CY 2021 Medicare Physician Fee Schedule Proposed Rule Summary

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2021 Medicare Physician Fee Schedule proposed rule on Monday, August 3, 2020. This rule proposes several items relevant to therapy services, including payment updates for services paid via the Physician Fee Schedule, telehealth and communication technology-based services policy updates, changes to maintenance therapy regulations, and updates to the Merit-based Incentive Payment System (MIPS). The comment period for this rule ends October 5, 2020.

Of note, CMS is waiving the 60-day effective date of the Physician Fee Schedule final rule due to the COVID-19 public health emergency (PHE), and replacing it with a 30-day delay in the effective date. This means that CMS could release the final rule December 1, 2020, and still have policies effective January 1, 2021.

Payment Updates:

CMS proposes a more than 10% decrease in the fee schedule conversion factor for 2021. This is a result of a relative value unit (RVU) budget neutrality adjustment of -10.61% with a statutory increase of 0.0% (there are no adjustments to the fee schedule by law through 2025), resulting in a proposed conversion factor of 32.2605 (vs. 36.0896 for CY 2020).

As a result of this significant decrease in the conversion factor, PT and OT services are expected to see an overall 9% reduction in reimbursement in services paid via the physician fee schedule (PFS) in 2021. In last year's final rule, CMS finalized changes to increase reimbursement for the outpatient/office physician evaluation and management (E/M) CPT codes in CY 2021. As a result of the requirement for fee schedule updates to remain budget neutral, many specialties now face cuts in 2021 to offset the increase in payment for the physician E/M codes. Physician specialties that bill office/outpatient E/M codes will generally see increases in payment – some are very significant; specialties that do not provide these services and bill these office/OP E/M codes will see payment cuts.

In the CY 2021 proposed rule, CMS emphasizes that rates noted in Table 90 of the rule are based on aggregate estimates of allowed charges (including coinsurance and deductibles) summed across all services and are therefore "averages," and do not represent what will actually happen to a particular service furnished by a single provider.

Excerpt from TABLE 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (million)	Combined RVU Impact
Allergy/Immunology	$246	9%
Audiologist	$74	-7%
Cardiac Surgery	$264	-9%
Chiropractor	$759	-10%
Clinical Social Worker	$851	0%
Emergency Medicine	$3,065	-6%
Endocrinology	$506	17%
Family Practice	$5,982	13%
Geriatrics	$190	4%
Independent Laboratory	$639	-5%
Internal Medicine	$10,654	4%
Nurse Anesthetist / Anes Asst	$1,316	-11%

Nurse Practitioner	$5,069	8%
Ophthalmology	$5,328	-6%
Orthopedic Surgery	$3,796	-5%
Physical Medicine	$1,157	-3%
Physical / Occupational Therapy	$4,946	-9%
Radiology	$5,253	-11%
Rheumatology	$546	16%

CMS published an addendum file along with the proposed rule that lists the expected RVUs per CPT code for CY 2021. Work, practice expense, and malpractice RVUs for therapy codes essentially remain unchanged from current values, except for PT/OT evaluation codes and the SLP speech-language evaluation codes, which are proposed to see an increase in the work RVUs for 2021 (see additional information below). Using this RVU file and the proposed conversion rate of 32.2605, anticipated payment changes for 2021 as compared to current rates for commonly-billed outpatient therapy CPT codes* are:

HCPCS Code	Description	CY 2020 Rate	Proposed CY 2021 Rate	% Change in Payment
92507	Treatment of speech	$81.20	$71.97	-11.4%
92523	Eval speech sound prod & language comprehension	$198.49	$216.47	8.3%
92526	Treatment of swallow	$89.50	$80.01	-10.6%
92610	Eval of swallow function	$89.14	$80.97	-9.2%
97035	Ultrasound	$14.80	$13.55	-8.4%
G0283	Unattended estim	$14.07	$12.26	-12.9%
97110	Therapeutic exercise	$31.40	$28.07	-10.6%
97112	Neuro re-ed	$36.09	$32.58	-9.7%
97116	Gait training	$31.04	$28.07	-9.6%
97140	Manual therapy	$28.87	$25.81	-10.6%
97162	PT eval, mod complexity	$87.70	$94.85	7.5%
97166	OT eval, mod complexity	$92.75	$97.10	4.5%
97530	Therapeutic activities	$40.42	$36.45	-9.8%
97535	Self-care/home mgmt.	$35.01	$31.29	-10.6%
97542	Wheelchair mgmt.	$33.92	$30.32	-10.6%

*_NOTE:_ These rates reflect national payment rates, without consideration for geographic area/wage index, MPPR, etc.

Therapy Evaluations

With the revaluing of the physician office/outpatient E/M code set, CMS has identified other services paid under the PFS that are similar to this code set and include the work associated with assessment and management, like the E/M codes do. Therapy evaluations have been identified as one of these types of services. As such, **CMS is proposing to adjust (i.e., increase) the work RVUs for therapy evaluations** and have calculated the adjustment based on a "volume-weighted average" of the increases to the office/outpatient E/M work RVUs. CMS estimates the percentage increase to the work RVU for the therapy evaluations to be 28%. (_Note:_ While the increase to the therapy evaluation codes is a positive adjustment, it does not counterbalance the significant decrease to every other PT, OT, and SLP CPT code proposed for CY 2021 as noted above).

Excerpt from TABLE 21: Current and Proposed Work RVUs for Therapy [Evaluation Codes]

HCPCS Code	Description	Current Work RVU	Proposed Work RVU
97161	PT Evaluation, low complexity	1.2	1.54
97162	PT Evaluation, moderate comp	1.2	1.54
97163	PT Evaluation, high complexity	1.2	1.54
97164	PT Re-evaluation	0.75	0.96
97165	OT Evaluation, low complexity	1.2	1.54
97166	OT Evaluation, moderate comp	1.2	1.54
97167	OT Evaluation, high complexity	1.2	1.54
97168	OT Re-evaluation	0.75	0.96
92521	Eval of speech fluency	1.75	2.24
92522	Eval of speech sound production	1.5	1.92
92523	Eval of speech sound production w/ eval of language comp & expression	3	3.84
92524	Behavioral & qualitative analysis of voice & resonance	1.5	1.92

Maintenance Therapy:

CMS proposes to make permanent the Part B policy for maintenance therapy services that was put in place with the second COVID-19 PHE Interim Final Rule published May 1, 2020. Under this revised (proposed) policy, **the PT or OT who establishes the maintenance program may delegate the performance of maintenance therapy services to a PTA or OTA, as clinically appropriate**. This policy would be effective January 1, 2021, and if adopted, would dovetail with the current policy in place for the duration of the PHE. This also aligns Medicare Part B policy with current policy under Part A in the skilled nursing facility (SNF) and home health (HH) settings.

Telehealth and Communication Technology-Based Services (CTBS):

As a result of the PHE, CMS added a number of services to the Medicare telehealth services list. In this rule, **CMS is proposing to add services to the telehealth list permanently, to create a new option for adding services to the list on a temporary basis ("Category 3"), and is proposing not to retain some services on the telehealth list after the PHE ends**. As outlined in the proposed rule, therapy CPT codes are on the list to not be retained on the Medicare telehealth services list (after the end of the PHE), however CMS is seeking comments on whether or not to add/include them.

Note: CMS has clarified that changes to the approved/eligible provider list for telehealth services – that is, including PTs, OTs, and SLPs as approved providers of telehealth on a permanent basis – requires a change to statute (Congressional action). Therefore, the addition of therapy-specific CPT codes to the Medicare telehealth services list on a permanent basis would make these codes available for other eligible providers (physicians, nurse practitioners, etc.) to provide these services via telehealth, but not for therapists once the PHE ends.

CMS also states that if these therapy services were included on the telehealth list, they could be furnished by a therapist and billed by a physician or practitioner who can furnish and bill for telehealth services provided that "all of the incident to requirements are met." This would potentially allow a small window of opportunity for therapists in private practice who bill incident to a physician to deliver and bill for telehealth.

Table 12 in the final rule summarizes CMS's proposed changes to the Medicare telehealth services list for CY 2021.

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

Type of Service	Specific Services and CPT Codes
1. Services CMS proposes for permanent addition to the Medicare telehealth services list	▪ Group psychotherapy (CPT 90853) ▪ Domiciliary, rest home, or custodial care services, established patients (CPT 99334-99335) ▪ Home visits, established patient (CPT 99347-99348) ▪ Cognitive assessment & care planning services (CPT 99483) ▪ Visit complexity inherent to certain office/OP E/M (HCPHC GPC1X) ▪ Prolonged services (CPT 99XXX) ▪ Psychological and neuropsychological testing (CPT 96121)
2. Services proposed as Category 3, temporary additions to the Medicare telehealth services list	▪ Domiciliary, rest home, or custodial care services, established patients (CPT 99336-99337) ▪ Home visits, established patient (CPT 99349-99350) ▪ Emergency dept visits, levels 1-3 (CPT 99281-99283) ▪ Nursing facilities discharge day management (CPT 99315-99316) ▪ Psychological and neuropsychological testing (CPT 96130-96133)
3. Services not being proposed as additions to the Medicare telehealth list, but CMS is seeking comment on whether they should be added on either a Category 3 basis or permanently	▪ Initial nursing facility visits, all levels (CPT 99304-99306) ▪ Psychological and neuropsychological testing (CPT 96136-96139) ▪ Therapy services, physical and occupational therapy (CPT 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507) ▪ Initial hospital care and hospital discharge day mgmt. (CPT 99221-99223, 99238-99239) ▪ Inpatient neonatal and pediatric critical care, initial and subsequent (CPT 99477-99480) ▪ 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, 90962) ▪ Radiating treatment management services (CPT 77427) ▪ Emergency department visits, levels 4-5 (CPT 99284-99285) ▪ Domiciliary, rest home, or custodial care services, new (CPT 9932-99328) ▪ Home visits, new patient, all levels (CPT 99341-99345) ▪ Initial and subsequent observation and observation discharge day management (CPT 99217-99220, 99224-99226, 99234-99236)

CMS is proposing to adopt the policy established during the PHE that allows PTs, OTs, and SLPs (and clinical social workers and clinical psychologists) to furnish and bill HCPCS G2061, G2062, and G2063 (E-visits) on a permanent basis. CMS is also proposing to allow billing of other communication technology-based services (CTBS) by nonphysician practitioners who cannot independently bill E/M services (e.g., therapists) by **creating two new HCPCS G codes to represent virtual check-ins and remote assessment of recorded video/images**. These codes would be used instead of G2010 and G2012 for these practitioners and would be valued the same.

G20X0 – Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation and follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.

G20X2 – Brief communication technology-based service, e.g., virtual check-in, by a qualified health professional who cannot report E/M services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

CMS proposes to designate G2061, G2062, G2063, G20X0, and G20X2 as "sometimes therapy services," such that when billed by a private practice PT, OT, or SLP, the codes would require the corresponding GP, GO, or GN modifier. (*Note:* This language implies these codes would only be available to therapists in private practice, that is, those who bill on professional claims, not institutional providers who bill on a UB-04.)

CMS is not proposing to extend coverage of the telephone assessment codes beyond the PHE, but is seeking comments on whether they should develop coding and payment for virtual check-ins with increased time and value.

CMS clarifies in the proposed rule that if audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, the practitioner should bill as if the service was furnished in person and the service would not be subject to any of the telehealth requirements.

CMS also states that services that may be billed incident to may be provided via telehealth under direct supervision of the billing professional. And, direct supervision may be provided virtually.

Direct Supervision:

Direct supervision means the physician or practitioner must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision does not require the physician/practitioner to be present in the room when the service or procedure is performed. Direct supervision as defined applies to therapists in private practice as PTAs and OTAs require direct supervision of the PT or OT in the private practice setting.

For the duration of the COVID-19 PHE, CMS adopted an interim final policy revising this definition of direct supervision to include the "virtual presence" of the supervising physician/practitioner using "interactive audio/video real-time communications technology." In this rule, **CMS proposes to extend this virtual direct supervision policy until the later of the end of the calendar year in which the PHE ends or December 31, 2021**.

CMS also clarifies that the requirement for direct supervision could be met by the supervising physician or practitioner (or therapist) being "immediately able to engage via audio/video technology," and does not require real-time presence or observation of the service via interactive audio/video technology throughout the performance of the procedure.

Remote Physiologic Monitoring (RPM):

Remote physiologic monitoring (RPM) involves the collection and analysis of patient physiologic data used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. CMS states they have received many questions about five of the CPT codes describing RPM services and about CMS's RPM policies. In the proposed rule, CMS clarifies its payment policies related to RPM and proposes clarifications related to RPM services that were finalized in response to the COVID-19 PHE.

First, and most relevant to therapists, **CMS clarifies that the CPT codes for RPM services are E/M codes and therefore may only be billed by physicians and practitioners who are able to bill these codes – i.e., not PTs, OTs, or SLPs.**

The CPT codes specifically addressed in this rule include:

- 99453: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- 99454: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- 99091: Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time, each 30 days
- 99457: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month, first 20 minutes
- 99458: Add on code…each additional 20 minutes

The RPM process begins with CPT codes 99453 and 99454, which are valued to include clinical staff time, supplies, and equipment, including the medical device for the "typical" case of remote monitoring. Neither of these codes can be billed for a patient more than once during a 30-day period, and 99453 can only be billed once "per episode." Monitoring must occur over at least 16 days of a 30-day period.

Once the 30-day collection period is complete, the data are analyzed and interpreted by the physician or non-physician practitioner (NPP) as described by CPT 99091. Then a treatment plan, informed by the data, is developed. CPT codes 99457 and 99458 are billed to reflect the time spent by the physician/NPP or clinical staff under the general supervision of the physician/NPP in "interactive communication" with the patient, defined as real-time, synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.

During the PHE, CMS allows RPM for both new and established patients and allows for billing for a minimum of two days of data collection over the 30-day period (vs. 16 days). Following the COVID-19 PHE, CMS will again require that an established patient-physician relationship exists for RPM services to be furnished and that data collection occurs over at least 16 days of a 30-day period. CMS is proposing as permanent policy to allow consent to be obtained at the time the RPM services are furnished.

Merit-based Incentive Payment System (MIPS):

PT, OT, and SLP eligibility for participation in MIPS continues into the 2021 performance year (i.e., the 2023 payment year). MIPS remains available for therapists in private practice only (i.e., those who bill on professional claims).

MIPS Value Pathways (MVPs)

CMS proposes to delay implementation of the MIPS Value Pathways until at least performance year 2022. The MVP framework will connect measures and activities across the four MIPS categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance the information provided to patients. CMS believes this MVP framework will reduce the complexity of the program and the burden to participate and will balance flexibility with standardization to allow for better comparisons across providers/clinicians.

Quality Category

CMS does not propose any changes to the minimum number of quality measures (six) or to the data completeness threshold, which will remain at ≥ 70% of all eligible patients *regardless of payer*, if using a reporting method other than via the claim, such as a Qualified Registry or Qualified Clinical Data Registry (QCDR). If utilizing Medicare Part B claims reporting (available again in 2021 to small practices of ≤ 15 clinicians), data must be submitted on ≥ 70% of eligible Medicare Part B patients. CMS will also continue quality category scoring and bonus policies, including improvement scoring.

CMS is proposing to sunset the CMS Web Interface measure option for quality data reporting beginning with performance year 2021, given a decrease in participation in this method by groups and virtual groups over the past three years. (The CMS Web Interface option required the submission of a specific set of measures and was available to large groups and virtual groups only. It did not apply to PTs, OTs, and SLPs.)

The proposed rule outlines a few changes (noted below in red) to the MIPS Quality Measure Specialty Sets applicable to PTs, OTs, and SLPs in 2021.

The PT/OT Specialty Set (Appendix B.32):

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient w/ Knee Impairments using FOTO Patient Reported Outcome Measurement
127	Diabetic Foot/Ankle Care, Ulcer Prevention – Eval of Footwear	218	…Hip Impairments using FOTO PROM
128	BMI Screening and Follow-up	219	…Foot/Ankle Impairments using FOTO PROM
130	Documentation of Current Meds	220	…Lumbar Impairments using FOTO PROM
134	Screening for Depression & Follow-up	221	…Shoulder Impairments using FOTO PROM
154	Falls: Risk Assessment	222	… Elbow/Wrist/Hand Impairments using FOTO PROM
155	Falls: Plan of Care	478	…Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen & Follow-up Plan	281	Dementia: Cognitive Assessment (eCQM)

182	Functional Outcome Assessment	282	~~Dementia: Functional Status Assessment~~ Proposing to remove this measure as it is duplicative of measure 182
226	Tobacco Use: Screening & Cessation Intervention	283	Dementia Associated Behavioral & Psychological Symptoms Screening & Management
318	Falls: Screening for Future Fall Risk (eCQM)	286	Dementia Safety Concern Screening & Follow-up
		288	Dementia: Education & Support of Caregivers for Patients with Dementia

The Physical Medicine Specialty Set measures applicable to PT/OT (Appendix B.31):

Measure	Description	Measure	Description
128	BMI Screening and Follow-up	182	Functional Outcome Assessment
130	Documentation of Current Meds	226	Tobacco Use: Screening and Cessation Intervention
154	Falls: Risk Assessment	402	Tobacco Use and Help with Quitting Among Adolescents
155	Falls: Plan of Care	431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

The SLP Specialty Set (Table B.39):

Measure	Description	Measure	Description
130	Documentation of Current Meds	182	Functional Outcome Assessment
134	Screening for Depression & Follow-up	226	Tobacco Use: Screening and Cessation Intervention
181	Elder Maltreatment Screen & Follow-up Plan		

CMS is proposing "substantive changes" to many of the measures applicable to PT, OT, and SLP. These changes include clarifications of denominator exceptions, changes to the lookback period, changes to verbiage/naming conventions, and the addition of telehealth encounters as denominator-eligible (however, this would not apply to PT, OT, and SLP after the PHE ends).

CMS states it anticipates a gap in MIPS quality data due to potentially fewer submissions for CY 2019 due to the COVID-19 PHE, thus skewing historical benchmarks that would use CY 2019 data for the CY 2021 performance period. In light of this, CMS is proposing to use *performance period benchmarks* for the CY 2021 performance period. CMS recognizes this methodology does not allow clinicians to know the benchmarks ahead of the performance period and states another other option is to use CY 2018 historical benchmarks again for 2021.

For the 2023 payment year (the 2021 performance year), scoring remains essentially the same as for the 2022 payment year. "Case minimum" requirements for quality measures in 2021 is 20 cases, which is unchanged from both performance years 2019 and 2020.

TABLE 43: Quality Performance Category: Proposed Scoring Policies for the CY 2021 MIPS Performance Period

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

Improvement Activities Category

In addition to the Quality category, MIPS-eligible PTs, OTs, and SLPs will continue to report Improvement Activities in 2021. Eligible clinicians or groups must attest to completing improvement activities for at least a continuous 90-day period during the 12-month performance period.

Activities continue to be categorized as "high-weighted" or "medium-weighted" based on the amount of time and resources it takes to implement and complete the activity. Scoring for Improvement Activities remains unchanged.

MIPS Category Weighting

CMS states it will continue reweighting the Cost and Promoting Interoperability categories for PTs, OTs, and SLPs to the Quality category in 2021. For the 2023 payment year (the 2021 performance year), CMS proposes weighting of the four MIPS categories as follows:

MIPS Category	2023 Weight	2023 Weight for PT/OT/SLP
Quality	40%	85%
Cost	20%	0%
Improvement Activities	15%	15%
Promoting Interoperability	25%	0%

MIPS Scoring

In last year's final rule, CMS finalized a performance threshold of 60 points for 2023 payment year (the 2021 performance year). In this proposed rule, CMS states they are revising this threshold due to "disruptions caused by the COVID-19 PHE." CMS anticipates some clinicians will opt to use flexibilities and the "uncontrolled circumstances and hardship exception," and will not participate in 2020, making a jump from 45 to 60 points too high. Therefore, **CMS is proposing a performance threshold of 50 points for the 2023**

payment year. The "additional performance threshold" – or exceptional performance benchmark – will remain 85 points as finalized last year.

The maximum payment adjustment for payment year 2023 is +/- 9%. The MIPS program remains budget neutral, however, such that incentives are paid based on penalties incurred. Incentive percentages are based on a "scaling factor" that increases as the number (and amount) of penalties increase. More MIPS eligible clinicians with scores above the performance threshold means the scaling factor decreases; more clinicians below the performance threshold means the scaling factor increases. As the scaling factor increases, the incentive percentage increases. For example, if the scaling factor is 0.395, a clinician who scores 100 points in MIPS would receive a 3.95% adjustment, along with the exceptional performance bonus (which is paid from additional dollars).

TABLE 51: Illustration of Points System and Associated Adjustments Comparison between Finalized 2023 MIPS Payment Year and the Proposed Policies for the 2023 Payment Year

*_NOTE_: Table 51 in the proposed rule compares payment years 2022 and 2023 – both finalized as of last year's final rule and the proposed changes outlined in the current proposed rule. Only stats for 2023 are summarized here for information purposes.

Previously Finalized 2023 MIPS Payment Year		**New Proposed 2023 MIPS Payment Year**	
Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment
0.0-15.0	Negative 9%	0.0-11.25	Negative 9%
15.01-59.99	Negative adjustment greater than -9% and less than 0% on a sliding scale	11.26-49.99	Negative adjustment greater than -9% and less than 0% on a sliding scale
60.0	0% adjustment	50.0	0% adjustment
60.01-84.99	Positive adjustment greater than 0% on a sliding scale ranging from 0-9% for scores from 60.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.	50.01-84.99	Positive adjustment greater than 0% on a sliding scale ranging from 0-9% for scores from 50.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.
85.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5-10% for scores from 85.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.	85.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5-10% for scores from 85.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.

Qualified Registries and QCDRs (i.e., Third Party Intermediaries)

In last year's final rule, CMS finalized that Qualified Registries and QCDRs must be able to submit Quality, Improvement Activities, and Promoting Interoperability data, and Health IT vendors must be able to submit data for at least one category beginning in performance year 2021. Qualified Registries and QCDRs that only represent MIPS eligible clinicians that are eligible for reweighting under the promoting interoperability category (for example, physical therapists) are not required to report this category.

In this proposed rule, CMS also outlined expectations that QCDRs and Qualified Registries must conduct annual data validation audits (changed terminology), and if one or more deficiencies or data errors are noted, the intermediary must conduct random audits. Both types of audits must comply with sampling methodology CMS outlines in the proposed rule, must be conducted for each submitter type (individual clinician, group, virtual group, opt-in clinician/group, voluntary participation), must use clinical documentation provided by the clinicians the entity is submitting data for to validate the action or outcome, and the audits must be completed and all deficiencies corrected prior to submitting data to CMS.

For more information, access **CMS's Fact Sheets**.

Access the **2021 Quality Payment Program Proposed Rule Overview Fact Sheet**.

Access the **CY 2021 Proposed Rule**.

Access the **addenda file** which includes the RVU breakdown for CY 2021.