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RESOURCE

- Chapter 12, Medicare Claims Processing Manual: www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

Billing

Physician assistants would be paid directly under Part B

CMS proposes to begin direct payment to physician assistants (PA) for professional services they provide. Right now, Medicare can only make payment to the PA's employer or provider for whom the PA is a contractor. Under the proposal, mandated by the Consolidated Appropriations Act of 2021 that passed in December 2020, PAs would also be able to accept or reassign payment for their services.

The update "creates a level playing field" for PAs with other non-physician practitioners, such as nurse practitioners or advanced practice RNs, explains Michael Powe, vice president for reimbursement and professional advocacy for the American Academy of PAs (AAPA), based in Alexandria, Va. The AAPA has been lobbying Congress for direct billing capabilities since 2017.

The change will allow PAs to directly bill for services performed in all settings, in both rural and non-rural areas. However, as non-physician practitioners (NPP), PAs will continue to be paid at 85% of the physician allowable amount. They also will continue to be required to work under physician supervision.

"This isn't changing the scope of practice or rate of payment for PAs, just making sure all health care providers are treated the same" for Part B reimbursement, Powe says.

"For the real-life practice implications, say a surgical PA wants to work on a contractual basis with" multiple surgical practices, Powe says. Unlike other NPPs, the PA would have to be paid for services through each practice instead of billing Medicare directly, making the reimbursement process more convoluted and time-consuming, he explains.

In a more costly scenario, PA-owned rural health clinics (RHC) until now have been unable to bill for services that Medicare requires but "carves out" of the RHC payment bundle. Where other providers are able to simply bill separately for such services, which include COVID-19 or pregnancy testing, PAs have not had a way to do that until now. — *Laura Evans, CPC* (levans@decisionhealth.com) ■

Value-based care

Shared Savings ACOs get a year off from electronic clinical quality measures

After their first year of using the Alternative Payment Model (APM) Performance Pathway (APP) reporting method, participants in the Shared Savings program are spared further challenges as CMS delays the full transition to electronic clinical quality measures (eCQM) and MIPS clinical quality measures (MIPS CQM) and scales back some program requirements.

Last year, participants in the largest CMS accountable care organization (ACO) program were told to report quality for both QPP and Shared Savings purposes via APP (*PBN 12/14/20*). This required that they swap out their CAHPS for ACOs reporting with CAHPS for MIPS, and the 2021 proposed rule required as well that they abandon the Web Interface reporting method and report instead eCQM and MIPS CQM via APP, which would require all-payer reporting, not just Medicare reporting. But in the final rule for 2021, CMS bowed to stakeholder pressure and pushed that requirement back a year.

This year, stakeholders objected again, complaining that, among other things, "the increased cost of modifying existing electronic health record (EHR) technology, obtaining new EHR interfaces and aggregation tools, and updating performance dashboards" made this transition burdensome. Commenters also expressed concern about the readiness of vendors such as registries.

CMS cites a survey from the National Association of ACOs (NAACOS) that found noted 77% of respondents "indicated they do not have the infrastructure in place to aggregate data on behalf of their ACO participant TINs on quality performance across all payers starting in 2022."

This year, CMS has postponed the eCQM/MIPS CQM requirement again and says it will do so in 2023 as well.

"The vast majority of Shared Savings ACOs will continue to use the Web Interface option of reporting this year — they are comfortable with this method and it is still available as part of the APP in 2021. As such, it's no change for 2021," says Lauren Patrick, president and CEO of Healthmonix in Malvern, Pa.

"However, many proactive Shared Savings ACOs are beginning the transition to the needed data collection, aggregation and analysis in order to achieve success once the Web Interface sunsets," Patrick adds. "While CMS has proposed extending the runway for movement to all-payer reporting, they have also offered a few incentives, such as scoring on one eCQM/CQM in the initial year(s)."

In 2022, forward-looking Shared Saving participants can, if they wish, report three eCQM/MIPS CQM measures and administer a CAHPS for MIPS survey, and CMS will calculate the two claims-based measures included under the APP. Whichever method they choose, they must achieve a score equivalent to or higher than the 30th percentile of the performance benchmark on at least one measure in the APP measure set to meet their program requirements. CMS originally proposed to move this to the 40th percentile in 2023, but will do so in 2024 instead.

That's good news for now, but when it happens the eCQM/MIPS CQM transition will remain tough until other parts of the process, particularly tech vendors, get it together, says Dave Halpert, chief, client team at Roji Health Intelligence in Chicago.

"Even if they have certified EHR, there are still some granular issues," Halpert says. "For example, ACOs with multiple EHRs — each with its own data output — don't have the ability to report some measures the way they're supposed to be measured." For instance, Halpert says, "if you're looking at the hemoglobin A1c measure for patients with diabetes, you're supposed to be looking for the most recent hemoglobin A1c level," but many systems "look at each encounter, rather than looking at the unique patient."

"We have been focused over the last year on convincing CMS to give ACOs more time before dramatically overhauling the way quality is measured within MSSP," a spokesman for NAACOS tells Part B News. "With an extra three years before moving to eCQMs, we need CMS to work closely with ACOs and EHR vendors to find a solution that accurately measures quality performance, is manageable for ACO providers, executable for EHR vendors and improves the quality of care Medicare beneficiaries receive."

In this rule CMS is also proposing to allow new Shared Savings participants who are in the early, one-sided, reward-no-risk BASIC track to stay an extra year in that status before accepting two-sided risk.

"All ACOs have been challenged by the COVID-19 pandemic and public health emergency (PHE)," Patrick explains. "Utilization has been difficult to predict and managing expenditures and revenue have been difficult. Participation in the Shared Savings program is optional for health care providers, and CMS wants ACOs to be successful. Allowing this flexibility for those in the BASIC track provides the ability to better ensure foundational footing before moving into additional risk."

Another break for Shared Saving ACOs: CMS will allow primary care services supplied by telehealth during the PHE to be included among the primary care services used in the Shared Savings Program's beneficiary assignment methodology, provided the ACO sees the patient in person every six months.

"It appears that allowing the inclusion of telehealth serves to further cement the relationship and should be counted in the beneficiary assignment," Patrick says. "There is a trend to a larger percentage of care occurring through telehealth; if we do not include telehealth, then attribution could be skewed inappropriately for those patients that are receiving more of their care through these platforms."

CMS also proposes to add the primary care codes used for attribution, pending finalization, the proposed chronic care management (CCM) code **99X21**, principal care management (PCM) codes **99X22**, **99X23**, **99X24** and **99X25**, as well as prolonged office or other outpatient E/M service code **G2212** and communication technology-based service (CTBS) code **G2252** if payment for that code is made permanent in the final. — *Roy Edroso (redroso@decisionhealth.com)* ■