Final 2022 Medicare Physician Fee Schedule Rule:

What ACOs Need to Know

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.

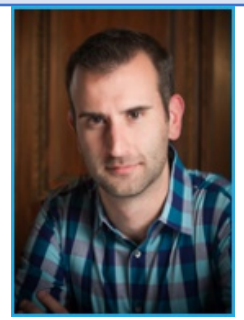
Agenda

1. Housekeeping
2. Presentation:
   - Final payment policies included in the Medicare Physician Fee Schedule (MPFS) rule
   - MSSP policies
   - Quality Payment Program (QPP) updates
   - Key telehealth changes
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. 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** Senior Policy Advisor NAACOS

Overview and Key Payment Changes

Overview

- 11/2: CMS released the final 2022 Medicare Physician Fee Schedule (MPFS) rule
  - CMS factsheet on the MPFS rule and Quality Payment Program factsheet
- The rule includes important policy changes for MSSP ACOs which we will discuss in today's webinar
- **Coming soon!** NAACOS's in-depth analysis of the rule
  - That will be available on this webpage along with NAACOS's comments on the proposed rule and other helpful MPFS resources and documents for this rule and prior years MPFS rules.
- Please share your feedback on the policies in the final rule by emailing us at advocacy@naacos.com

Overall Payment Update

- The Medicare Access and CHIP Reauthorization Act (MACRA) included a 0% update to the Conversion Factor (CF) for 2022
  - 2022 CF: $33.598, which is 3.8% lower than the 2021 CF of $34.893
  - Minor payment shifts among specialties (see Table 136 on page 1818).
- The Consolidated Appropriations Act, 2021 provided an increase of 3.75% for 2021 which is set to expire Dec. 31.
- **Given the flat MACRA update, sequestration cuts and expiration of the CAA increase, overall cuts are around 9.75%**

Evaluation and Management (E/M) Visits

CMS continues to refine the overhaul of office and outpatient E/M services, which went into effect in recent years. Policies as finalized:

- Revise the definition of split/shared visits to only include E/M visits in institutional settings for which "incident to" payment is not permitted
- Clarify that the split/shared visit should only be billed by the practitioner who performed the substantive portion of the visit when furnished by a physician and NPP in the same group
  - Definition of "substantive portion":
    - CY 2022: either one of the three key components of an E/M visit (history, exam, and/or medical decision making) or more than half the total time spent on the visit)
    - CY 2023 and beyond: more than half the total time spent on the visit

Evaluation and Management (E/M) Visits

- Allow practitioners who bill for critical care services to report another E/M visit for the same patient on the same day only if all 3 of the following criteria are met:
  - The E/M service was provided prior to critical care when critical care was not necessary,
  - The E/M service was medically necessary, and
  - The E/M service is separate and distinct from the critical care services
- Clarify that only the time a teaching physician is present can count toward E/M visit level for teaching services with a “primary care exception”
  - Clarify that only medical decision making may be used for visit level selection under this exception

Care Management Services

- CMS is increasing payment for many chronic care management services, such as 99490, and is adopting higher work RVUs for many codes based on recommendations from the AMA RUC.
- CMS is shifting more towards using CPT codes instead of G-codes
- The CCM/CCCM/PCM code family now includes five sets of codes, each set with a base code and an add-on code. The sets vary by the degree of complexity of care (that is, CCM, CCCM, or PCM), who furnishes the care (that is, clinical staff or the physician or NPP), and the time allocated for the services.
- 5 new CCM/CCCM/PCM codes going into effect in 2022: 99437, 99424*, 99425, 99426*, 99427 *(*replaces existing G-code)*
- Learn more about the codes in Table 20 (see page 408-410)

MSSP Quality Changes

Key Changes

- **NAACOS advocacy results in 3-year delay for the eCQM requirement for ACOs!**
  - ACOs will have the option to report either via Web Interface or eCQM/MIPS CQM through 2024. Beginning in 2025, CMS will require all ACOs to report via eCQM/MIPS CQM
  - CMS altered incentives to report eCQMs earlier than required
  - CMS removed the proposal to require at least one eCQM is reported in 2023
  - The quality performance standard threshold (30th percentile of MIPS quality performance category scores) will remain through 2023 and increase to the 40th percentile in 2024
- Work remains
  - CMS continues to rely on the MIPS structure to assess ACOs and compares ACO quality scoress to MIPS quality scores for purposes of determining shared savings/losses
  - These will continue to be key advocacy issues for NAACOS moving forward

Quality Changes

- In the 2021 MPFS rule, 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)
- In this rule, CMS finalizes further changes to these policies including:
  - Delaying the requirement to move to eCQM reporting for ACOs
  - Freezing the MSSP quality performance threshold for one additional year
  - Updating the Extreme & Uncontrollable Circumstances policy to reflect these changes – in place for all ACOs for 2021 due to the PHE
  - Providing incentives to ACOs who elect to report eCQMs earlier than required
  - Maintaining the all payor requirement associated with reporting eCQMs/MIPS CQMs for ACOs
  - CMS does not clarify how entities eligible for facility-based scoring will be excluded from reporting/scoring for ACOs
  - CMS confirms ACOs can report BOTH WI and eCQMs, and will be given the higher of the scores

Timeline for Implementation

2021-2024: ACOs can report either WI or eCQMs, or both. If you report both WI and eCQMs, you will receive the higher of the scores

2022-2023: ACOs can report WI or eCQMs w/ incentives for those who report eCQMs

2024: Quality Performance Standard Increases from 30th percentile of MIPS quality performance category scores, to the 40th percentile of MIPS quality performance category scores

2025: All ACOs must report eCQMs

Measure Updates 2022

- For 2022, three of the CMS WI measures (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: Tobacco Cessation: Screening and Cessation Intervention (Quality ID# 236)) do not have benchmarks for PY 2022, and, therefore, will not be scored
  - Reminder: Beginning in 2021, measures with no BM are suppressed (not pay for reporting)
  - These measures are required to be reported in order to complete the CMS WI dataset
- See Table 35: Measures included in the APM Performance Pathway Measure Set found on page 797 in the final rule for the list of measures available in 2022
  - 3 APP eCQM/MIPS CQMs, OR
  - 10 WI measures
  - BMs vary based on reporting method chosen!

De-duplication Instructions

- CMS provides instructions for de-duplication for ACOs in the rule. This raises additional questions/challenges but is the current instruction from the agency on how ACOs are to aggregate data, de-duplicate data and submit to CMS as a QRDA III file:
  - *We note that the ACO would utilize the QRDA I format, which specifies patient level collection of data from each of the ACO's participant TINs. The ACO would then aggregate these data across the ACO and submit them to CMS in the QRDA III format. Collecting and aggregating these data in the QRDA I format allows for de-duplication given the granularity of the data. (p. 781)*
- The QRDA I format provides additional patient-level detail such as name, sex, DOB, and contact information that will assist w/ de-duplication, however ACOs will still need to match patients and data across NPIs and TINs on a measure-by-measure basis

Quality Performance Standard

- The MSSP quality performance standard is the minimum performance threshold required to meet reporting obligations and earn shared savings in the MSSP
  - For PY 2018 the MIPS Quality performance category score at the 30th percentile was equivalent to 83.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 93.3
  - For PY 2019 the MIPS Quality performance category score at 30th percentile was equivalent to 87.9 and the MIPS Quality performance category score at the 40th percentile was equivalent to 95.7
  - **Roughly 1-in-5 ACOs, or approximately 20 percent of ACOs, could fall below the 40th percentile MIPS Quality performance category score by performance year 2023, and would not be eligible to share in savings or would owe maximum shared losses, according to CMS's estimates looking at historical MIPS performance data**

Quality Performance Standard

- **2021:** ACOs' final quality score must be equal to or higher than the 30th percentile across all MIPS Quality performance category scores. If met, ACOs are eligible to share in savings earned at the maximum sharing rate available in their particular track
- **2022-2023:** An ACO will meet the quality performance standard used to determine shared savings and losses if the ACO:
  - Achieves a final quality score equivalent to or higher than the 30th percentile across all MIPS quality performance category scores; **or**
  - Reports the 3 eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements) and achieves a quality score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set and achieves a quality score equivalent to or higher than the 30th percentile of the performance benchmark on at least 1 of the remaining 5 measures in the APP measure set.
- **2024:** ACOs final quality score must be equal to or greater than the 40th percentile across all MIPS Quality performance category scores
- **NOTE:** The Extreme & Uncontrollable circumstances policy will be in place for 2021 due to the COVID-19 PHE

Data Sharing & BAAs

- ACOs have raised concerns with the sharing of PHI beyond Medicare patients and beyond Medicare ACO assigned patients, particularly in the context of their current Business Associate Agreements (BAAs) as well as the HIPAA Privacy Rules for BAAs
- In this rule, CMS notes the disclosure of all-payer data to CMS as required by § 414.1340(a) would be permitted by the HIPAA Privacy Rule under the provision that permits disclosures of PHI as "required by law." Under this provision, a HIPAA covered entity, or its business associate when authorized by its BAA, may use or disclose PHI to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
- CMS also notes the HIPAA Privacy Rule minimum necessary standard does not apply to uses or disclosures that are required by law
- See pages 772-773 in the final rule

Data Sharing & BAAs

- *Regarding disclosures of PHI between an ACO participant TIN and the ACO, we encourage ACOs and their ACO participants to consult with their legal counsels as necessary to ensure that their Business Associate Agreements (BAAs) address the need to share data for patients covered by all payers with the ACO to permit the ACO to comply with its legal obligation to completely and accurately report data to CMS on eCQMs/MIPS CQMs.*

  (p. 783 of the final 2022 MPFS rule)

- NAACOS encourages ACOs adjust BAAs as necessary. Please share your feedback regarding the level of burden this will add to your operations, as well as any other concerns you may have, by emailing us at advocacy@naacos.com

Quality Benchmarks

- CMS does NOT finalize the proposal to use performance period benchmarks or data from the CY 2019 performance period to calculate quality measure benchmarks for the CY 2022 performance period/2024 MIPS payment year
  - According to CMS, analysis of the CY 2020 performance period data supports its use for benchmarking purposes
  - This refers to the individual quality measure benchmarks – not the quality performance standard
- CMS notes they will publish historic information regarding the MIPS quality performance category scores for purposes of allowing ACOs to see what the MSSP quality performance standard may look like in future years
  - NAACOS continues to call on CMS to use a different approach in scoring ACOs, and emphasizes the need for ACOs to have this threshold amount prior to the beginning of the performance year

Polling Question

Will your ACO be ready to report eCQMs in 2025?

- Yes
- No
- Unsure

Polling Question

Do you feel your ACO will be able to meet the quality performance standard in 2022?

- Yes
- No
- Unsure

Polling Question

How will you choose to report quality measures in 2021?

- Web Interface
- eCQM/MIPS CQM
- Both WI & eCQM
- Have not decided

Other MSSP Policies

MSSP Assignment

- CMS finalized updates to the list of primary care services it uses to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. The additional codes include:
  - 99437 (chronic care management)
  - 99424, 99425, 99426, and 99427 (principal care management)
  - G2212 (prolonged office or other outpatient E/M service)
  - G2252 (communication technology-based service)

- CMS finalized keeping 99441, 99442, and 99443 in MSSP assignment until they are no longer payable under Medicare FFS policies

- Finally, CMS finalized policy to use CPT codes that are directly replaced by another code in the fee schedule for purposes of MSSP assignment

MSSP Benchmarking

- CMS sought feedback on the regional adjustment of MSSP benchmarks
  - Specifically, how to account for the removal of ACO-assigned beneficiaries from the regional reference population, which NAACOS calls the “rural glitch”
  - ACOs lose the benefit of the regional adjustment if they lower spending
- NAACOS advocated for the removal of ACO-assigned beneficiaries from the regional reference population and a regional-only trend
- Despite NAACOS advocacy, CMS didn’t finalize any changes but said it will take comments into consideration for future refinements
- Notably, CMS doesn’t propose any changes to ACO benchmarking polices to account for the COVID-19 pandemic
- **NAACOS will continue to advocate CMS and Congress on the need to correct the rural glitch**

MSSP Risk Adjustment

- CMS sought feedback on the MSSP risk adjustment methodology
  - Specifically, how to improve risk adjustment for ACOs with medically complex, high-cost beneficiaries
  - CMS discussed alternative approaches to their current methodology such as increasing the cap on an ACO's risk score growth in relation to the risk score growth in the ACO's region
- NAACOS advocated for a risk adjustment cap of no less than 5% and a downward cap no greater than -5% and to align the ACO's cap with that of its region
- Despite NAACOS advocacy, CMS didn't finalize any changes but said it will take comments into consideration for future refinements
- **NAACOS will continue to advocate CMS and Congress for fair and accurate risk adjustment policies**

Repayment Mechanisms

- CMS requires repayment mechanisms (letter of credit, surety bond, funds in escrow) for ACOs in risk-based MSSP tracks
- CMS finalized its 2022 MPFS proposals resulting in new policies that cut in half the percentages required for ACO repayment mechanisms. New amounts are based on:
    1) 0.5% of total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned population
    2) 1.0% of the total Medicare Parts A and B revenue of ACO's participants
- ACOs' will pay the lesser of either amount; amounts are based on data from the most recent calendar year (i.e., 2020 for 2022 participation)
- CMS will allow ACOs that already have established repayment mechanisms an option to decrease those to reflect the rule changes
- CMS also finalized a change for when ACOs must increase their repayment mechanism amounts, such that an ACO must only increase its repayment mechanism if the required amount increases by at least $1 million

Beneficiary Notification

- In order to alleviate beneficiary confusion and reduce burden, CMS finalized the proposal that ACOs that have selected **prospective assignment** must provide standardized written notice **only to each prospectively assigned beneficiary** prior to or at the first primary care visit of the performance year but would not have to provide the notice to any other beneficiaries
    - ACOs at have selected preliminary prospective assignment with retrospective reconciliation must continue to provide notice to each FFS beneficiary
- All notices still have to be furnished prior to or at the first primary care visit of the performance year.
- **NAACOS will continue to advocate for the removal of the burdensome beneficiary notification requirement for MSSP ACOs**

Application Process

CMS finalized several changes to the application process, including:

- Removing the requirements to submit prior participation information
  - Still required upon the request of CMS
- Removing the requirements to submit sample ACO participant agreements during the application process
  - Still required upon the request of CMS
- Removing the requirements to submit an executed ACO participant agreement for each ACO participant during its initial application or renewal process
  - Still required to submit executed ACO participant agreement for those the ACO seeks to add to its list of ACO participants

QPP Advanced APM Policies

Advanced APMs for 2022

- Medicare Shared Savings Program (Basic Level E and Enhanced)
- Global and Professional Direct Contracting Model
- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Kidney Care Choices Model (Kidney Care First; Professional and Global Options)
- Maryland Total Cost of Care Model (Care Redesign Program)
- Oncology Care Model (Two-Sided Risk Arrangements)
- Primary Care First Model
- Radiation Oncology model
- Vermont All-Payer ACO Model

Advanced APMs for 2022

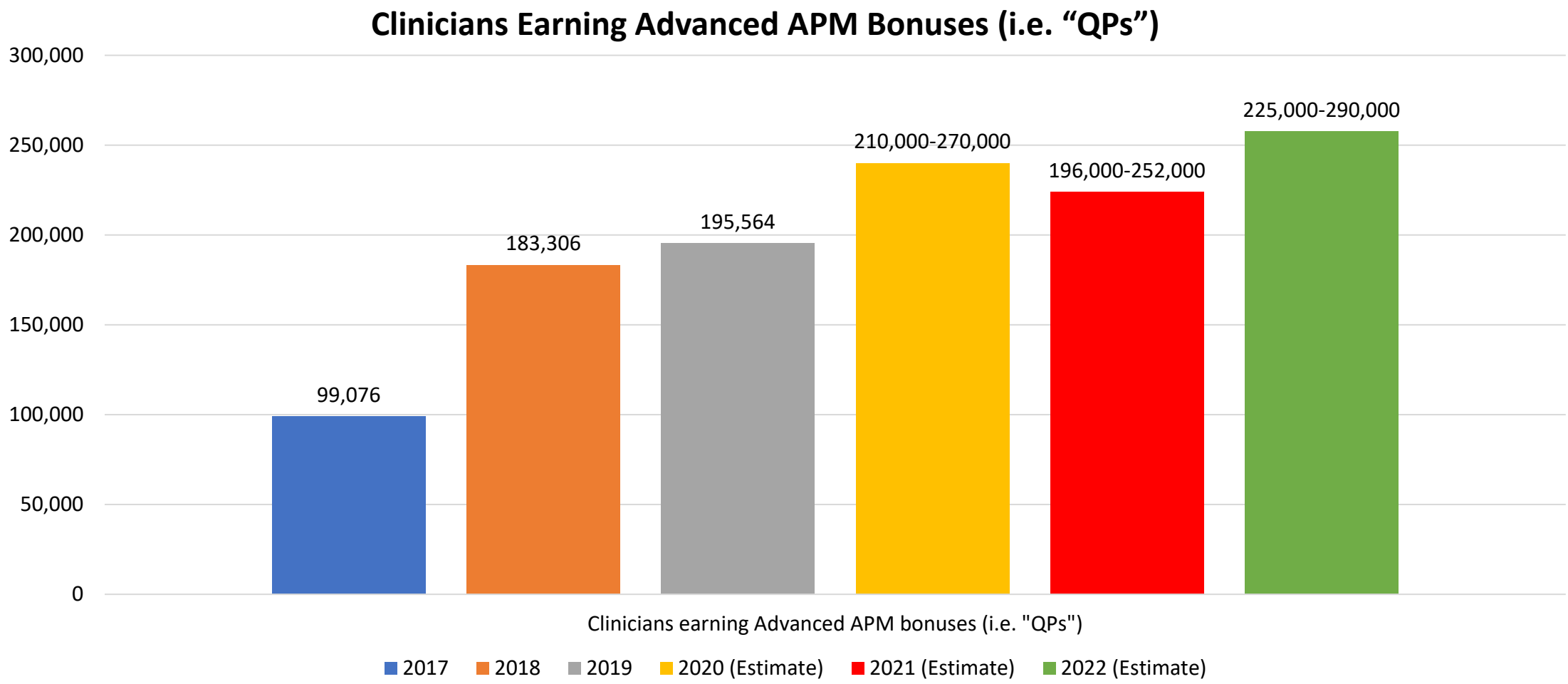
- After extensive advocacy by NAACOS and others, Congress prevented a sharp increase in QP thresholds for PY 2021 and 2022
- Performance year (PY) 2022 → payment year 2024

QP Threshold Type:	Payment	Patient Count
Medicare		
QP	50%	35%
Partial QP	40%	25%
All-Payer Combination		
QP	50% (25% Medicare)	35% (20% Medicare)
Partial QP	40% (20% Medicare)	25% (10% Medicare)

BACKGROUND: Qualifying APM Participants (QPs):

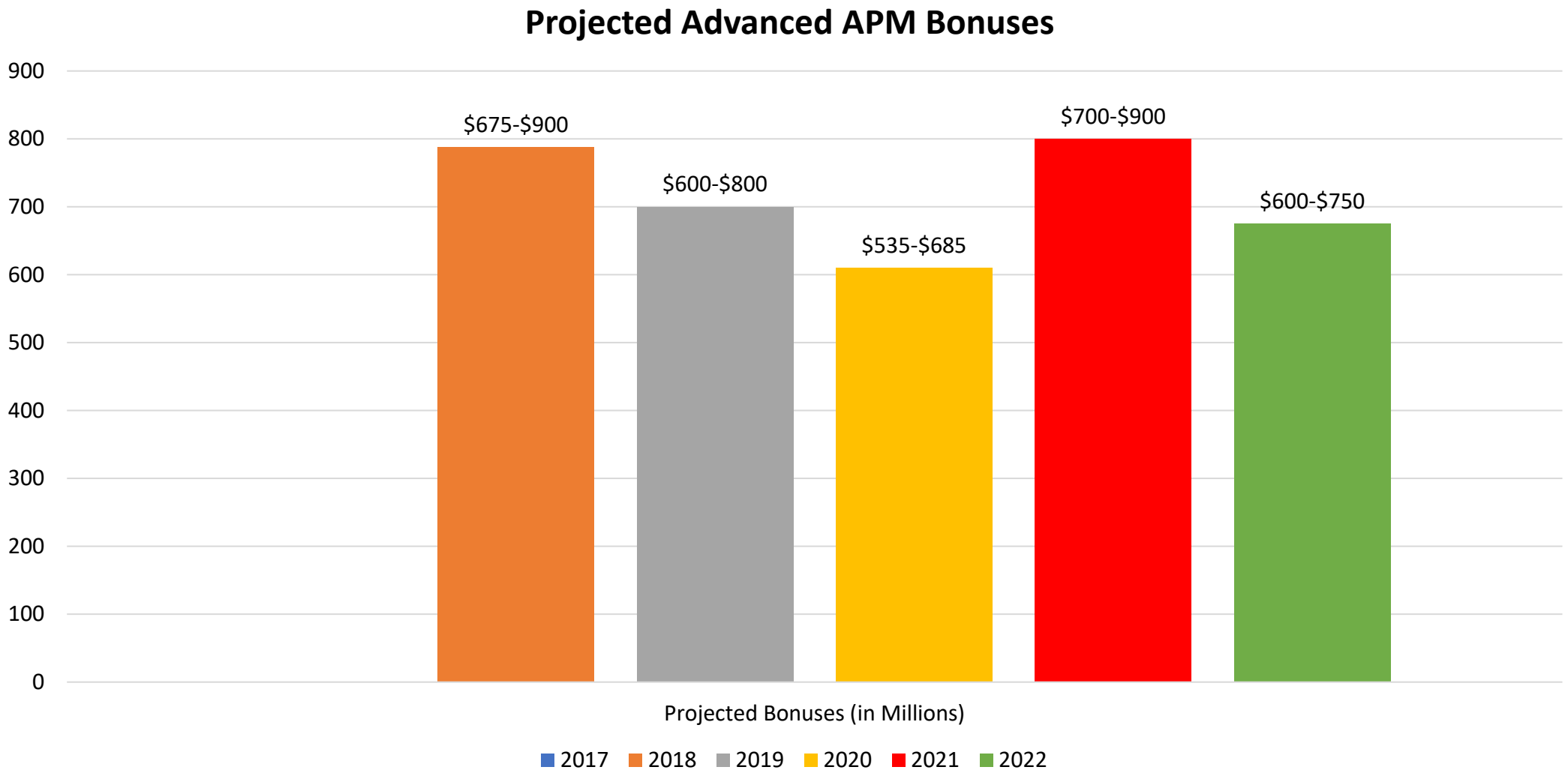
Advanced APMs must have a certain proportion of patients or payments go "through" the APM. The ACO is evaluated collectively and if it meets/exceeds the thresholds, those ECs are designated as QPs and earn 5% bonuses

Advanced APMs for 2022



All years refer to performance year. Payment year is two years post-performance year.

Advanced APMs for 2022



All years refer to performance year. Payment year is two years post-performance year.

Advanced APMs for 2022

- Performance year 2022 (payment year 2024) is the last year of the 5% Advanced APM bonus
- Starting in payment year 2026, CMS will provide QPs with a higher automatic payment update of 0.75% compared to those in MIPS receiving an automatic update of 0.25%
- CMS does not make notable Advanced APM updates in the 2022 MPFS rule
- CMS finalized a proposal to refine the hierarchy for finding QPs who earn the bonus but are no longer affiliated with the TIN associated with their Advanced APM participation. They need updated TIN info to distribute the bonuses.
  - Under the revised approach, the agency will look at the Medicare enrollment records in PECOS for the QP, focusing on the "base year" which is the year between the performance and payment year, then looking at the enrollment in the payment year. This adds to the approach finalized in 2021.

QPP MIPS Policies

2022 MIPS

Overview

- Delays implementation of the MIPS Value Pathways (MVP) overhaul to 2023
- CMS does not make any changes to the way ACOs subject to MIPS are scored via the APP in 2022, maintaining the 2021 performance category weights for all four performance categories
- CMS alters the definition of a MIPS eligible clinician, to include clinical social workers and certified nurse midwives starting in 2022
    - Note that clinical social workers will not receive a score for the Promoting Interoperability (PI) performance category when calculating average ACO PI scores, while certified nurse midwives will be included

2022 MIPS

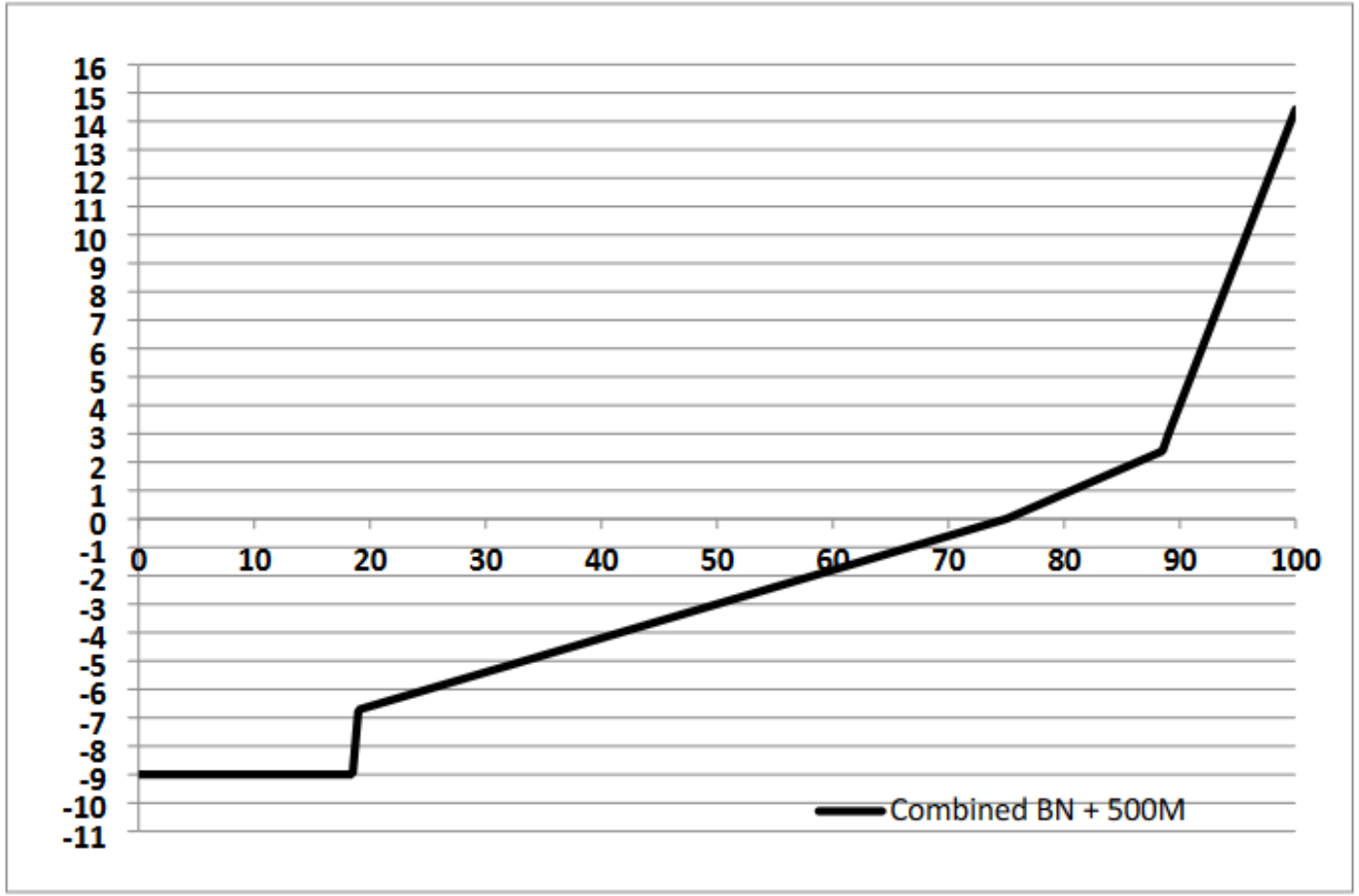
Performance Category	Weights	Overview of Requirements for ACOs
Quality	50%	APP structure and measure set as well as scoring approach used for both MIPS scoring and MSSP scoring
Cost	0%	ACOs continue to not be scored on Cost in MIPS
Improvement Activities	20%	ACOs continue to be awarded full points automatically for Improvement Activities
Promoting Interoperability	30%	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

2022 MIPS

- 2022 performance year is the first year CMS is required to begin establishing MIPS thresholds based on actual MIPS performance – max penalty of -9%
- CMS raises the MIPS thresholds for the 2022 performance year
  - 75 points= performance threshold (increase of 15 points)
  - 89 points = exceptional performance threshold (increase of 4 points)
- CMS projects MIPS adjustments of up to 14%, while also anticipating lower bonuses due to high performance in the MIPS program overall
- **PY 2022, corresponding to 2024 payment adjustments, is the final year that additional funding is provided to those meeting or exceeding the exceptional performance threshold under section 1848(q)(6)(C)**
  - This will impact total available funding and therefore max bonus amounts in the future considerably

2022 MIPS

Figure A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2024 MIPS Payment Year



2022 MIPS

Other notable policies

- CMS changes the formula used to provide the ‘complex patient bonus’. CMS indicates this bonus is available to ACOs and CMS will award double the points earned for this bonus in 2021 and 2022, due to impact of COVID-19
- NAACOS continues to ask CMS for more information regarding which quality bonus points are available to ACOs, however MIPS offers the following bonus points:
  1. Small practice bonus
  2. Improvement bonus (up to 10 points)
  3. Complex patient bonus

Telehealth & Remote Monitoring Updates

Telehealth

- CMS finalized its proposal to keep all of the services temporarily added to the list of those eligible to be delivered via telehealth on the list through the end of 2023, regardless of when the PHE ends
  - This move allows CMS more time to collect additional information regarding utilization of these services
- CMS will permanently cover G2252 (a “virtual check-in” between 11 and 20 minutes)
  - Virtual check-ins are audio-only, patient-initiated communications with a practitioner
  - G2252 was temporarily added last year but CMS is moving to make it permanent in 2022 given concerns about avoiding unnecessary in-person visits
  - Payment would be cross-walked with 99442

- **NAACOS believes all ACOs, regardless of risk level or choice of attribution, should be given the freedom to use telehealth in broader circumstances**

Telehealth

- CMS finalized making a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth
  - As required by Congress, beneficiaries must have an in-person visit within six months before their initial tele-mental health service
  - However, CMS is allowing beneficiaries to go as long as 12 months between in-person visits. CMS originally proposed six months but increased.
- Audio-only tele-mental health services delivered at patients' homes are allowed
  - Payment for audio-only services is limited to clinicians who have the capacity to furnish two-way, audio/video telehealth but the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology
- These changes also apply to FQHCs and RHCs

Remote Monitoring

- CMS finalized adding five new “remote therapeutic monitoring” (RTM) codes (98980, 98981, 98975, 98976, and 98977) in 2022
- In contrast to the remote physiological monitoring (RPM) codes, RTM could be used to cover “non-physiologic” patient data such, as pain and medication adherence
- Expected to be primarily billed by nurses and physical therapists, although conducted “incident to” physician supervision
- RTM would include self-reported data - a departure from RPM requirements that require data be automatically transmitted by a connected device
  - Would require the use of a medical device approved by the FDA

Other Recent Medicare Payment Rules

- CY 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule
  - Released November 2, 2021
  - Press release and fact sheet
- CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Expansion – Final Rule
  - Released November 2, 2021
  - Press release and fact sheet
- CY 2022 End Stage Renal Disease Prospective Payment System Final Rule
  - Released October 29, 2021
  - Press release and fact sheet

NAACOS Boot Camp

NAACOS Winter 2022 Boot Camp
Full days Monday and Tuesday, February 7-8
Orlando Airport Marriott Lakeside
In-Person Only (will not be streamed or recorded)

Registration now open: www.naacos.com/2022-boot-camp

Expert insight into the core competencies for ACOs and DCEs!

Boot camp faculty will present essential resources and policy updates as well as the basics on successful care management and resource allocation. Faculty will also facilitate learning groups for ACOs, DCEs, and those interested in either model. These learning groups will drill down into issues such as using data, claims and reports, as well as operationalizing care management tools and managing waivers. The format for this boot camp will include presentations by leaders in accountable care, case studies, hands-on exercises, and peer-to-peer learning. After completing two full days, boot camp attendees will leave with actionable knowledge to enhance the most critical operations within their ACO or DCE.

Q&A

Thank you!