spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

CY 2021 PFS, QPP, and MDPP Final Rule

OVERVIEW

On December 1st, the Centers for Medicare and Medicaid Services (CMS) released a final rule to establish the CY 2021 Physician Fee Schedule (PFS). The rule also revises the CY 2021 Quality Payment Program (QPP) and certain Medicare Diabetes Prevention Program (MDPP) policies during the remainder of the COVID-19 Public Health Emergency (PHE) as well as any future applicable 1135 emergency waiver events.

This document summarizes major provisions of the final rule, which is available here.

PHYSICIAN FEE SCHEDULE PROVISIONS

General Payment Provisions

The rule realigns evaluation and management (E/M) codes largely as proposed. The overall impact of these changes is to rebalance payments in favor of primary care and chronic care, while reducing payments for surgery, radiology and other technical work with less patient interaction.

In order to meet budget neutrality requirements after the increases in E/M codes, CMS is setting the CY 2021 PFS conversion factor to $32.41 (an increase from the proposed $32.26, but a decrease of $3.68 from the CY 2020 PFS conversion factor of $36.09).

Examples of the changes include:

- General practice - Increased by 7% (proposed: 8%)
- Family practice - Increased by 13% (as proposed)
- Endocrinology - Increased by 16% (proposed: 17%)
- Hematology/Oncology - Increased by 14% (as proposed)
- Rheumatology - Increased by 15% (proposed: 16%)

- General surgery - Decreased by 6% (proposed: -7%)
- Cardiac surgery - Decreased by 8% (proposed: -9%)
- Radiation Oncology – Decreased by 5% (as proposed)
- Nurse anesthesiology - Decreased by 10% (proposed: -11%)

These changes and others result from recommendations of the American Medical Association's Relative Value Scale Update Committee, as reviewed and implemented by CMS, regarding relative value units (RVUs) for the services performed by different specialties, and the continuing implementation of indirect practice expense allocation for some office-based services.

CMS is rebasing the Federally Qualified Health Center (FQHC) market basket to reflect a 2017 base year. The 2017-based FQHC market basket update for CY 2021 is 2.4%, and the multifactor productivity adjustment for CY 2021 is 0.7%. This results in a final payment update of 1.7%, instead of the proposed 1.9%. CMS attributes this difference to not having the second quarter of 2020 historical data at the time of the proposed rule.

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Telehealth

CMS is adding a number of services to the Medicare telehealth list, and is creating a temporary category (Category 3) which describes services added to the Medicare telehealth list during the COVID-19 PHE that will remain on the list through the calendar year in which the PHE ends. Category 3 includes 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. However, CMS has stated that adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking.

As proposed, CMS is adding the following nine services to the Medicare telehealth services list on a permanent basis:

- Group Psychotherapy (CPT 90853)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99334-99335)
- Home Visits, Established Patient (CPT 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS G2211)
- Prolonged Services (HCPCS G2212)
- Psychological and Neuropsychological Testing (CPT 96121)

CMS is also adding the following services to the list of Medicare telehealth services provisionally on a Category 3 basis:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facilities discharge day management (CPT 99315-99316)
- Psychological and Neuropsychological Testing (CPT 96130-96133; CPT 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524 , 92507)
- Hospital discharge day management (CPT 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT 99478-99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224-99226)

CMS originally proposed to add only the CPT codes related to Domiciliary, Rest Home, or Custodial Care services, Home Visits, Emergency Department Visits, Nursing facilities discharge day management, and Psychological and Neuropsychological Testing as Category 3 services. However, CMS received a number of public comments regarding additional services that should be added to the

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Medicare telehealth services list for the duration of the PHE, which were incorporated into this final rule.

CMS is also adding two new HCPCS G codes that will allow certain non-physician practitioners (NPPs) (practitioners who cannot independently bill for E/M services) to bill for communication technology-based services for remote evaluation of patient-submitted video or images and virtual check-ins:

- G2250: 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.
- G2251: 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.

The final rule also clarified a number of matters related to remote physiologic monitoring (RPM) services and billing, both during and after the state of emergency. Among these clarifications are the ability to obtain consent at the time RPM services are furnished, the ability to provide "incident to" services, the availability of RPM for patients with acute as well as chronic conditions, and that the 20-minute monthly interactive communication requirement can include time used for provision of care management services.

Finally, CMS revised the definition of direct supervision to include the virtual presence of a supervising physician or practitioner using interactive audio/video real-time communications technology when auxiliary personnel provide services "incident to" the billing practitioner's services, and extended this definition until the end of the calendar year in which the PHE ends.

Scope of Practice Changes

As proposed, CMS will permanently allow certain NPPs to supervise diagnostic tests; meaning nurse practitioners, clinical nurse specialists, physician assistants and certified nurse-midwives will be authorized to provide the appropriate level of supervision assigned to diagnostic tests, to the extent authorized under State law and scope of practice. In the final rule, CMS added certified registered nurse anesthetists to this list. CMS also clarified that physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS.

CMS finalized the proposal to allow pharmacists to provide services incident to the services of a billing physician or NPP if payment for services is not made under the Medicare Part D benefit.

CMS also finalized the Part B policy for maintenance therapy services allowing 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.

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Lastly, CMS finalized the policy to allow teaching physicians to use interactive, real-time audio/video to interact with residents in order to meet the requirement that they be present for a key portion of services provided, even when a resident provides Medicare telehealth services.

Opioid Use Disorder Treatment Provisions

CMS is finalizing the proposal to extend the definition of opioid use disorder (OUD) treatment services to allow for Medicare coverage of naloxone and other opioid antagonist medications that are approved by the Food and Drug Administration. The revised definition of OUD treatment services also incorporates overdose education, which includes how to recognize respiratory depression, the signs and symptoms of a possible opioid overdose, how to administer naloxone in the event of an overdose, and the importance of calling 911 or getting emergency medical help right away, even if naloxone is administered.

CMS finalized the following add-on code for nasal naloxone:

- HCPCS code G2215: Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program)

The new code will include both a drug component and a non-drug component for overdose education. The payment for the non-drug component of this code will be determined using a crosswalk to the Medicare payment rate for CPT code 96161 of $2.53. CMS did not finalize the proposed HCPCS code GOTP2, as both the brand and authorized generic formulation of the auto-injector naloxone has been discontinued. CMS is finalizing the proposed frequency limit on the add-on code for naloxone to once every 30 days, but is allowing exceptions in situations where a beneficiary overdoses and the use of naloxone is medically reasonable and necessary.

CMS finalized the proposal to allow opioid treatment program periodic assessments to be furnished via two-way interactive audio-video communication technology instead of face-to-face encounters. Lastly, CMS finalized the policy that that prescribers be required to use the National Council for Prescription Drug Programs SCRIPT 2017071 standard for electronic prescribing of Schedule II, III, IV, and V controlled substances covered under Medicare Part D. However, CMS finalized an earlier effective date of January 1st, 2021, instead of the proposed effective date of January 1st, 2022.

QUALITY PAYMENT PROGRAM PROVISIONS

CMS is delaying the Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) implementation until *at least* 2022, however, CMS intends to propose an initial set of MVPs and implementation policies in the CY 2022 rulemaking cycle. CMS also stated that the agency intends to release the MVP candidate template as soon as possible, and "potentially in coordination with the publication of this final rule," but as of yet has not done so. However, the rule finalizes the proposed updates to the MVP framework guiding principles.

CMS will sunset the CMS Web Interface beginning with the 2022 performance period. The rule also eliminates the MIPS Alternative Payment Model (APM) scoring standard and replaces it with the APM Performance Pathway (APP), which is intended to make performance measurement for MIPS Accountable Care Organizations (ACOs) less burdensome and more consistent with performance measurement for non-ACO providers included under the QPP. Under the final policies, the total number

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of measures will be reduced from 23 to either 6 or 13 (depending on the ACO's chosen reporting option) for performance year 2021 and to 6 measures beginning in performance year 2022.

Under the APP, the four performance categories would be weighted as follows:

- Quality: 50%
- Promoting Interoperability: 30%
- Improvement Activities: 20%
- Cost: 0%

For performance year 2021, ACOs will be required to report quality data via the APP, and can choose to report either the 10 measures under the CMS Web Interface or the 3 electronic clinical quality measures (eCQM) / MIPS CQM measures. For performance year 2022 and subsequent performance years, ACOs will be required to actively report quality data on the 3 eCQM/MIPS CQM measures via the APP. In addition, ACOs will be required to field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, and CMS will calculate 2 measures using administrative claims data (Note: CMS is waiving the requirement for ACOs to field a CAHPS survey and provide automatic full credit for CAHPS in MSSP performance year 2020).

ACOs will report the following 3 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.

CMS will calculate the following two claims-based measures under the APP:

- Hospital Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (MCC)

The rule updates the quality performance standard and allows ACOs in performance years 2021 and 2022 who receive a quality score equivalent to the 30th percentile or above across all MIPS Quality performance category scores to meet the Shared Savings Program quality performance standard. CMS originally proposed that ACOs would have to receive a quality score equivalent to the 40th percentile for performance years 2021 and 2022, but will instead apply that standard to performance year 2023 and years.

CMS is finalizing the proposal to incorporate 2 new administrative claims outcome quality measures, address substantive changes to 112 existing MIPS quality measures, address changes to specialty sets, and remove measures from specific specialty sets. CMS is also removing 11 quality measures from the MIPS program instead of the proposed 14.

Lastly, the rule adjusts policies regarding repayment mechanisms. Renewing and re-entering ACOs that intend to continue use of their existing repayment mechanism in a new agreement period may decrease their repayment mechanism amount if a higher amount is not needed for their new agreement period. A renewing ACO that uses its existing repayment mechanism to establish its ability to repay any shared losses incurred for performance years in the new agreement period will be required to have a repayment mechanism amount equal to the lesser of the following:

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- 1% of the total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available; or
- 2% of the total Medicare Parts A and B FFS revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available.

The rule also allows a one-time opportunity for an ACO that renewed its agreement period beginning on July 1st, 2019, or January 1st, 2020, to decrease the amount of its repayment mechanism if:

- Upon renewal, it elected to use an existing repayment mechanism to establish its ability to repay any shared losses incurred in its new agreement period and the amount of that repayment mechanism was greater than the repayment mechanism amount estimated for the ACO's new agreement period; and
- The recalculated repayment mechanism amount for performance year 2021 is less than the existing repayment mechanism amount.

MEDICARE DIABETES PREVENTION PROGRAM PROVISIONS

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

The provisions allow CMS to determine whether an 1135 waiver event could disrupt in-person MDPP services. During such an event, MDPP suppliers can either deliver MDPP services virtually or suspend in-person services and resume services at a later date. They can also start new MDPP cohorts during the PHE and all future 1135 waiver events. MDPP beneficiaries themselves will maintain eligibility for MDPP services, and receive MDPP services more than once per lifetime if an 1135 waiver event resulted in a suspension in service. In particular, MDPP beneficiaries who are in the first 12 months of the set of MDPP services as of the start of an applicable 1135 waiver event are eligible to restart the set of MDPP services at the beginning, or resume with the most recent attendance session of record, after an 1135 waiver event has ended. Second-year MDPP beneficiaries are only permitted to restart the ongoing maintenance session interval in which they were participating, or resume the set of MDPP services at the most recent attendance session of record.

The finalized MDPP provisions also introduced a number of flexibilities related to telehealth. In general, MDPP providers can use telehealth in place of or alongside in-person services. However, CMS declined to actually add MDPP services to the list of Medicare telehealth services outside of the PHE, stating that "virtual MDPP services do not qualify as telehealth services," which implies that they are not subject to any future limitations on telehealth (such as for non-rural areas).

Lastly, the flexibilities found in the March 31st COVID-19 IFC were originally only extended to beneficiaries who were receiving MDPP services as of March 1st, 2020. CMS is moving that date to March 31st, as a number of beneficiaries began receiving services after that date because state timelines for shelter-in-place requirements varied across the country.