Proposed 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.

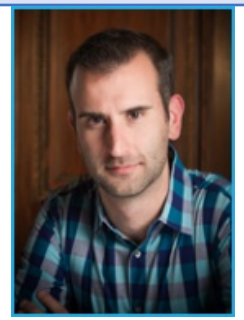
Agenda

1. Housekeeping
2. Presentation:
   - Proposed payment policies included in the Medicare Physician Fee Schedule (MPFS) rule
   - MSSP proposals
   - 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

- On July 13, CMS released the proposed 2022 Medicare Physician Fee Schedule (MPFS) rule
  - MPFS factsheet
  - QPP factsheet
- The rule includes important proposed policy changes for MSSP ACOs which we will discuss in today's webinar
- Access NAACOS's in-depth analysis of the rule here
- CMS will accept comments on the rule until September 13
  - Submit your comments via regulations.gov
- Please share your feedback on the proposals by emailing us at advocacy@naacos.com

Payment and E/M Updates

- The Medicare Access and CHIP Reauthorization Act (MACRA) included a 0% update to the Conversion Factor (CF) for 2022
  - 2022 CF: $33.58, which is 3.75% lower than the 2021 CF of $34.89
- Minor payment shifts among specialties (see Table 123 on page 39531)
- CMS continues to refine the overhaul of office and outpatient evaluation and management (E/M) services, which went into effect in recent years. Proposals:
  - Clarify that physicians in a facility setting may bill for a split/shared visit only if they perform a substantive portion of the visit, for new and established patients, when the visit is performed in part by both a physician and a NPP and both practitioners are in the same group.
  - Prohibit practitioners who report critical care services from reporting another E/M visit for the same patient on the same day /during the same time period as a procedure with a global surgical code.
  - 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”

Care Management Services

- CMS proposes to increase payment for services 99490, 99439, 99491, 99487, and 99489
- CMS is shifting more towards using CPT codes for care management services and proposes to add the codes below (replacing 2).

Code	Descriptor
99X21	CCM services each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99X22 ***Currently G2064***	PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99X23	PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99X24 ***Currently G2065***	PCM services, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month)
99X25	PCM services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Proposed MSSP Quality Changes

Proposed 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)
  - Learn more about these req's in our NAACOS resource
- In this rule, CMS proposes 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 proposed changes
  - Providing incentives to ACOs who elect to report eCQMs earlier than required
  - Solicit comments on a number of additional policy issues related to quality
- NAACOS advocacy was critical in obtaining these policy changes, thank you to our members for your participation in our grassroots advocacy on this issue!

Proposed Quality Changes

Proposed Quality Reporting Options		
2021	Report via Web Interface	Report via APP eCQMs/MIPS CQMs
2022	Report via Web Interface	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard (30th percentile of all MIPS final quality scores) for at least one of the three measures. This is a lower standard than WI reporting and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2023	Report via WI + one APP eCQM/MIPS CQM	Report via APP eCQMs/MIPS CQMs If electing to report eCQM/MIPS CQMs, ACOs only need to meet or exceed the performance standard (30th percentile of all MIPS final quality scores) for at least one of the three measures. This is a lower standard than WI reporting and is designed to act as an incentive for ACOs to elect to report the eCQMs/MIPS CQMs
2024	All ACOs must report the APP eCQMs/MIPS CQMs. The quality performance standard also rises in 2024, as proposed, to the 40th percentile of all MIPS final quality scores	

Note: If an ACO elects to report eCQMs/MIPS CQMs, data completeness and case minimum requirements must be met

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 25: Measures included in the Proposed APM Performance Pathway Measure Set found on page 39271 in the proposed 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!

Proposed Quality Changes

- CMS states if an ACO decides to report both the ten CMS Web Interface measures and the three eCQM/MIPS CQM measures, it will receive the higher of the two quality scores. NAACOS has reached out to CMS to clarify whether this policy also applies for PY 2021, as this is not expressly stated in the rule
- CMS clarifies that ACOs must de-duplicate patient data when submitting aggregate QRDA III files- NAACOS will seek more clarification regarding how ACOs can technically accomplish this goal
- CMS left many APP implementation questions unanswered – we will continue to seek greater detail to support ACOs working on transitioning to eCQM reporting
- Please send us your questions at advocacy@naacos.com

Performance Threshold

- CMS proposes to maintain the 30th percentile quality performance standard in 2021, 2022 and 2023 and proposes to increase the threshold to the 40th percentile beginning in 2024
  - **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:** Same as 2021, however if an ACO elects to report all three eCQM/MIPS CQMs in the APP, the ACO will satisfy the quality performance standard if the final quality score is equal to or greater than the 30th percentile on at least one measure in the APP measure set. This is designed as an incentive to encourage eCQM reporting.
  - **2023:** Same as 2022, however ACOs must also report at least one eCQM/MIPS CQM measure in the APP in order to meet the quality performance standard
  - **2024:** Beginning in 2024 CMS proposes to require mandatory eCQM reporting for all ACOs. ACOs final quality score must be equal to or greater than the 40th percentile across all MIPS Quality performance category scores
- Note: If electing to report eCQMs/MIPS CQMs data completeness and case minimums apply and must be met on all measures

Performance Threshold

- CMS seeks comment on publishing prior year performance scores for the 30th and 40th percentile MIPS Quality performance category score, as well as other ways the agency could provide additional information prior to the start of the performance year regarding the performance standard
- CMS provides prior year performance data in this rule as an example:
  - 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, if applicable**
  - The estimated percent of MSSP ACOs falling below the 40th percentile MIPS Quality performance category score was 6.5 percent based on a simulation using 2018 data and 22.9 percent based on a simulation using 2019 data
- NAACOS continues to call for greater transparency around this calculation

Data Aggregation

- CMS seeks comment on policy changes that may alleviate concerns with ACO data aggregation issues related to the move to eCQM/MIPS CQM reporting, including alternatives to the current approach:
  - Allowing ACO providers/suppliers to submit eCQMs/MIPS CQM measures to CMS at the ACO participant TIN level, instead of requiring ACOs to aggregate this data and submit one numerator/denominator to CMS
  - Calculate an ACO-level numerator for each measure (sum of performance met across TINs within the ACO) and an ACO-level denominator (sum of the met and performance not met across TINs within the ACO), then divide the two —numerator/denominator x 100 — to obtain the ACO-level performance rate
- An ACO that submits eCQM quality data to CMS must de-duplicate the patient level measures data across its ACO providers/suppliers to ensure that the aggregated QRDA III file that is submitted to CMS incorporates only quality data that meets the intent of the measure

Polling Question

Does this alternate approach solve the data aggregation concerns you have regarding requiring ACO-level eCQM reporting?

- Yes
- No
- Unsure

All Payor Req.

CMS notes that ACOs have raised concerns with the move to eCQM/MIPS CQM reporting and the issues that arise with requiring reporting on all-payor data. As such, CMS seeks comment on alternatives to this all-payor requirement in eCQM reporting applied to ACOs. Specifically, CMS seeks feedback on the following questions:

- Should ACOs report on a small sample size similar to the sample size for the CMS WI?
- Should CMS revise the beneficiary sample to include all ACO assigned beneficiaries that meet the denominator for a given measure?
- Should CMS provide ACOs with a bigger sample size which is larger than the size that has historically been used for CMS WI but smaller than all of the assigned beneficiaries that meet the denominator for a given measure, regardless of payor?
- Should CMS develop other ACO-level eCQM/MIPS CQM measure sampling specifications?

Polling Question

Which of the alternate options would you prefer?

- Sample size similar to the WI
- All patients meeting measure criteria for ACO assigned patients only
- Something else

Polling Question

Is moving the eCQM requirement to 2024, requiring one eCQM in 2023, enough time to implement ACO level eCQM reporting?

- Yes
- No
- Unsure

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
- Both
- Have not decided

Other Proposed MSSP Policies

Assignment

- CMS proposes to amend the list of primary care services it uses to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. The additional proposed codes include:
  - 99X21 (chronic care management)*
  - 99X22, 99X23, 99X24, and 99X25 (principal care management)*
  - G2212 (prolonged office or other outpatient evaluation and management [E/M] service)*
  - G2252 (communication technology-based service)

  *not yet finalized
- CMS is also proposing to keep using 99441, 99442, and 99443 in MSSP assignment until they are no longer payable under Medicare FFS policies
- Finally, CMS proposes to use CPT codes that are directly replaced by another code in the fee schedule for purposes of MSSP assignment

Application Process

- To alleviate burden, CMS proposes several changes to the application process, including:
- Remove requirements that ACOs tell CMS about past participation
  - Would only be required if CMS requests it
- Remove requirements that ACOs submit sample participant agreements during the application process
  - Would only be required if CMS requests it
- Remove the requirement that ACOs submit executed participant agreements for returning participant during the renewal process
  - Instead, ACOs would only be required to submit agreements during initial application and when requesting additions to their ACO participant list

Benchmarking

- CMS seeks feedback on the regional adjustment of MSSP benchmarks
  - Specifically, how to account for the removal of ACO-assigned beneficiaries from the regional reference population
  - This benchmarking flaw is often referred to as the "rural glitch"
  - NAACOS has consistently called for this to be fixed since ACOs that make up a large market share lose the benefit of the regional adjustment, penalizing themselves if they lower spending on their populations
- CMS seeks comment on what would constitute a heavy market penetration and how to strike a balance between helping ACOs with high market share without harming ACOs with relatively low market share
- Notably, CMS doesn't propose any changes to ACO benchmarking polices to account for the COVID-19 pandemic

Repayment Mechanisms

- CMS requires repayment mechanisms (letter of credit, surety bond, funds in escrow) for ACOs in risk-based MSSP tracks
- Proposals in the 2022 MPFS:
  - Cut in half the percentages required for ACO repayment mechanisms:
    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' would pay the lesser of either amount
- If finalized, CMS would allow certain ACOs that already have established repayment mechanisms an option to decrease those to reflect the rule changes
- CMS also proposes to only require an ACO to increase its repayment mechanism if the required amount were to increase by at least $1 million

Beneficiary Notification

- CMS is maintaining the beneficiary notification requirement but proposes a modification for ACOs using prospective assignment
- Specifically, ACOs that have selected prospective assignment must provide standardized written notice 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.
- The notices would still have to be furnished prior to or at the first primary care visit of the performance year.

Proposed QPP Advanced APM Policies

Advanced APMs for 2022

- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Global and Professional Direct Contracting Model
- Kidney Care Choices Model (Kidney Care First; Professional and Global Options)
- Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program)
- Medicare Shared Savings Program (Basic Level E and Enhanced)
- 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

Quality Payment Program Advanced APM Participation			
Performance Year	**Payment Year**	**Clinicians earning Advanced APM bonuses (i.e. "QPs")**	**Projected bonuses (in millions)**
2017	**2019**	99,076	
2018	**2020**	183,306	$675 - $900
2019	**2021**	195,564	$600 - $800
2020	**2022**	Estimated between 210,000 – 270,000	$535 - $685
2021	**2023**	Estimated between 196,000 – 252,000	$700 - $900
2022	**2024**	Estimated between 225,000 – 290,000	$600 - $750

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 AAPM proposals in the proposed 2022 MPFS rule
- CMS proposes 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
  - Under the proposed approach, the agency would 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

Proposed QPP MIPS Policies

2022 MIPS

Overview

- Delays implementation of the MIPS Value Pathways (MVP) overhaul to 2023
- CMS does not propose any changes to the way ACOs subject to MIPS are scored via the APP, maintaining the 2021 performance category weights for all four performance categories
- CMS proposes changes to the definition of a MIPS eligible clinician, to include clinical social workers and certified nurse midwives.
  - 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

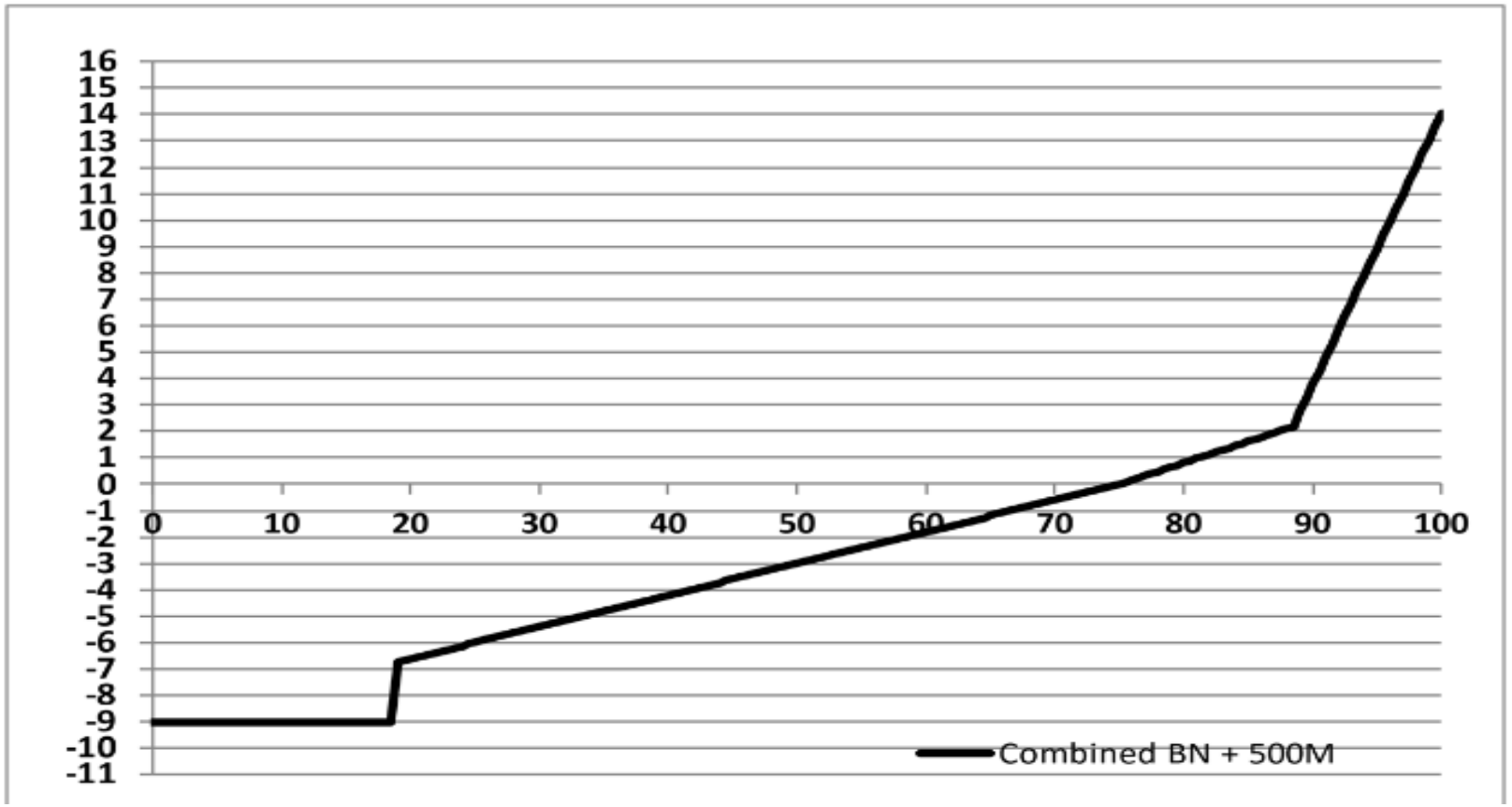
Performance Category	Weights	Overview of Requirements for ACOs
Quality	50%	APP structure and measure set as well as scoring approach used for both MIPS scoring and MSSP scoring
Cost	0%	ACOs continue to not be scored on Cost in MIPS
Improvement Activities	20%	ACOs continue to be awarded full points automatically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

Quality Benchmarks

- CMS proposes to establish MIPS quality benchmarks using performance year data (2022) or 2019 data, due to anomalies in the 2020 data set due to COVID-19
- These quality benchmarks are now used in the MSSP so this will be important to follow as CMS notes this decision is pending based on the 2020 performance they observe

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 as proposed, due to impacts of COVID-19
- NAACOS continues to ask CMS for more information regarding which quality bonus points are available to ACOs

Proposed Telehealth & Remote Monitoring Updates

Telehealth

- CMS proposes 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, if finalized, will allow CMS more time to collect additional information regarding utilization of these services
  - CMS doesn't state this, but the move also anticipates additional action from Congress to extend telehealth flexibilities beyond the COVID-19 PHE
- CMS proposes to permanently cover G2252 (a "virtual check-in" between 11 and 20 minutes) beyond the PHE
  - 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

Telehealth

- CMS proposes to make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth
  - If finalized, audio-only tele-mental health services delivered at patients' homes would be allowed
  - However, CMS proposes that beneficiaries must have an in-person visit within six months before the date of their at-home tele-mental health service
  - CMS is seeking ways to minimize this in-person requirement
  - This in-person requirement wouldn't apply to telehealth services for treatment of a diagnosed substance use disorder with a co-occurring mental health disorder
  - If finalized, these changes would also apply to FQHCs and RHCs
- CMS continues to seek feedback on flexibility around allowing direct supervision and immediate availability requirements to be provided via telehealth

Remote Monitoring

- CMS proposes to add five new “remote therapeutic monitoring” (RTM) codes (989X1, 989X2, 989X3, 989X4, and 989X5) 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, which is a departure from RPM requirements, which require data be automatically transmitted by a connected device
  - Would require the use of a medical device approved by the FDA
- Because CMS believes RTM codes will require similar staff and clinician work, the agency proposes similar payment rates for RPM services

Questions?

advocacy@naacos.com