Final 2021 MPFS Rule:

Key Changes for ACOs

The webinar will begin at 2:00 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

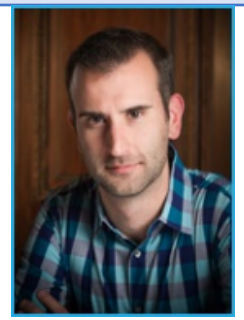
Agenda

1. Housekeeping
2. Presentation:
   - Political climate
   - Final policies for 2021 included in the Medicare Physician Fee Schedule (MPFS) rule
     - MSSP changes w/emphasis on ACO quality changes
     - Payment highlights
     - Key telehealth changes
     - Quality Payment Program (QPP) updates
3. Audience Q&A and follow-up

Housekeeping

1. Speakers will present for around 60 minutes
2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab (not chat) on your dashboard to the right of your screen at any time during the webinar
   - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question. Please make sure you have dialed in on the telephone and used your audio pin to connect.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours.

Speakers

	**Allison Brennan** Senior Vice President of Government Affairs NAACOS
	**Jennifer Gasperini** Director of Regulatory and Quality Affairs NAACOS
	**David Pittman** Health Policy and Communications Advisor NAACOS

Political Climate

Congressional Lame Duck Update

- Congress has until midnight on Friday, Dec. 18 to extend government funding and expiring health programs.
- A short-term funding extension is expected, which will allow more time to negotiate a comprehensive spending and COVID-19 package.
- Congressional leaders are working around the clock on final details of a $900 billion COVID-19 stimulus bill that is expected to be attached to a fiscal 2021 omnibus spending package.
  - Lawmakers are also pushing to include provisions that address expiring health programs, Medicare payment cuts, QP thresholds, and surprise medical billing.
  - More than 500 ACOs, health systems, and medical practices sent a letter in early December asking Congress to freeze QP thresholds at their current levels.
- The final year-end packages are expected to be introduced as soon as an agreement is reached.

Looking Ahead to the 117th Congress

- A new Congress and President take office in January with a full slate of health issues on the agenda.
  - Democrats will maintain a slim majority in the House.
  - Senate control will be determined by two Jan. 5 runoff elections in Georgia. The outcome will have a significant impact on the healthcare agenda in 2021 and beyond.
- Managing the coronavirus response will be the top priority for the Biden Administration.
- Policymakers are also expected to prioritize additional COVID-19 relief, insurance reforms, telehealth, and value-based care.

Presidential Transition

- This week the Electoral College affirmed Joe Biden as the President-Elect
- Several key health appointments were announced last week
  - Surgeon General, CDC Director, COVID Response Coordinator and others
- Calif. Attorney General Xavier Becerra was nominated to serve as HHS secretary
  - Created a reputation as ACA defender against Trump administration as Calif. AG
  - Has a history of fighting for cost containment dating back to days in Congress
  - Ability to gain confirmation is not totally certain
- No word yet on CMS administrator
  - Might have to navigate Democratic party interests and Senate Republicans
  - Could be very soon…stay tuned!
- NAACOS has reached out to the HHS review team with a short list of policy requests
- COVID-19 will be a top initial priority; we expect support for the transition to value

Dates to Watch in 2021

Event	Dates
Beginning of 117th Congress	January 3
Georgia Senate Runoff Elections	January 5
Inauguration Day	January 20
Administration Official Confirmation Hearings	January through May
Presidential Address to Joint Session of Congress	February *(Dates TBD)*
President's Budget Submission to Congress	February *(Date TBD)*

Final 2021 MPFS Rule

Overview and Key Payment Changes

Overview

- Dec 1: CMS released the 2021 Final Medicare Physician Fee Schedule (MPFS) rule
- MPFS factsheet available here and QPP Factsheet available for download here
- NAACOS submitted detailed comments to CMS advocating for policies to benefit ACOs. Our comments are available here.
- This final regulation includes numerous policies affecting Medicare Part B payment, notable quality changes for MSSP ACOs, and QPP updates for 2021
- Access our in-depth analysis of the rule here
- Please share your feedback on the policies by emailing us at advocacy@naacos.com

Key Payment Changes

- Notable payment changes in the final PFS :
  - A decrease the Medicare conversion factor to $32.41, which is a drop of approx. 10% from $36.09 finalized in 2020
    - **Key factors:** 0% automatic update, E/M changes go into effect, budget neutrality requirements
  - Payment shifts among specialties, resulting in some seeing increases as high as 16% and decreases of up to 10%.
  - Table 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

E/M and Care Management Changes

- CMS previously finalized significant changes to office and outpatient E/M services, updating reporting and payment as summarized in this NAACOS resource. Changes go into effect in 2021.
- In this year's rule, CMS finalized a revaluation of code sets that include, rely upon or are analogous to, office/outpatient E/M visits to align with increased E/M values finalized for 2021.
- New E/M add-on codes: G2211 for complex E/M; G2212 for prolonged E/M
- Transitional Care Management Services (99495 and 99496): CMS to allow concurrent billing with 15 new codes
- Replaced Chronic Care Management add-on code G2058 with CPT code 99439, which describes 20+ additional minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

MSSP Quality Changes

Quality Changes

Overview

- CMS finalized policies to align MSSP ACO quality requirements with the MIPS approach to quality assessments under a new quality assessment structure called the APM Performance Pathway (APP)
- As a result of NAACOS advocacy, CMS delayed retiring the Web Interface until 2022
- Most other APP policies were finalized
- CMS did not finalize additional updates to the Extreme & Uncontrollable (E&U) circumstances policy for 2020 quality – MSSP ACOs will be given the higher of their 2020 score or the mean quality score for 2020 and provided full credit for CAHPS measures
- Next Gen ACOs will receive the higher of their 2019 or 2020 quality scores in 2020 due to COVID-19 and receive full points for CAHPS measures

Quality Changes

Reporting WI Measures in 2021

- Web Interface (WI) measures & reporting are available in 2021 under the new APP structure, otherwise you may choose to report the new APP measure set
- To report via WI for 2021, you will report on a sample of patients provided by CMS as is currently the case
- CMS will use MSSP 2020 WI BMs for 2021- based on data reported by ACOs, physicians, and groups through the CMS Web Interface from 2016, 2017, and 2018
- CMS will require all ACOs to implement the CAHPS for MIPS survey starting in 2021
- CMS will use alternate administrative claims measures under the APP for all ACOs starting in 2021 to assess ACO quality

Quality Changes

Scoring WI Measures for ACOs in 2021

- Three WI measures will not be scored in 2021 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) – note ACOs must still report these measures to fulfill reporting requirements
- Multiple measures in the WI have specification changes, outlined in Table Group D on p. 1850 of the final rule, including important new exclusions for frailty for certain cancer screening measures as advocated for by NAACOS
- Table 40 on page 704 of the final rule lists the Web Interface and optional APP measures available to ACOs in 2021
- Those reporting via WI in 2021 will be scored using the new APP scoring approach (not the current MSSP quality scoring approach)

2021 WI Scoring

Web Interface Measures for 2021 Only	3-10 points earned per measure based on performance compared to MIPS benchmarks per reporting mechanism used	Final score must meet or exceed the 30th percentile MIPS score in 2021 and 2022, and the 40th percentile in 2023 and subsequent years
CAHPS for MIPS	10 maximum points	100 total points available NOTE: CMS will suppress measures that undergo significant changes mid-year as well as newly introduced measures, and as a result remove 10 points per affected measure from the total measure points available for the year
Diabetes HbA1c Poor Control	10 maximum points	
Controlling High Blood Pressure	10 maximum points	
Screening for Falls	10 maximum points	
Influenza Immunization	10 maximum points	
Tobacco Screening & Cessation	10 maximum points	
Colorectal Cancer Screening	10 maximum points	
Breast Cancer Screening	10 maximum points	
HWR Administrative Claims Measure	10 maximum points	
MCC Administrative Claims Measure	10 maximum points	
*ACOs in their first year of their first agreement period are given full points for complete and accurate reporting for one year		

Quality Changes

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

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Prevention and Treatment of Opioid and Substance Use Disorders
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

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

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

Measures Available for Reporting in 2021, found on page 704 of the final rule

ACO Quality

CAHPS Differences – effective 1/1/2021

- CAHPS for MIPS uses the same survey instrument as the CAHPS for ACO survey that is currently used by ACOs
- CMS will use the BM and scoring methodology used for CAHPS for MIPS; a single set of benchmarks will be calculated using data from all applicable CAHPS for MIPS reporters
- CMS will continue to draw the CAHPS survey samples for MSSP ACOs administering the CAHPS for MIPS survey at the MSSP ACO level, with a target sample size of 860 going forward
- CAHPS for MIPS does not use a flat percentage approach. Therefore, the shift away from flat percentage benchmarks may have the effect of creating larger differences in quality scores across MSSP ACOs

Quality Changes

Reporting APP Measures in 2022 and Subsequent Years

- CMS finalizes the new APP measure set (required in 2022) which contains 3 clinical quality measures, CAHPS for MIPS and 2 administrative claims measures
- New benchmarks = all MIPS reporters not all ACOs or all Web Interface reporters, and unique benchmarks based on the reporting mechanism selected
- MIPS quality benchmarks are established based on one year of historical data (data two years prior to the PY)
- The APP measure set will be required for all MSSP ACOs beginning in 2022
- Must report using a registry or direct via EHR using eCQM standards
- NOTE: eCQMs require reporting on all qualifying patients regardless of payer!

Quality Changes 2022

TABLE 46: APM Performance Pathway Quality Measure Set

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Quality ID:001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID: 236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Measure # TBD	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions

Measures Available in 2022 and Subsequent Years, found on page 1119 of the final rule

New Scoring Approach

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

Quality Changes

Revised MSSP Minimum Attainment Standard

- Current = Meet or exceed the 30th percentile among all WI reporters on at least one measure in each of the four quality domains
- Revised = Meet or exceed the 30th percentile among all MIPS reporters excluding "entities/providers eligible for facility-based scoring" in 2021 and 2022 (40th percentile in 2023 and subsequent years)
- Meeting the minimum attainment standard will earn the ACO the max shared savings rate, regardless of final quality score
- Must fully and accurately report all measures to meet min. attainment standard

Quality Changes

Determining Shared Loss Rates

- To determine shared loss rates, CMS will use an approach that awards ACOs with higher quality scores, a lower shared loss rate (and vice versa)
- To determine shared loss rates CMS will:
  1. Calculate the quotient of quality points earned divided by the total quality points available
  2. Calculate the product of the quotient described in step 1 and the sharing rate for the relevant track
  3. Calculate the shared loss rate as 1 minus the product determined in step 2
- CMS will continue to use a fixed percentage, based on Track as applicable (Basic Tracks C,D, E and Track 1+ have a fixed 30% loss sharing rate)

Polling Question

What is your biggest concern with CMS's quality policies finalized?

- Removing the Web Interface reporting mechanism
- Requiring reporting on all patients regardless of payer
- 2020 quality adjustments for COVID-19
- Changing the minimum attainment standard

Polling Question

How will you choose to report quality measures in 2021?

- Via the Web Interface
- New APP measures via direct EHR
- New APP measures via registry
- Don’t know

MSSP E&U Policy

- The MSSP has an Extreme & Uncontrollable (E&U) Circumstances Policy to address things such as natural disasters, etc which affect ACO performance
- There are two components of this policy: one to make adjustments to expenditures and one to make adjustments for quality performance
- CMS has made several updates to this policy for 2020, issuing two Interim Final Rules with Comment to account for the COVID-19 pandemic's unique circumstances
- The NAACOS website has numerous updates and resources to explain these policy adjustments
- The COVID-19 Public Health Emergency is in effect through the remainder of 2020

2021 E&U Changes

- In this final rule, CMS finalized a change to the quality portion of the E&U policy beginning with the 2021 performance year, to align with the finalized ACO quality changes
- Starting in 2021, CMS will give the higher of an ACO's own score or the minimum attainment level score if unable to report or unable to meet the minimum attainment standard due to an extreme/uncontrollable circumstance
- CMS will use the quarter 4 list of assigned beneficiaries to determine the percentage affected by the E&U circumstance
- As a reminder, in 2020 CMS has not made changes to the quality component of the E&U policy (ACOs will receive the higher of the mean ACO score for 2020 or their own 2020 quality score)

E&U Policy, COVID-19 Adjustments

- Unless the PHE is ended early, any shared losses an ACO incurs for 2020 would be reduced completely and the ACO would not owe any shared losses. Additionally, CMS will adjust certain MSSP financial calculations including the determination of benchmark and performance year expenditures, to remove payment amounts for episodes of care for treatment of COVID-19 triggered by an inpatient service
- CMS clarifies in this rule that CMS identifies episodes of care for treatment of COVID-19 based on discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the IPPS such as Critical Access Hospitals, when the date of discharge occurs within the PHE
- Other clarifications and details about these policies are available in this CMS COVID-19 FAQ document

Other MSSP Policies

MSSP Assignment

- CMS finalized the addition of 11 codes to the list of primary care services it uses to assign beneficiaries to ACOs starting in PY 2021. The additional codes include:
  - 99421, 99422, and 99423 (online digital evaluation and management, also known as "e-visits")
  - 99483 (assessment of and care planning for patients with cognitive impairment)
  - 99491 (chronic care management)
  - 99439 (non-complex chronic care management)
  - G2064 and G2065 (principal care management)
  - G2214 (psychiatric collaborative care model)
  - G2010 and G2012 (remote evaluation of patient video/images and virtual check-ins)

- CMS also finalized the exclusion of advance care planning (99497 and 99498) when billed in an inpatient setting from being used in assignment starting in PY 2021
- CMS also finalized its proposal to exclude professional services furnished by FQHCs or RHCs when those services are delivered in a SNF

MSSP: Repayment Mechanisms

Repayment Mechanism Requirement Updates

Current policy: If an ACO's repayment mechanism amount for the last PY of the previous agreement is higher than what is required for its new agreement, the ACOs must maintain the higher amount.

- CMS eliminated this requirement, effective beginning with agreements starting on/after Jan. 1, 2022
- CMS will allow ACOs an option to decrease their repayment mechanism amount if the recalculated amount is less than the existing amount.
- CMS will contact ACOs that renewed in 2019 and 2020 if they are eligible to lower their current repayment mechanism amounts.

QPP Advanced APM Policies

Advanced APMs

- Advanced APMs for PY 2021 include these and more…
  - MSSP Tracks 1+, 2 and 3 / Pathways Basic Level E, Enhanced Track
  - Next Generation ACO model
  - Direct Contracting Model
  - Comprehensive Primary Care Plus (CPC+)
  - Oncology Care Model (two-sided risk arrangement)
  - Comprehensive Care for Joint Replacement Payment Model (Track 1 - CEHRT)
  - Vermont Medicare ACO Initiative
  - Maryland Total Cost of Care Model
  - BPCI Advanced
  - Primary Care First
- More information on the models can be found on the Innovation Center webpage

Advanced APMs

QP Threshold Type:	Payment	Patient Count
Medicare		
QP	**75%**	**50%**
Partial QP	50%	35%
All-Payer Combination		
QP	75% (25% Medicare)	50% (20% Medicare)
Partial QP	50% (20% Medicare	35% (10% Medicare)

Estimated number of QPs for PY 2021: between 196,000 and 252,000 with total bonuses of between $700 and $900 million (paid in 2023)

BACKGROUND: Qualifying APM Participants (QPs):
Advanced APMs must have a certain proportion of patients or payments go "through" the APM. The ACO is evaluated collectively and if it meets/exceeds the thresholds, those ECs are designated as QPs and earn 5% bonuses

Key NAACOS Advocacy Priority:

Lower QP Thresholds for 2021.

Make your voice heard using our Take Action page!

Advanced APMs

CMS finalized policies to:

- Specify that beneficiaries prospectively attributed to an APM Entity would be excluded from the attribution-eligible beneficiary count for other APM Entities where the beneficiary is ineligible. As a result, CMS would remove prospectively attributed beneficiaries from denominators when calculating QP scores.
  - **Key takeaway:** this will help raise QP scores for some ACOs.
- Create a targeted review process for certain circumstances surrounding QP determinations. This will allow ECs/APM Entities to raise concerns about CMS errors in the QP determination.
  - CMS will align the timing of this review with the 60-day MIPS targeted review.
- Clarify that Advanced APM bonuses are based on the paid amounts, not allowed charges (a change which NAACOS advocated against)

QPP MIPS Policies

2021 MIPS

Overview

- CMS removes the MIPS APM Scoring Standard and replaces it with the new APM Performance Pathway (APP) to score APMs subject to MIPS, including ACOs starting in 2021
- ACOs will report quality and be scored for purposes of the MSSP through the APP. CMS will use that same score to provide a MIPS quality performance category score for ACOs
- CMS does not finalize a proposal to lower the minimum performance threshold for MIPS in 2021 and instead finalizes a 60-point threshold for 2021 (corresponding to 2023 payment adjustments) and an 85-point exceptional performance threshold
- The maximum possible MIPS penalty is 9% for 2021 (2023 payments)

2021 MIPS

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

2021 MIPS

CMS finalized changes to how MIPS scores are awarded when multiple scores exist for the same clinician:

Finalized Hierarchy When Multiple MIPS Scores Exist	Current Hierarchy When Multiple MIPS Scores Exist
Virtual Group score	APM Entity score (highest score if multiple scores exist)
Highest available score from an APM Entity, group and/or individual clinician	Virtual Group final score
	Group or individual clinician score (whichever his higher)

2021 MIPS

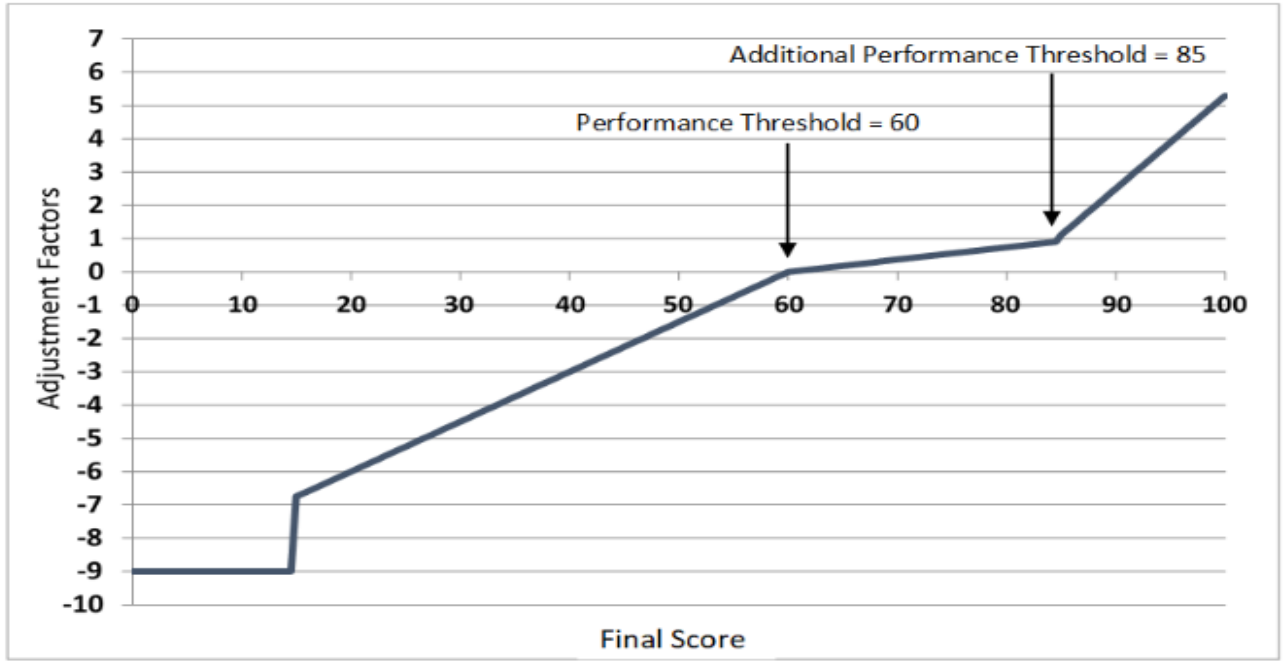
ACOs and MIPS ECs Joining Late in the Year

- CMS finalizes a change that MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the three snapshot dates (March 31, June 30, August 31), as well as December 31 during a performance period, would be considered participants in an APM Entity group for MIPS
- This would allow ACOs to capture all clinicians added to the ACO at any time in the performance year for purposes of determining the ACO final MIPS score and resulting payment adjustment

2021 MIPS

CMS projects MIPS adjustments of about +5% for those who score 100 points in MIPS (p. 1320 of the final rule)

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



2021 MIPS

MIPS COVID-19 Exceptions for 2020

- CMS is allowing APM Entities, including ACOs, the ability to request a MIPS hardship exception for full reweighting of all categories in order to receive a neutral MIPS score for 2020
- Once a hardship application is requested, if awarded it will override any data submitted by the ACO or its participants
- ACOs will be required to attest that at least 75% of participant MIPS eligible clinicians would be eligible for reweighting the Promoting Interoperability performance category for the applicable performance period to be eligible for this full reweighting
- Hardship exceptions are due by **2/1/21** for the 2020 performance year and determinations apply to all clinicians in the ACO- applications can be submitted via the QPP website

Telehealth & Remote Monitoring

Telehealth

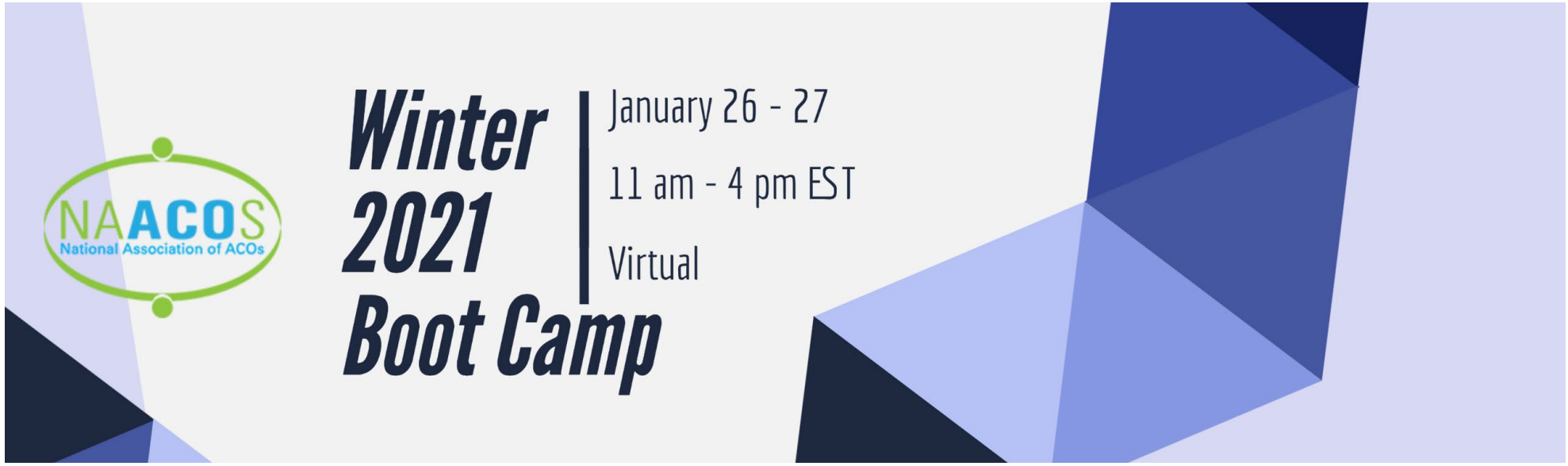
- CMS finalized permanently adding nine codes to the list of those eligible to be delivered via telehealth
  - Group Psychotherapy (90853)
  - Domiciliary, Rest Home, or Custodial Care services, Established patients (99334-99335)
  - Home Visits, Established Patient (99347- 99348)
  - Cognitive Assessment and Care Planning Service (99483)
  - Visit Complexity Inherent to Certain Office/Outpatient E/Ms (G2211)
  - Prolonged Services Psychological and Neuropsychological Testing (G2212)
  - Psychological and Neuropsychological Testing (96121)
- Will keep another 60 codes on the Medicare telehealth list through the end of the year in which the PHE ends
  - These include ESRD treatment, psychological and neuropsychological testing, home visits for established patients, observational stay care for hospitals, ICUs, and emergency care, ED visits, observation and discharge day management visits, critical care visits, and others
- The full list is on Table 16 of the final rule

Telehealth

- CMS created a new G-code for longer audio-only telehealth visits for CY 2021
  - G2252 (11-20 minutes of medical discussion to determine the necessity of an in-person visit)
  - Payment to be cross walked with outpatient E/M code 99442
  - Same as “virtual check-ins” and are patient-initiated calls to see if an in-person visit is necessary
- Changed frequency limitations to allow subsequent nursing visits to be furnished via telehealth once every 14 days in the nursing facility setting
- Finalized decision to allow direct supervision to include the virtual presence of a supervising physician or clinician using interactive, real-time audio-video technology through at least 2021
- Established two new codes to cover the remote assessment of recorded video and/or images (G2250) and 5-to-10 minute telephone calls (G2251) that can be billed by non-physician practitioners

Remote Patient Monitoring

- CMS went to great lengths in the final rule to clarify how to correctly deliver and bill for remote physiologic monitoring, which is much appreciated
- Other clarifications made:
  - Not extending the PHE policy that allows RPM services to be furnished to new patients as well as established patients
  - Will allow RPM services to be delivered to patients with acute conditions as well as those with chronic conditions
  - Finalized policy that allows patient consent to collected for RPM at the time that RPM services are furnished
  - Not allowing fewer than 16 days of data collected for a 30-day period in order to bill codes 99453 and 99454
  - Will require medical devices that deliver RPM be FDA approved, which means data must be electronically and automatically collected and transmitted rather than self-reported
  - Auxiliary personnel, including contracted employees, may furnish RPM services 99453 and 99454 under the general supervision of the billing physician or practitioner



Topics Include:

- Identifying the Best VBC Model/Track for Your Organization
- Is Direct Contracting in Your Future? How to decide and how to move forward
- Setting Up and Maintaining Chronic Care Management Programs
- Using Data
- Physician Comp: Going Beyond RVUs on the Road to Value
- Understanding QP and Its Benefits to Your ACO
- Succeeding with Commercial Contracts: From Negotiating Contracts to Designing/Maintaining Your Program
- Discussing groups for peers from same ACO tracks

For more information or to register: https://www.naacos.com/2021-boot-camp

Questions?

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