at the time that RPM services are furnished.
- Proposing as permanent policy to allow auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician’s supervision (includes RDNs). Auxiliary personnel include contracted employees.
- The medical device supplied to a patient as part of CPT code 99454 must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be
reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.

- CPT 99453/99454 are not to be reported for a patient more than once during a 30-day period. Even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected.
- CPT 99453 can be billed only once per episode of care where an episode of care is defined as “beginning when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals”.
- After the PHE for COVID-19, they will maintain the current requirement that 16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454. However, they are seeking comment on whether the RPM codes, as described, adequately capture the work furnished to patients with acute conditions or whether coding revisions are needed.
- RPM services are considered to be evaluation and management (E/M) services.
- Only physicians and NPPs who are eligible to furnish E/M services may bill RPM services.
- Practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.
- For CPT codes 99457 and 99458, an “interactive communication” is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.
- They are seeking comment from the medical community and other members of the public on whether the current RPM codes accurately and adequately describe the full range of clinical scenarios where RPM services may be of benefit to patients.
- The CPT Codebook lists the RPM codes under the main heading Evaluation and Management (E/M). As E/M codes, CPT codes 99453, 99454, 99091, 99457, and 99458, can be ordered and billed only by physicians or nonphysician practitioners (NPPs) who are eligible to bill Medicare for E/M services.

Conversion Factor

The proposed CY2021 PFS conversion factor is $32.26, almost an 11% decrease in the conversion factor compared to last year. The conversion factor is part of the formula used by CMS to establish final payment rates for services under the PFS.

Under the Medicare Access and CHIP Reauthorization Act (MACRA), the statutory payment update for 2021 is 0%. The proposed rule indicates that a very steep budget neutrality adjustment will be required in 2021 to offset payment increases for office visits (E/M codes) and other services. CMS is required under the Social Security Act to maintain what is called “budget neutrality” when setting payment rates under the PFS. That means that increases or decreases in 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.

The payment impacts in this proposed rule reflect averages by specialty based on Medicare utilization. CMS estimates Medicare providers in the “Other” category (includes RDNs) as a group will see a 5% cut in their payment rates. The payment impact for an individual practitioner could vary from the average and would depend on the mix of services he or she furnishes. Since December, the Academy has been participating in a coalition of over 100 physician and non-physician national associations advocating with
CMS and HHS to delay implementation of the payment increases for office services. The coalition has also been lobbying Congress to waive the budget neutrality requirement for 2021 and 2022 until after CMS reports to Congress on the overarching effects of the COVID-19 PHE.

**Principal Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

Starting January 1, 2020, CMS began paying for 2 new codes, G2064 and G2065, for Principal Care Management (PCM) services. These codes are designed for comprehensive care management services for a single high-risk disease. CMS is now proposing to add these codes to the general care management code G0511 for RHCs and FQHCs starting January 1, 2021. The G0511 payment rate would be increased to reflect the addition of these 2 new codes. Similar to the complex care management codes, RDN time could be counted towards the time billed for G2065.

**HCPCS code G2064** is for at least 30 minutes of PCM services furnished by physicians or non-physicians during a calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

**HCPCS code G2065** is for at least 30 minutes of PCM services furnished by clinical staff under the direct supervision of a physician or non-physician practitioner with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

**Annual Wellness Visit**

Section 2002 of the SUPPORT Act, enacted on October 24, 2018, required the Annual Wellness Visit (AWV) to including screening for potential substance use disorders (SUDs) and a review of any current opioid prescriptions, effective January 1, 2020. CMS is proposing to add these new elements to the AWV. The review includes review of the potential risk factors to the individual for opioid use disorder, an evaluation of the individual’s severity of pain and current treatment plan, educational information on non-opioid treatment options, and a referral to a specialist, as appropriate. CMS considers these elements as already encompassed under the existing elements of the AWV, but has chosen to call them out as separate regulatory elements of the AWV to elevate the importance of health care professionals identifying and addressing opioid risks and SUDs in Medicare beneficiaries. Note: The AWV may be performed by an RDN working under the direct supervision of a physician.

**Medicare Diabetes Prevention Program (MDPP) expanded model Emergency Policy**

Although CMS has permitted many MDPP services to be provided virtually during the COVID-19 PHE, they still required the first core session to be provided in-person, which prevents any new patients from participating. CMS is proposing to drop that requirement and allow all MDPP services to be delivered virtually during the current PHE as well as in future declared emergencies. Their proposal specifically does not allow providers of virtual-only DPP services to enroll as MDPP suppliers.
CMS is proposing to establish an Emergency Policy that applies broadly to any future 1135 waiver events that disrupts in-person MDPP services. If finalized, the proposed flexibilities would supersede the flexibilities finalized in the March 31st COVID-19 IFC for the COVID-19 PHE, if the PHE is still in place when the CY 2021 PFS final rule becomes effective. If finalized, the proposed changes would be available to all future applicable 1135 waiver events, effective January 1, 2021.

Specifically, CMS is proposing the following flexibilities under this Emergency Policy:

- Allowing MDPP suppliers to either deliver MDPP services virtually or suspend in-person services and resume services at a later date.
- Permitting certain MDPP beneficiaries to obtain the set of MDPP services more than once per lifetime, for the limited purposes of allowing a suspension in service due to an applicable 1135 waiver event and to provide the flexibilities that will allow MDPP beneficiaries to maintain eligibility for MDPP services despite a break in service. MDPP beneficiaries who elect to receive MDPP services virtually in accordance with the MDPP Emergency Policy are not eligible to restart the set of MDPP services at a later date.
- Allowing all sessions, including the first core session, to be offered virtually, so long as the virtual services are furnished in a manner that is consistent with the CDC Diabetes DPRP standards for virtual sessions, follow the CDC-approved DPP curriculum requirements, and the supplier has an in-person DPRP organizational code.
- MDPP suppliers may only furnish a maximum of one regularly scheduled session virtually and a maximum of one virtual make-up session per week to an MDPP beneficiary.
- Allowing MDPP suppliers to obtain weight measurements from MDPP beneficiaries either in-person (when it can be done safely), via digital technology, or self-reported weight measurements from a participant’s own at-home digital scale. Self-reported weights must be submitted via video, by the MDPP beneficiary to the MDPP supplier. The video must clearly document the weight of the MDPP beneficiary as it appears on his/her digital scale on the date associated with the billable MDPP session.
- Based on the above, effective January 1 2021, all MDPP beneficiaries would be required to achieve and maintain the required 5 percent weight loss goal in order to be eligible for the ongoing maintenance sessions, even if the COVID-19 PHE remains in place as of that date.
- MDPP beneficiaries who are in the first 12 months of the set of MDPP services as of the start of an applicable 1135 waiver event would be eligible to restart the set of MDPP services either at the beginning, or resume with the most recent attendance session of record, after the applicable 1135 waiver event has ended. MDPP beneficiaries who are in the second year of the set of MDPP services as of the start of the 1135 waiver event, would only be permitted to resume the set of MDPP services with the most recent attendance session of record. MDPP beneficiaries who are in the second year of the set of MDPP services would not be allowed to restart the set of MDPP services at the beginning.
- Beneficiaries who elect to suspend the set of MDPP services at the start of an 1135 waiver event and subsequently choose to restart the MDPP set of services at the beginning or to resume with the most recent attendance session of record, may only make such an election once per 1135 waiver event.
- Amending the definition of “engagement incentive period” to further qualify when the period ends in the case of the COVID-19 PHE or an applicable 1135 waiver event: the MDPP supplier has not had direct contact, either in person by telephone, or via other telecommunications technology, with the MDPP beneficiary for more than 90 consecutive calendar days during the MDPP services period, unless the lack of direct contact is due to the suspension or cancellation.
of MDPP services and the MDPP services are eventually resumed or restarted. CMS is soliciting comments on when the engagement incentive period should end if the MDPP services are not eventually resumed.

- When the beneficiary engagement incentive is furnished during the COVID-19 PHE or an 1135 waiver event that CMS has determined may disrupt in-person MDPP services, and the item or service is furnished to an MDPP beneficiary who is receiving MDPP services virtually, the MDPP beneficiary must be capable of using the item or service during the COVID-19 PHE or the 1135 waiver event, as applicable.

Quality Payment Program
Due to the COVID-19 PHE, CMS is proposing minimal changes to the Merit-based Incentive Payment System (MIPS) and is delaying its proposal for initial MIPS Value Pathways (MVP) until at least the 2022 performance year. CMS is proposing a new MIPS pathway for participants in alternative payment models (APMs) called the APM Performance Pathway (APP). Key provisions of the proposals are summarized below. A full summary of the proposed changes is available at [https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1100/2021%20QPP%20Proposed%20Rule%20Fact%20Sheet.pdf](https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1100/2021%20QPP%20Proposed%20Rule%20Fact%20Sheet.pdf)

MIPS
CMS has limited their 2021 performance year proposals in light of the COVID-19 pandemic to promote program stability and lessen any distraction as clinicians focus on responding to this public health emergency. The proposed changes relevant to RDNs include:

- Performance threshold and category weights for the 2021 performance period (which equates to the 2023 payment year):
  - Performance threshold to be 50 points (change from 60 points as originally proposed in the CY20 rules). No changes to the additional performance threshold of 85 points for exceptional performance.
  - Quality: 40% (5% decrease from PY 2020)
  - Cost: 20% (5% increase from PY 2020) [Note: RDNs are not scored on this category]
  - Promoting Interoperability: 25% (no change) [Note: RDNs are not scored on this category]
  - Improvement Activities: 15% (no change)
  - Continue to automatically reweight Cost and Promoting Interoperability categories for RDNs to the Quality category. Net result is Quality would continue to be weighted at 85% and Improvement Activities would continue to be weighed at 15% (no change)

- Decrease the weight of the Quality performance category to 40% for the 2023 MIPS payment year and 30% for the 2024 MIPS payment year. By law, the weight must be set at 30% for 2024, so the question is at what rate does CMS lower it from 45% for the 2020 payment year?

- Use performance period, not historical, benchmarks to score quality measures for the 2021 performance period due to the COVID-19 PHE impacting data submission in 2020.

- Remove the CMS Web Interface as a collection type and submission type for groups and virtual groups beginning with the 2021 performance period.

- Change the maximum number of points available for the complex patient bonus to account for the additional complexity of treating patients during the COVID-19 Public Health Emergency. As proposed, clinicians, groups, virtual groups, and APM Entities could now earn up to 10 bonus points towards their final score for the 2020 performance year (increases max from 5 point and only for 2020).

- No proposed changes to what quality measures are included in the Nutrition/Dietitian Specialty Measures Set. Some changes in the measure specifications are being proposed to incorporate
updates made to existing quality measure specifications made by the measure steward (additional details available from Academy staff upon request).

- Establish a process for agency-nominated improvement activities.

## MVPs

For this year, CMS limited proposals to guidance necessary for the collaborative development of MVPs. They are proposing some updates to the MVP framework guiding principles based on input received via last year’s proposed rules (changes shown in italics):

1. MVPs should consist of limited, **connected complementary** sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.
2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care; **MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.**
3. MVPs should include measures **selected using the Meaningful Measures approach and, wherever possible, the patient voice must be included,** to encourage performance improvements in high priority areas.
4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.
5. **MVPs should support the transition to digital quality measures.**

Beginning with the 2022 MIPS performance period, CMS is proposing to develop and select MVPs using the following criteria:

1. Utilize measures and activities across all four performance categories, if feasible (Quality, Cost, Improvement Activities, and Promoting Interoperability)
2. Have a clearly defined intent of measurement
3. Align with the Meaningful Measure Framework
4. Have measure and activity linkages within the MVP
5. Be clinically appropriate
6. Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties
7. Be comprehensive and understandable by clinicians, groups, and patients
8. To the extent feasible, include electronically specified quality measures
9. Incorporates the patient voice
10. Ensures quality measures align with existing MIPS quality measure criteria, and considers the following: Whether the quality measures are applicable and available to the clinicians and groups, collection types measures are available through
11. Beginning with the 2022 performance period, may include QCDR measures that have been fully tested
12. Ensures that the cost measure is related to the other measures and activities included in the MVP, and if a relevant cost measure for specific types of care are not available, includes a broadly applicable cost measure that is applicable to the clinician type, and considers what additional cost measures should be prioritized for future development and inclusion in the MVP
13. Includes improvement activities that can improve the quality of performance in clinical practice, that complement and/or supplement the quality action of the measures in the MVP, and uses broadly
applicable improvement activities when specialty or sub-specialty improvement activities are not available

14. Must include the entire set of Promoting Interoperability measures
15. Includes the administrative-claims based measure, Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups
16. Propose that stakeholders that are developing MVPs to submit to CMS as candidate MVPs should include patients/patient representatives as part of the MVP development process.

CMS is also proposing a process for candidate MVP collaboration, solicitation, and evaluation.

New APM Performance Pathway (APP) Reporting Option
Proposing an APP to start on January 1, 2021 that aligns with the MVP concept to facilitate transition of clinicians from MIPS to APMs. The APP would be a voluntary pathway for reporting and scoring under MIPS. APP is designed to provide a predictable and consistent MIPS reporting standard to reduce reporting burden and encourage continued APM participation.

- This new Pathway is a complementary Pathway to the MVPs.
- The APP would be available only to participants in MIPS APMs. It may be reported by the individual eligible clinician, group TIN, or APM Entity.
- The APP, like an MVP, would be comprised of a fixed set of measures for each performance category.
- In the APP, the Cost performance category would be weighted at 0%, as all MIPS APM participants are already responsible for cost containment under their APMs.
- The Improvement Activity performance category score would automatically be assigned based on the Improvement Activity requirements of the MIPS APM in which the MIPS eligible clinician participates. All APM participants reporting the APP would earn a score of 100% for the 2021 performance period.
- The Promoting Interoperability performance category would be reported and scored as required for the rest of MIPS.
- The Quality performance category would be comprised of 6 measures designed specifically focused on population health and believed to be widely available to all MIPS APM participants.

Proposing that MIPS eligible clinicians scored under the APP would be scored on the quality measure set finalized for the performance period. For payment year 2021, proposed the following core quality measure set:
Proposing to reweight the performance categories for APM participants reporting through the APP to:

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

Final scoring for APM participants reporting to MIPS through the APP would follow the same methodology as established for MIPS generally. Performance feedback would be made available to MIPS eligible clinicians reporting through the APP according to the methods applicable to all MIPS eligible clinicians.

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<tr>
<th>Measure #</th>
<th>Measure Title</th>
<th>Collection Type</th>
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<td>Quality ID # 321</td>
<td>CAHPS for MIPS</td>
<td>CAHPS for MIPS Survey</td>
<td>Third Party Intermediary</td>
<td>Patient's Experience</td>
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<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control</td>
<td>eCQM/MIPS CQM</td>
<td>APM Entity/Third Party Intermediary</td>
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<td>Quality ID # 134</td>
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