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CY 2021 PFS, QPP, and MDPP Rule

OVERVIEW

On August 3rd, the Centers for Medicare and Medicaid Services (CMS) released an omnibus proposed rule that, if finalized, would update the calendar year (CY) 2021 Physician Fee Schedule (PFS), the CY 2021 Quality Payment Program (QPP), and policies for the Medicare Diabetes Prevention Program Expanded Model (MDPP). In particular, proposed changes to the PFS are more substantial than in recent years. This document summarizes major provisions of the proposed rule, which is available here. CMS is seeking comment on the rule through October 5th.

PHYSICIAN FEE SCHEDULE PROVISIONS

General Payment Provisions

CMS is proposing to set the CY 2021 PFS conversion factor to $32.26, representing a decrease of $3.83 from the CY 2020 PFS conversion factor of $36.09, due to a budget neutrality reduction of 10.61%.

The rule proposes to realign evaluation and management codes which, in general, results in increased payments to certain general practitioners and decreased payment to certain specialists. Examples of this include, but are not limited to:

- General practice - Increased by 8%
- Family practice - Increased by 13%
- General surgery - Decreased by 7%
- Cardiac surgery - Decreased by 9%
- Nurse anesthesiology - Decreased by 11%

Certain specialties, however, would see major increases to payments in CY 2021:

- Endocrinology - Increased by 17%
- Hematology/Oncology - Increased by 14%
- Rheumatology - Increased by 16%

CMS stated that these increases can largely be attributed to previously finalized policies for increases in valuation for office/outpatient evaluation and management (E/M) visits that represent higher percentages of total PFS spending and recommendations from the American Medical Association's Relative Value Scale Update Committee and CMS review.

CMS is also proposing to rebase and revise the Federally Qualified Health Center (FQHC) market basket to reflect a 2017 base year, which equates to a market basket update of 2.5%. The proposed payment update for FQHCs is 1.9% for 2021, with a multifactor productivity adjustment of 0.6%.

Telehealth

CMS is proposing to add a number of services to the Medicare telehealth list, and create a temporary category which describes services added to the Medicare telehealth list during the COVID-19 Public

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Health Emergency (PHE) that will remain on the list through the calendar year in which the PHE ends. This category would include the services that were added during the PHE that are likely to be clinically beneficial when furnished via telehealth, but there isn't enough evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Category 3 services will need to meet the criteria under categories 1 or 2 in order to be permanently added to the Medicare telehealth services list.

CMS is proposing to add the following services to the Medicare telehealth services list on a permanent basis:

- Group Psychotherapy (CPT code 90853)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347- 99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X)
- Prolonged Services (CPT code 99XXX)
- Psychological and Neuropsychological Testing (CPT code 96121)

CMS is proposing to add the following services to the Medicare telehealth services list on a temporary (Category 3) basis:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337)
- Home Visits, Established Patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133)

CMS is seeking public comment on whether any other service added to the Medicare telehealth services list for the duration of the PHE should be added to the Medicare telehealth services list on a temporary, Category 3 basis.

CMS is proposing to add two new HCPCS G codes that will allow certain non-physician practitioners to bill for communication technology-based services for remote evaluation of patient-submitted video or images and virtual check-ins:

- G20X0 (Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)
- G20X2 (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.)

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CMS is proposing to extend the interim policy that revises the definition of direct supervision to include virtual presence of a supervising physician or practitioner using interactive audio/video real-time communications technology until the later of either the end of the calendar year in which the PHE ends or December 31st, 2021. CMS will not continue to pay for audio-only telephone visits beyond the PHE, and they will once again need to be provided using an interactive two-way video and audio telecommunications system.

However, CMS is seeking comments on whether the audio-only services should be made permanent or whether CMS should develop coding and payment for a similar virtual check-in for a longer unit of time. Finally, CMS is proposing to revise the 30-day frequency limitation for subsequent nursing facility visits furnished via Medicare telehealth to one visit every 3 days, and is also seeking comment on whether frequency limitations in general are burdensome and if they limit access to care when services are available only through telehealth.

Scope of Practice Changes

The rule would allow certain nonphysician practitioners to supervise diagnostic tests, meaning nurse practitioners, clinical nurse specialists, physician assistants and certified nurse-midwives would be authorized to provide the appropriate level of supervision assigned to diagnostic tests, to the extent authorized under State law and scope of practice. The rule would allow physical therapists (PTs) and occupational therapists (OTs) who establish a therapy maintenance program to assign the duties to perform maintenance therapy services to a physical therapy assistant or occupational therapy assistant, whether they are an enrolled private practice PT or OT or a therapist working for an institutional provider. The proposed rule also would extend some policies implemented under the PHE declaration that relate to services furnished by pharmacists, such as providing services incident to the professional services of a physician or other nonphysician practitioner.

Opioid Treatment Provisions

CMS is proposing to add naloxone to the definition of opioid use disorder (OUD) treatment services, which would allow opioid treatment programs (OTPs) to be paid under Medicare for dispensing naloxone to Medicare beneficiaries who are receiving other OUD treatment services from the OTP. CMS is also proposing to amend the definition of OUD treatment services to include opioid antagonist medications that are approved by FDA under the Federal, Food, Drug and Cosmetic Act for the emergency treatment of known or suspected opioid overdose.

CMS is proposing to adjust the bundled payment rates for naloxone through the use of add-on codes to account for instances in which OTPs provide Medicare beneficiaries with the drug. They are proposing the following add-on G codes:

- HCPCS code GOTP1: Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.
- HCPCS code GOTP2: Take-home supply of auto-injector naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.

CMS is proposing to price the add-on code HCPCS code GOTP1 using the same methodology previously adopted for pricing the drug component of an episode of care that includes implantable or

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injectable medications, except that payment amounts determined based on ASP and wholesale acquisition cost (WAC) would not include any add-on percentages. CMS is proposing to price the add-on code HCPCS code GOTP2 using WAC + 0. CMS is proposing to limit Medicare payment to OTPs for naloxone to one add-on code (either HCPCS code GOTP1 or GOTP2) every 30 days, but is seeking comment on whether the proposed limit is reasonable and whether special circumstances might justify more frequent payment, as well as comment on the types of circumstances that should qualify for higher frequencies. Additionally, CMS is seeking comment on whether to create a code establishing an add-on payment for injectable naloxone.

CMS is implementing section 2003 of the SUPPORT Act by proposing to require that all prescribers conduct electronic prescribing of Schedule II, III, IV, and V controlled substances using the National Council for Prescription Drug Programs SCRIPT 2017071 standard by January 1st, 2022. CMS stated that because prescribers are already required to use this standard when conducting e-prescribing for covered Part D drugs for Part D eligible individuals, they should use the same standard for their electronic prescribing of controlled substances.

QUALITY PAYMENT PROGRAM PROVISIONS

CMS is proposing to begin Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) implementation in 2022 instead of 2021. Instead, CMS is updating MVP framework guiding principles, development criteria, and processes.

CMS is proposing to sunset the CMS Web Interface, removing a set of ten measures from the MIPS data submission types for groups beginning with the 2021 MIPS performance year. CMS believes that these measures have highly clustered performance and cannot meaningfully distinguish quality performance across groups or Accountable Care Organizations (ACOs). Additionally, CMS would eliminate the MIPS Alternative Payment Models (APM) scoring standard and replace it with the APM Performance Pathway (APP) in order to make performance measurement for MIPS ACOs less burdensome and more consistent with performance measurement for non-ACO providers included under the QPP. ACOs would only need to report one set of quality metrics to meet requirements for MIPS and MSSP. The total number of measures included in the ACO quality measure would be reduced from 23 to 6.

ACOs would report on the following 3 claims-based measures under the APP:

- Quality ID#: 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%).
- Quality ID#: 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan.
- Quality ID#: 236 Controlling High Blood Pressure.

Due to COVID-19, and as part of the extreme and uncontrollable circumstances policy, CMS is proposing to waive the requirement for the performance year 2020 to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. ACOs would be given automatic full credit for CAHPS in MSSP performance year 2020.

CMS is proposing changes to the MIPS quality measure set, which include the addition of 2 new administrative claims outcome quality measures, substantive changes to 112 existing MIPS quality measures, changes to specialty sets, removal of certain measures from specific specialty sets, and removal of 14 quality measures. CMS is proposing a total of 206 quality measures starting in the 2021 performance year.

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CMS is proposing the following MIPS Category Weights for CY 2021:

- Quality: 40%
- Cost: 20%
- Improvement Activities: 15%
- Promoting Interoperability: 25%

For Quality, CMS will use performance year benchmarks instead of historical data to score measures for performance year 2021 due to the PHE, as well as CMS sunsetting the CMS Web Interface submission method. Cost measure specifications will be updated to include telehealth services for existing episode-based cost and Total Per Capita Cost measures. Improvement Activities will see minimal changes based on the nomination process detailed below. Promoting Interoperability features a new optional health information exchange bidirectional exchange measure. The query of the Prescription Drug Monitoring Program measure will remain voluntary and worth 10 bonus points

CMS is proposing changes to the Annual Call for Activities, specifically an exception to the nomination period timeframe during a PHE, and a new criterion for nominating new improvement activities. During a PHE, stakeholders would be able to nominate improvement activities outside of the established timeframe. Instead of only accepting nominations and modifications submitted February 1st through June 30th each, CMS would accept nominations for the duration of the PHE as long as the improvement activity is considered relevant. CMS is proposing to adopt an additional nomination criterion entitled "Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible" to the criteria for nominating new improvement activities beginning with the CY 2021.

CMS is proposing to update the quality performance standard, requiring ACOs to receive a quality score equivalent to the 40th percentile or above across all MIPS Quality performance category scores, and allow ACOs that meet or exceed the threshold their maximum sharing rate or avoid owing maximum losses. Under this proposal, there would be no quality "phase in." All ACOs, regardless of performance year and agreement period, would be scored on all the measures in the APP for purposes of the MSSP quality performance standard.

Finally, the rule proposes two policies that would allow renewing ACOs more flexibility to select a repayment mechanism, potentially resulting in a lower established ability to repay potential losses. The first would apply prospectively to any renewing ACO that uses an existing repayment mechanism to establish its ability to repay any shared losses incurred for performance years in its new agreement period. An ACO would be required to have a repayment mechanism amount equal to the lesser of either 1% of the total per capita Medicare Parts A and B fee for service (FFS) expenditures for the ACO's assigned beneficiaries, or 2% of the total Medicare Parts A and B FFS revenue of its ACO participants. The second policy would allow an ACO whose current agreement period began July 1st, 2019 or January 1st, 2020 to elect to reduce the amount of its repayment mechanisms.

MEDICARE DIABETES PREVENTION PROGRAM PROVISIONS

CMS is proposing to amend the MDPP expanded model to revise certain policies adopted in the March 31st COVID-19 IFC. Namely, the provisions would allow those flexibilities to be applied to future 1135 waiver events, and would they add new flexibilities in addition to those established by the IFC that would apply both during the PHE and future 1135 waiver events.

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The provisions would allow CMS to determine whether an 1135 waiver event could disrupt in-person MDPP services if MDPP suppliers are unable to conduct classes in-person, or if MDPP beneficiaries would be unable to attend in-person classes, for reasons related to health, safety, or site availability or suitability, which could include avoiding the transmission of contagious diseases such as COVID-19. If CMS determines that an 1135 waiver event may disrupt in-person MDPP services, the agency would notify all impacted MDPP suppliers via email and other means as appropriate. MDPP suppliers affected by such an event would be permitted to either deliver MDPP services virtually or suspend in-person services and resume services at a later date. MDPP beneficiaries who elect to receive MDPP services virtually in accordance with the MDPP Emergency Policy would not be eligible to restart the set of MDPP services at a later date. Beneficiaries who elect to suspend the set of MDPP services at the start of an 1135 waiver event and subsequently choose to restart the MDPP set of services at the beginning or to resume with the most recent attendance session of record, would only be able make such an election once per 1135 waiver event. There would be no limit placed on the number of virtual make-up sessions during an 1135 waiver event.