August 4, 2020

To: Strategic Health Care Clients

From: David Introcaso, Ph.D., VP, Regulatory Affairs (david.introcaso@shcare.net)

Re: CMS Publishes the Agency's Proposed Physician Fee and Quality Payment Program 2021 Rule

Late Monday, CMS published the Agency's proposed Physician Fee Schedule and Quality Payment program 2021 Rule. The 1,355-page proposed rule is here. The physician fee schedule fact sheet is here and the Quality Payment Program fact sheet or slide deck is here. Comments are due October 5 – please let us know if you need assistance on a comment letter.

Here is a brief summary of major provision in the proposed 2021 rule.

Payment Update

The proposed 2021 conversion factor is $32.26. This is a decrease of $3.83 from the $36.09 2020 conversion factor.

Telehealth

Per a related White House Executive Order signed yesterday (here), CMS is expanding telehealth payment coverage, i.e., the agency is proposing to add approximately 20 new telehealth billing codes including: group psychotherapy; care planning for patients with cognitive impairment; home visits; and, psychological and neuropsychological testing. The agency is also proposing add on codes for visit complexity and for prolonged services.

Evaluation and Management (E/M) Payments

Again, CMS adopted the AMA's recommended values for E/M codes for 2021. The agency proposes an add on code to account for prolonged servicer time and is proposing to revalue codes for: End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services; Transitional Care Management (TCM) Services; Maternity Services; Cognitive Impairment Assessment and Care Planning; Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits; and, others.

Expansion of Scopes of Practice

CMS proposes to make permanent May interim final rule regulatory changes to allow NPs, PAs, CNSs, and CNMs to supervise the performance of diagnostic tests, allow physical therapist (PT) and occupational therapist (OT) to delegate the performance of maintenance therapy services to a

therapy assistant or a physical therapist assistant (PTA) or an occupational therapy assistant (OTA).

Episode Bundle for Counseling and Treatment of Opioid Use Disorders/OUDs

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Part B benefit for OUD treatment services, including medications for medication-assisted treatment (MAT) furnished by opioid treatment programs (OTP). CMS is proposing to: add two add-on codes for nasal naloxone, reimbursed at average sales price (ASP) + 0, and another add-on code for auto-injector naloxone, using lowest price available (lower of ASP + 0, wholesale acquisition cost (WAC), or national average drug acquisition cost, to be used for a bundled episode of care for treatment of opioid use disorders; use WAC + 0 for the drug component when ASP is not available; allow enrollment submission on institutional claims; and, require a face-to-face medical exam or biopsychosocial assessment to bill the periodic assessment add-on code and allow periodic assessments to be furnished via two-way interactive audio-video communication technology.

MIPS

Among other changes, CMS proposes to lower the previously finalized performance threshold of 60 points to 50 points for 2021; proposes to increase the cost component from 15% to 20% and reduce the quality component from 45% to 40%; proposing 206 total quality measures by removing 14 and making substantive changes to 12; and, proposing to use performance period, not historical benchmarks, to score quality measures for 2021. In addition, CMS is proposing to end the APM scoring standard and to establish a new MIPS APM Performance Pathway.

COVID-19 Flexibilities for PY 2020

Because of the pandemic, CMS is proposing to change the maximum number of points available for the complex patient bonus during 2020 performance year, i.e., clinician, virtual and APMs could earn up to 10 bonus points toward their final performance threshold score. Also because of the COVID-19 PHE, CMS is also proposing to allow APM entities to submit an application to reweight MIPS performance categories under the agency's extreme and uncontrollable circumstances policy.

MIPS Value Pathways

Because of the ongoing PHE, CMS is proposing not to introduce MVPs in 2021. Instead, the agency is proposing additions to the MVP framework's guiding principles and development criteria.

The Medicare Shared Savings Program/MSSP

CMS proposes to use new E/M and care management codes in calculating beneficiary assignment and proposing to exclude certain SNF services from the assignment methodology when provided by clinicians in FQHCs and RFCs. Concerning quality reporting, ACOs would report through a new APM Performance Pathway (APP) rather than the CMS Web Interface and ACOs would report on six core measures including CAHPS for MIPS, Diabetes Hemoglobin A1c Poor Control, Preventive Care and Screening: Screening for Depression and Follow-up Plan, Controlling High Blood Pressure, and other measures. For 2020, CMS is waiving the

requirement for ACOs to field CAHPS, i.e., ACOs will receive full credit for patient experience of care measures.

Proposed New APM Pathway

CMS is proposing a new APM Performance Pathway (APP) that would be is complementary to the MVPs. The pathway would be only available to participants in MIPS APMs. The proposed APP would amount to a fixed set of MIPS-like measures. For example, the quality performance category would be composed of six core measures focused on population health and the cost performance category would be weighted zero percent since participants would be responsible for cost containment under their respective APMs.

Advanced Alternative Payment Models (A-APM) Bonus

Beginning with 2021 QP Performance Period, CMS is proposing changes to the calculation of the QP threshold scores to prevent score dilution for A-APMs that use retrospective alignment. The proposal would remove prospectively attributed Medicare beneficiaries from the denominator for APM entities or individual eligible clinicians in A-APMs that do not allow for attribution of Medicare patients that have already been prospectively attributed elsewhere. CMS is also proposing a targeted review process by which an eligible clinician or APM entity can request review of a QP or partial QP determination if they believe in good faith that, due to a CMS clerical error, an eligible clinician was omitted from a participation list used for purposes of QP determinations.