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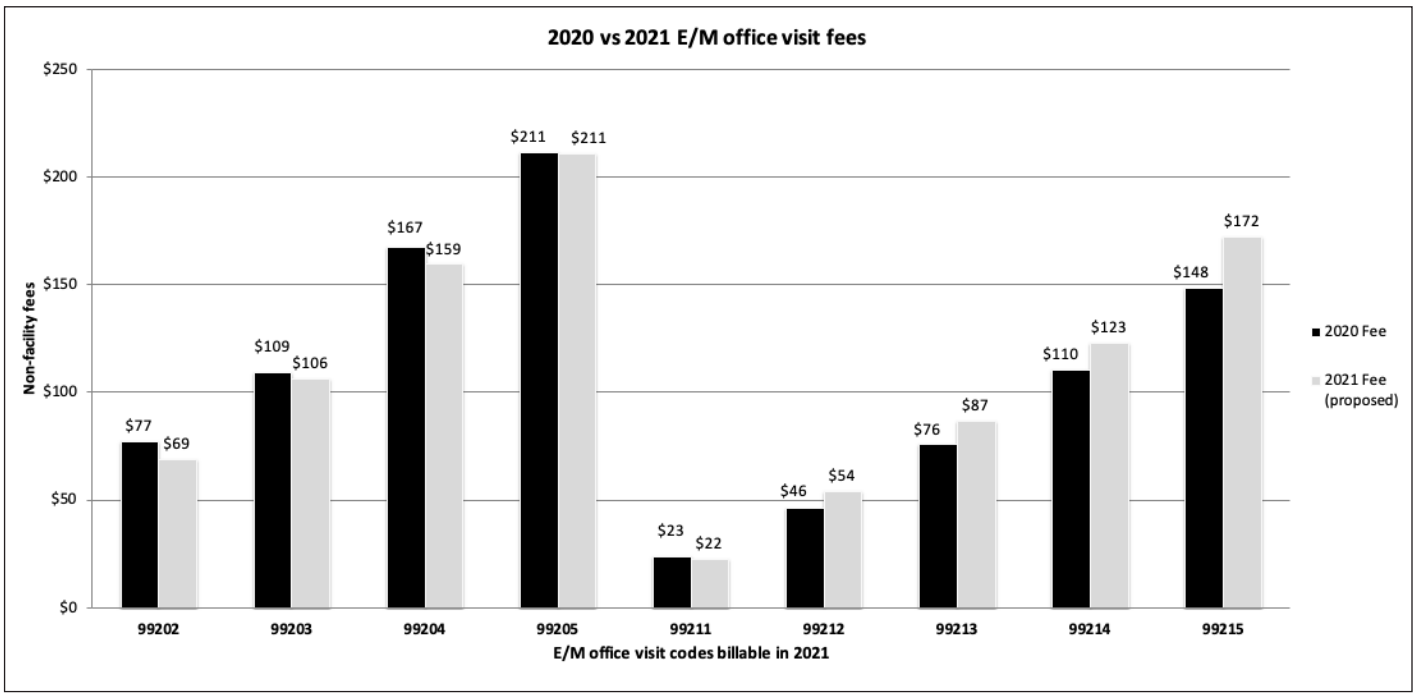
SPECIAL ISSUE

Coverage of the proposed 2021 Medicare physician fee schedule and Quality Payment Program



(*continued from p. 4*)

concerns regarding our utilization assumptions, since we assumed that specialties that predominantly furnish the kind of care described by the code would bill it with every visit. Therefore, we are soliciting from the public comments providing additional, more specific information regarding what aspects of the definition of HCPCS add-on code GPC1X are unclear, how we might address those concerns, and how we might refine our utilization assumptions for the code."

How does CMS view the scope of the add-on code? "GPC1X could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team," the agency states. — *Richard Scott (rscott@decisionhealth.com)* ■

Quality Payment Program

QPP updates in 2021: Big rise in measures, easier performance threshold, no MVP

The Quality Payment Program (QPP) is slated to retrench slightly due to COVID-19, but take note of several big news items: You'll find a new reporting scheme for MIPS Alternate Payment Models (APM), a smaller-than-expected rise in the overall performance threshold and several telehealth innovations.

The MIPS Value Pathways (MVP) model proposed in the 2020 Medicare physician fee schedule final rule — then planned for a 2021 implementation — has been postponed (*PBN 8/15/19*). CMS says it had to "recognize stakeholder concerns about this timeline" during the pandemic.

"The initial goal announced in 2019 to kick off MVPs in 2021 was already aggressive, based on the lack of detail and some very real technical challenges related to implementation," says Matt Fusan, general manager, population health for SPH Analytics in Alpharetta, Ga. "Once the industry began to feel the full impacts of the pandemic, trying to implement MVPs in 2021 felt like an unfair burden to already overburdened provider organizations who are on the frontlines of patient care during an unprecedented time."

An upside to the delay is that the collaborative process begun in last year's rule, which relied to an unusual degree on stakeholder feedback to develop the program, will be ongoing. "CMS is engaging stakeholders to a large degree in defining these MVPs, which should lead to better implementation and adoption," says Lauren Patrick, founder and president of Healthmonix in Malvern, Pa.

Nuts and bolts

There are a few nuts and bolts changes proposed for MIPS participants in 2021. The threshold for quality drops to 40% next year, down from 45% in 2020. Cost goes from 15% to 20% year to year — a gentle adjustment, considering that according to the law cost must account for 30% of your score by 2022. Thresholds for the promoting interoperability and improvement activities categories remains at 25% and 15%, respectively. Remember, if you're planning farther ahead on the category thresholds, that the cost and quality performance categories must be equally weighted at 30% beginning in the 2022 performance period.

A bigger change is that the MIPS performance threshold is now projected to increase to 50 points in 2021. The prior expectation was that the performance threshold would escalate to 60 points, Patrick says. The difference is notable because providers who reach the threshold avoid a penalty. The exceptional performance threshold, at which participants become eligible for more bonus money, remains at 85 points. But because the performance threshold is lower, more participants will achieve some bonuses, so the maximum incentive is projected to reach 6.9% instead of 7.4%, Patrick says. The positive and negative adjustment maximums remain at 9%.

And if you think that's a challenge to gain meaningful incentive dollars under MIPS, wait until next year: Dan Golder, principal with Impact Advisor in Cody, Wyo., reminds you that in 2022 CMS is required to set the performance threshold equal to the mean or median of all final scores from a prior period.

"As a general trend many providers are currently scoring quite well, with many achieving perfect MIPS scores," Golder says. "Yet to date, even a perfect score has resulted in what is perceived to be a meager incentive increase — in most cases less than 3%. Many providers are asking if it's worth the effort. If the carrot isn't significant, you're then left with only the stick. And in 2022, with the change in the performance threshold calculation methodology, we're likely to see a stick for essentially half of all providers, who will either receive zero incentive or be penalized ."

84% more measures

You'll discover a few innovations in quality reporting. For example, largely because of COVID-19 and its effect on patient volume, CMS proposes to use performance period rather than historical benchmarks to score quality measures. Usually quality is scored based on program results from the period two years earlier; for 2021, CMS proposes the program will assess performance based on overall results in the same year.

You'll also find considerably more MIPS quality measures. Of the 112 existing measures, CMS proposes to remove 14 and add 108 for a total of 206. These will include two new administrative claims-based measures:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups.
- Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).

Note that the administrative claims measure All-Cause Hospital Readmission is proposed for removal.

"Clinicians are going to need to take note of the changes, as there are significant changes in denominations to include telehealth," Patrick says. The rule states that "Language has also been added, to all applicable 2021 quality measure specifications, in the form of an 'Instructions Note', to clarify that telehealth encounters are allowed for determination of denominator eligibility."

There are also some new exclusions for "frailty," Patrick says. For example, for measure 112, Breast Cancer Screening, and measure 113, Colorectal Cancer Screening, "there is now a proposed exclusion for patients 66 and older who are living long-term in an institution for more than 90 consecutive days during the measurement period for the eCQMs [electronic clinical quality measures], and 'added coding to identify patients with advanced illness and frailty' for the CQM versions," Patrick explains. This should improve scoring for providers with elderly and very ill patients.

CMS also proposes to change the maximum number of points available for the complex patient bonus to account for the additional difficulty of treating such patients during the public health emergency (PHE), up to 10 bonus points from the current five.

Non-quality measures

The cost category also will take account of telehealth services that are directly applicable to existing episode-based cost measures and the Total Per Capita

Cost (TPCC) measure. There were no serious changes proposed for the improvement activity category.

The promoting interoperability measure Query of Prescription Drug Monitoring Program (PDMP) has been upped from 5 to 10 points, and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure is now called Support Electronic Referral Loops by Receiving and Reconciling Health Information.

The category also gets a new optional health information exchange (HIE) bi-directional exchange measure, which "will require that provider organizations participate with HIEs in a way that allows for data to flow both ways," Patrick says. Golder thinks this ties in with the Trusted Exchange Framework and Common Agreement (TEFCA), an HHS initiative Golder describes as their proposed "single on-ramp" for HIE. "It's an attestation measure (Y/N) that gives providers the maximum 40 promoting interoperability points towards their MIPS score," Golder says. "While TEFCA is not yet operational, this certainly paves the way to promote its adoption with providers."

APP Happy?

MIPS APMs — the category of APMs that don't qualify as Advanced APMs, which include many accountable care organizations (ACO) — and the providers who belong to them represent a substantial bloc of MIPS attesters: 41% in 2018, according to the most recent QPP Experience Report (*PBN 7/16/20*).

CMS proposes to require these participants to use a new APM Performance Pathway (APP) reporting option for the 2021 performance period. APP, which may be reported at the individual eligible clinician (EC), group (TIN), or APM Entity level, would replace the current APM Scoring Standard. Shared Savings ACOs will also use this as their quality reporting method for that program (*see story, p. 11*).

One major effect of APP for MIPS reporters would be a trimmed-down quality requirement: That performance category would be composed of six measures specifically focused on population health. CMS states that the population health measures are "widely available to all MIPS APM participants," according to the proposed rule.

The six measures are:

- CAHPS for MIPS.
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control.
- Preventive Care and Screening: Screening for Depression and Follow-up Plan.
- Controlling High Blood Pressure.
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.
- Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs.

Bye, Web Interface

But APP will add a burden for some participants because it means the end of the CMS Web Interface reporting method.

"There has been a substantial decrease in [Web interface] participation each year since the inception of MIPS," Patrick says. In 2018, there were 111 groups using it. "The majority of users of this submission method are expected to pull eCQMs from their EHR as an alternative if they utilize a single EHR," Patrick adds.

Also, Web Interface did a lot of work for providers that they will now have to do themselves. "Even though there are fewer measures to report, looking at those measures globally rather than as a CMS-designated sample will mean a lot more work for ACOs," says David Halpert, chief, client team at Roji Health Intelligence in Chicago. "For an ACO with tens of thousands of patients, the sample size for each of these measures could be 10 or 20 times (or more) the size of the Web Interface sample."

Fusan says organizations such as ACOs typically have multiple electronic health records (EHR) within a TIN, and they will have a major adjustment to make. An alternative would be to move to a registry or QCDR, Patrick says.

Still, some sophisticated ACOs may be able to get an added financial advantage out of the APP switch. "Another substantial proposed change is that providers participating in ACOs will be able to submit data for standard MIPS in addition to the data submitted via the ACO," Fusan says. "This option would allow providers to potentially earn a higher MIPS score than they would have received via the data submitted with the APP model.

Advanced APM changes

The big news in the Advanced APM program has to do with how CMS designates a Qualifying APM Participant (QP) or partial QP status, which status helps determine whether an APM qualifies for Advanced APM status and is eligible for non-MIPS

QPP program. The designation also helps them achieve the APM's Incentive Payment, usually a flat 5% of billings, and a slice of the bonus.

One change is the proposed establishment of a "Targeted Review" process for eligible clinicians (EC) or APM Entities to challenge an EC's exclusion from an APM Entity Participation List, which is used to determine QP/partial QP status. CMS also requests comment on "whether to allow an APM Entity to make the Partial QP election on behalf of all of the individual eligible clinicians associated with such APM Entity."

Also, CMS is considering a "revised approach to identifying the TIN(s) to which we make the APM Incentive Payment" in tricky situations involving QPs. That could be, for example, when one has helped earn a bonus for an APM but left before the Incentive Payment was made, or when an incentive payment was made despite the fact that the QP "did not bill for any Part B covered professional services during the incentive payment base period." — *Roy Edroso (redroso@decisionhealth.com)* ■

Coding

Code and fee preview: Take a first look at the code changes coming your way in 2021

Coders will have a small set of new procedure codes to juggle while they adjust to the new system for coding E/M office visits. Here are some highlights gleaned from the proposed 2021 Medicare physician fee schedule. See the chart, p. 10, for a preview of projected payments based on the proposed relative value units (RVU) and conversion factor.

Note: New codes are represented with placeholder codes. They cannot be used to report claims.

Category III migration

External electrocardiographic recording services represented by four category III codes will be replaced with eight category I codes. The change will allow practices to receive reimbursement without having to rely on the Medicare Administrative Contractor's (MAC) whim.

Four new codes include review and interpretation of data and were assigned work RVUs. Example: **93XX0** (External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation). The remaining four codes are technical component codes and do not have work RVUs, such as **93XX1** (External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording [includes connection and initial recording]).

Three category III codes that describe the insertion, replacement or removal of implantable blood glucose monitors will receive the rare distinction of being granted national coverage status next year. CMS made the decision for codes **0446T-0448T** based on stakeholder feedback.

Existing CPT codes replaced

The continued drive to bundle imaging services into procedures hit lung biopsy code **32405** (Biopsy, lung or mediastinum, percutaneous needle). The biopsy code will be replaced with code **324X0** (Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed). According to CMS, the AMA identified 32405 and needle guidance code **77012** as a pair that was reported together more than 75% of the time.

Audiologists will replace codes **92585** (Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive) and **92586** (… ; limited) with four new codes next year. One code represents a screening service performed with automated analysis. The screening status earned it a non-covered designation by Medicare. The remaining three will include an interpretation and report. Example: **92X52** (Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report).

G codes replaced

Make sure your software is updated to swap two G codes effective Jan. 1, 2021. Chronic care management by clinical staff code **G2058** will be replaced with a new E/M code with the same descriptor. It is represented by placeholder code **94XXX** in the proposed rule.

Also, **712X0** (Computed tomography, thorax, low dose for lung cancer screening, without contrast material[s]) will replace G0297 (Low dose ct scan (ldct) for lung cancer screening). In addition, the descriptors for codes **71250**, **71260** and **71270** will be updated to state the services are diagnostic. Example: 71250 (Computed tomography, thorax, diagnostic; without contrast material).