NAACOS Review of Proposed 2021 MPFS and QPP Rule

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:
   - Proposed payment policies for 2021 included in the Medicare Physician Fee Schedule (MPFS) rule
   - Proposed ACO quality changes
   - Proposed Quality Payment Program updates
3. Audience Q&A and follow-up

Housekeeping

1. Speakers will present for around 50 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. You will receive an email when they are available.

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

Overview and Key Payment Changes

Overview

- Aug 4: CMS released the proposed 2021 Medicare Physician Fee Schedule (MPFS) rule.
- MPFS factsheet available here and QPP Factsheet available for download here.
- This proposed regulation includes numerous policies affecting Medicare Part B payment, quality measure changes for the Medicare Shared Savings Program ACOs, and Quality Payment Program requirements for 2021
- Comments are due October 5th and can be submitted via this specific regulations.gov webpage.
- Final rule expected in November or December
- Please share your feedback on the proposals by emailing us at advocacy@naacos.com

Key Payment Changes

- Notable payment changes in the PFS proposal:
  - A decrease the Medicare conversion factor to $32.26, which is a decrease of 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 17% and decreases of up to 11%.
  - Table 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty (p.50375)

E/M and Care Management

- 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 proposes 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.
- Transitional Care Management Services (99495 and 99496): CMS proposes to allow concurrent billing with 15 new codes
- Proposal to establish new G-code (GC0L1) to expand use of Psychiatric Collaborative Care Model services
- Proposal to update payment of G0511 – used for RHC and FQHC comprehensive care management

Proposed MSSP Quality Changes

Quality Changes

Overview

- Major changes proposed to the way quality is measured and assessed in the MSSP
- We see CMS move forward with the concepts they discussed, but did not formally propose last year – moving quality out of the MSSP team and instead to the QPP team
- Proposed new APM Performance Pathway (APP) of the MIPS program
  - This is how ACO quality would be assessed for MSSP and MIPS
  - Quality measures reduced from 23 to 6 measures
  - No pay-for-reporting year
  - Higher performance standard and different scoring method
- Soliciting feedback on option of giving ACOs higher of 2019 or 2020 quality score due to COVID-19

Quality Changes

Other key changes

- CMS proposes to remove the Web Interface reporting mechanism, instead ACOs will select an applicable group reporting method available in MIPS
- For the measures listed for APP this includes registry or direct EHR using eCQM specifications which require reporting on all patients, regardless of payer
- New measure set includes 3 clinical quality measures, CAHPS for MIPS measures, two administrative claims measures
- Removes the domain-based scoring approach used currently for MSSP

Quality Changes

TABLE 36: Measures included in the Proposed APM Performance Pathway 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

Found on page 50233 of the proposed rule

Quality Changes

Quality assessment changes

- New methodology for how quality contributes to your shared savings/losses rates. If you meet the minimum attainment standard you get the max shared savings rate, if you do not meet it you cannot share in savings
- Shared loss rates will vary based on your quality score, except Basic risk-based levels will apply the 30% loss rate regardless if the min. attainment standard is not met
- No points provided for improvement
- New benchmarks- all MIPS reporters not all ACOs or all Web Interface reporters
    - Note: MIPS proposes to use 2021 performance to generate 2021 benchmarks due to COVID-19 impact

Quality Changes

Minimum attainment standard

- Current = Meet or exceed the 30th percentile among all Web Interface reporters on at least one measure in each of the four quality domains
- Proposed = Meet or exceed the 40th percentile among all MIPS reporters excluding "entities/providers eligible for facility-based scoring"
- Note: the minimum attainment standard currently allows you to share in savings, but ultimately your final quality score determines your shared savings rate. While under the proposed approach, meeting the minimum attainment standard will earn you the max shared savings rate
- Must fully report all measures to meet min. attainment standard

Quality Changes

Quality scoring overview

- No more domains
- No pay for reporting year
- Measured on six measures found in Table 36 (Note: this counts CAHPS as one measure, while the MSSP counted each individual measure within the CAHPS survey), awarded 3-10 points per measure based on performance vs. BM
- NAACOS has reached out to QPP staff to clarify if they will calculate one score based on all six measures and assess the minimum attainment standard based on that one final score, or if each of the six individual measures must meet or exceed the 40th percentile

Quality Changes

- CMS also seeks feedback on an alternative approach that would allow ACOs to choose to opt out of the APP and report to MIPS as an APM entity, selecting more appropriate measures, if the 3 measures are not appropriate for the ACO
- CMS proposes to award full points in 2020 for CAHPS measures due to COVID-19
- **Compliance**: CMS also proposes to strengthen policies for compliance with the quality performance standard by broadening the conditions under which CMS may terminate an ACO's participation agreement when the ACO demonstrates a pattern of failure to meet the quality performance standard (aligns with MIPS Data Validation and Audit process as well)

E/U Policy Changes

- CMS also proposes to change the quality portion of the E/U policy to align with proposed ACO quality changes, beginning with the 2021 performance year
- CMS proposes, starting in 2021, to give the higher of an ACO's own score or the minimum attainment level (40th percentile) score if unable to report or unable to meet the minimum attainment standard
- Would use the quarter 4 list of assigned beneficiaries to determine percentage affected by the E/U circumstance
- CMS also solicits comments on 2020 E/U policy change to award the higher of your 2019 or 2020 quality scores if an ACO fully reports quality in 2020

Polling Question

What is your biggest concern with CMS's quality proposals?

- Removing the pay-for-reporting year
- Changing the minimum attainment standard to the 40th percentile for all MIPS reporters
- Removing the Web Interface reporting mechanism and instead requiring registry or direct EHR (eCQM) reporting
- Timing of proposals (implementing these changes effective for the 2021 performance year)

Other MSSP Proposals

MSSP Assignment

- CMS proposes to amend the list of primary care services used to assign beneficiaries to ACOs by adding nine more codes starting in PY 2021. The additional proposed codes include:
  - 99421, 99422, and 99423 (online digital evaluation and management, also known as “e-visits”)
  - 99483 (assessment of and care planning for patients with cognitive impairment)
  - 99491 (chronic care management)
  - G2058/994XX (non-complex chronic care management)
  - G2064 and G2065 (principal care management)
  - GCOL1 (psychiatric collaborative care model)*

    *not yet finalized
- CMS also proposes to exclude advance care planning (99497 and 99498) when billed in an inpatient setting from being used to determine beneficiary assignment starting in PY 2021.
- CMS also proposes to exclude professional services furnished by FQHCs or RHCs when those services are delivered in a SNF.

Repayment Mechanism Requirements

- **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 renewing ACOs must maintain the higher amount.
- **Proposed change:** CMS would eliminate this requirement.
- **Current policy:** ACOs must increase the value of a repayment mechanism when the recalculated amount increases by the lesser of 50% or $1 million.
- **Proposed change:** Allow ACOs an option to decrease their repayment mechanism amount if the recalculated amount is less than the existing amount.

QPP: Advanced APM Proposals

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
  - Comprehensive Primary Care Plus (CPC+)
  - Oncology Care Model (two-sided risk arrangement)
  - Comprehensive Care for Joint Replacement Payment Model (Track 1 - CEHRT) – if extended
  - Vermont Medicare ACO Initiative
  - Maryland Total Cost of Care Model
  - BPCI Advanced
  - Direct Contracting
  - Primary Care First
- More information on the models can be found on the Innovation Center webpage

Increasing PY 2021 QP Thresholds

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

Value Act

- On July 24, Reps. Welch (D-VT), DelBene (D-WA), and LaHood (R-IL) introduced the NAACOS supported Value in Health Care Act (H.R. 7791). Bill summary and NAACOS press release.
  - The Value Act will help boost MSSP success and spur adoption of Advanced Alternative Payment Models.
  - NAACOS is working with Senate offices to introduce a companion bill.
- We continue working with lawmakers to find opportunities to advance these ACO and value-based care measures this year, including **lowering the PY 2021 QP threshold.**
- **ACO Advocacy is critical! Use our Take Action page to get started!**

Advanced APM Proposals

CMS proposes 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 would allow ECs/APM Entities to raise concerns about CMS errors in the QP determination.
  - CMS would align this with the 60-day MIPS targeted review.
- Clarify that Advanced APM bonuses are based on the paid amounts, not allowed charges.

QPP: MIPS Proposals

MIPS Proposals

Overview

- CMS proposes to remove the APM Scoring Standard and move to the APM Performance Pathway (APP) to score APMs subject to MIPS, including ACOs
- ACOs would still report quality and be scored for purposes of the MSSP through the newly proposed APP. ACOs would also receive a separate quality score for purposes of MIPS (same measures and scoring approach)
- A key difference in this proposal would allow clinicians and groups to voluntarily elect to report outside the ACO for purpose of MIPS scoring. These clinicians/groups would be awarded with the higher of their own MIPS score or the ACO MIPS score

MIPS Proposals

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

Performance Category	Proposed Weights	Notable Changes Proposed
Quality	50%	Moves to APP structure and measure set as well as scoring approach.
Cost	0%	No changes proposed for ACOs. ACOs would continue to not be given a Cost score in MIPS.
Improvement Activities	20%	No changes proposed for ACOs. ACOs would continue to be awarded full points automatically for Improvement Activities.
Promoting Interoperability	30%	No changes proposed 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.

MIPS Proposals

- Proposed changes to how MIPS scores are awarded when multiple scores exist

Proposed 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)

MIPS Proposals

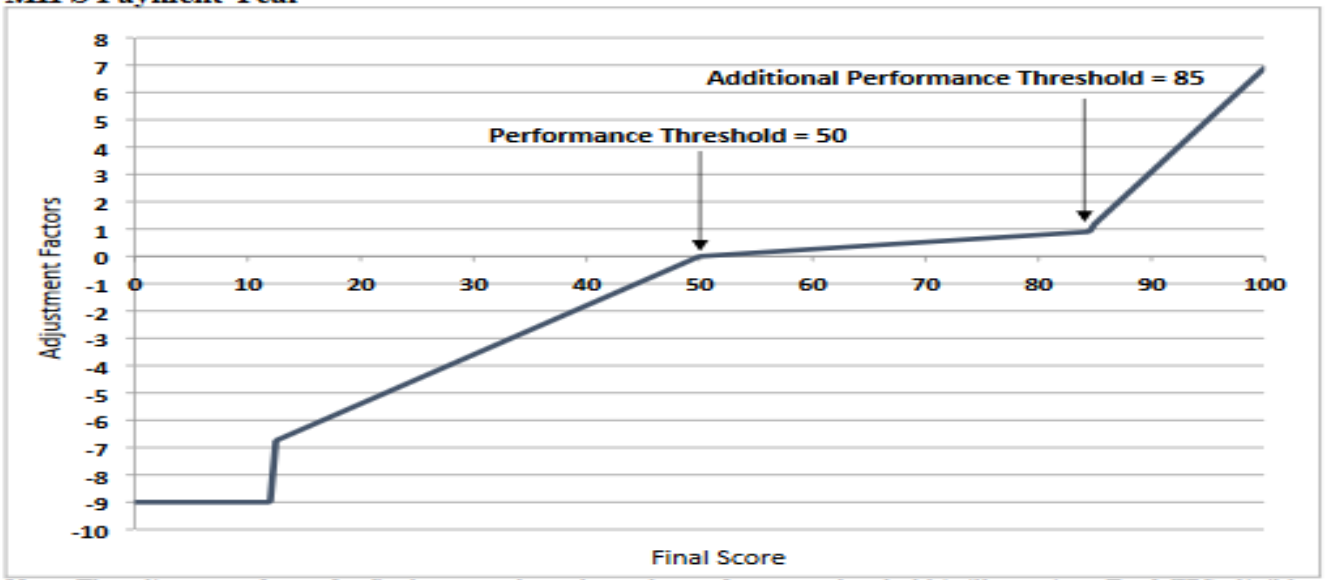
ACOs and MIPS ECs Joining Late in the Year

- CMS proposes 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
- 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

MIPS Proposals

- CMS projects MIPS final scores of up to 7% for those who score 100 points in MIPS (p. 50319 of the proposed rule)

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



Note: The adjustment factor for final score values above the performance threshold is illustartive. For MIPS eligible clinicians with a final score of 100, the adjustment factor would be 9 percent times a scaling factor greater than zero and less than or equal to 3.0. The scaling factor is inteded to ensure budget neutrality, but cannot be higher than 3.0. MIPS eligible clinicians with a final score of at least 85 points would also receive an additional adjustment factor for expectional performance. The additional adjustment factor starts at 0.5 percent, cannot exceed 10 percent, and is also mulitiplied by a scaling factor that is greather than zero and less than or equal to 1. MIPS eligible clinicians at or above the additional performance threshold will receive the amount of the adjustment factor plus the additional adjustment factor. This example is illustartive as the actual payment adjustments may vary based on the distribution of final scores for MIPS eligible clinicians.

MIPS Proposals

MIPS COVID-19 Exceptions

- CMS proposes to allow 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
- This option is available starting for the 2020 performance year. 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
- Hardship exceptions are due by 12/31/20 for the 2020 performance year and determinations apply to all clinicians in the ACO, applications can be submitted via the QPP website

Telehealth and Remote Monitoring

Telehealth

- CMS seeks to permanently add 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 (GPC1X)
  - Prolonged Services Psychological and Neuropsychological Testing (99XXX)
  - Psychological and Neuropsychological Testing (96121)
- CMS proposes to temporarily keep 13 additional codes on the Medicare telehealth list through the calendar year for which the PHE ends
  - Domiciliary, Rest Home, or Custodial Care services, Established patients (99336-99337)
  - Home Visits, Established Patient (99349-99350)
  - Emergency Department Visits, Levels 1-3 (99281-99283)
  - Nursing facilities discharge day management (99315-99316)
  - Psychological and Neuropsychological Testing (96130- 96133)

Telehealth

- CMS proposes to discontinue coverage of 60 codes that were added to the Medicare telehealth list during the PHE
  - ESRD treatment, Psychological and neuropsychological testing, Physical and occupational therapy, Observational stay care for hospitals, ICUs, and emergency care, Higher level ED visits, Observation and discharge day management visits, Critical care
- CMS seeks comment on the development of codes for audio-only visits
  - Recognizes the need and value of audio-only visits, which have been allowed during the COVID-19 PHE
  - Potentially new codes would be similar to the "virtual check-in" but for a longer period of time and with a higher reimbursement
  - Seeking input from the public on the appropriate time interval for such audio-only services and the resources in both work and PE that would be associated with furnishing them

Telehealth

- Proposes to change frequency limits of telehealth visits in nursing homes from once every 30 days to once every 3 days
  - Seeks comment on whether to allow required physician visits in SNFs to be initially conducted via telehealth
- Proposes to allow direct supervision to include the virtual presence of a supervising physician or clinician using interactive, real-time audio-video technology
  - If finalized, would extend through 2021 at least or the year in which the PHE ends to give themselves more time to solicit feedback and make additional changes as needed
  - Additional "guardrails" or limitations may be needed to ensure patient safety and clinical appropriateness
- Proposes to establish two new codes to cover the remote assessment of recorded video and/or images submitted by established patients (G20X0) and 5-to-10 minute telephone calls with established patients (G20X2)
  - Analogous to Medicare's "virtual check-in" codes created in the 2019 PFS
  - If finalized, would be billed by non-physician practitioners and others who cannot independently bill for E/M services

Remote Patient Monitoring

- CMS makes several clarifications to policy regarding remote patient monitoring in the proposed rule:
  - Allow patient consent be granted at the time RPM services are delivered
  - After the PHE ends, CMS will again limit RPM to established patients
  - Clarifying that RPM services may be furnished to patients with acute conditions, not just patients with chronic conditions
  - After the PHE ends, CMS will again require that monitoring occur over at least 16 days of a 30- day period for CPT codes 99453 and 99454
  - For 99454 to be billed, a medical device should automatically upload patient data – that is not rely on patient self-recorded and/or self-reported data.
  - Defines "interactive communication" for purposes of CPT codes 99457 and 99458 as involving a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission.
- CMS generally seeks feedback on whether or not current RPM codes adequately describe the full range of clinical services needed
  - Specifically, CMS seeks comment on whether new codes or payment rules are needed for stays shorter than 16 days

Fall Virtual Conference

Register for NAACOS Fall Conference
September 22 – October 2

Essential Information for ACOs

More at www.naacos.com/2020-fall-conference

Questions?