PYA SHORT COURSE: THE CONSOLIDATED APPROPRIATIONS ACT

CAA and the Medicare Physician Fee Schedule

January 19, 2021

Introductions

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PYA by the Numbers

Clients in ALL 50 STATES

Consistently ranked TOP 20 HEALTHCARE CONSULTING firm in the U.S. by Modern Healthcare

INSIDE PUBLIC ACCOUNTING TOP 100 FIRMS 2020

OVER 1200 Healthcare valuation opinions rendered annually

TOP 15 LARGEST AUDITOR of AHA's Top U.S. Multi-Hospital Systems - Ames Research Group

3,242

Number of healthcare projects during 2019

PYA Short Course Webinar Series: The Consolidated Appropriations Act

- **January 19 – CAA and the Medicare Physician Fee Schedule**
- January 21 – Introducing the New Rural Emergency Hospital
- January 26 – Hospital Payment and Reimbursement
- January 28 – Provider Relief Fund Update
- February 2 – Telehealth
- February 4 – Paycheck Protection Program

https://www.pyapc.com/insights/pya-short-course-webinar-series-provides-critical-information-on-the-consolidated-appropriations-act/

Agenda - CAA and the Medicare Physician Fee Schedule

1. What Happened?
2. Conversion Factor and E/M Code Changes
3. Changes to Quality Payment Program
4. Direct Payment to Physician Assistants

1. What Happened?

Timeline

- March 6, 2020 – Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020
- March 18, 2020 – Families First Coronavirus Response Act
- March 27, 2020 – Coronavirus Aid, Relief, and Economic Security (CARES) Act
- April 24, 2020 – Paycheck Protection Program (PPP) and Health Care Enhancement Act
- June 5, 2020 – PPP Flexibility Act of 2020
- July 4, 2020 – Bill to extend authority for commitments of PPP
- December 1, 2020 – CMS Releases 2021 MPFS Final Rule
- December 21, 2020 – Consolidated Appropriations Act (CAA) 2021 released
- December 27, 2020 – CAA signed into law

2. Conversion Factor and E/M Code Changes

Medicare Physician Fee Schedule

- Fee schedule payments established under Section 1848 of the Social Security Act
  - Relative value for the service
    - Work
    - Practice expense
    - Malpractice expense
  - Geographic adjustment factor
    - Reflects variation in practice costs between metropolitan and non-metropolitan areas between and regions
  - Conversion factor (RVU x CF = national payment rate)
    - Dollar amount based on statutory cap on MPFS spending
    - Sustainable Growth Rate replaced in 2015 by MACRA annual adjustment factor

2021 E/M Guidelines History: How Did We Get Here?

- CMS' and the AMA's collaboration has resulted in:
  - Revised Outpatient E/M code descriptions in the 2021 CPT Manual (99202-99215)
  - 2021 E/M Guidelines published in 2021 CPT Manual effective January 1, 2021
    - MDM and Time redefined
  - Omission of CPT Code 99201
  - Revised Work Relative Value Units (wRVUs)
- No other E/M code set guidelines have been changed at this time
- Since the change is in CPT, impact will be industry-wide.

2021 E/M Changes: Key Elements

Eliminated history and physical exam as elements for code selection

Modified MDM criteria with focus on tasks affecting management of patient conditions

Allows providers to choose to select code based on MDM or Total Time

CMS G-Code

- The 2020 MPFS Final Rule adopted an add-on G-code (effective 2021) to indicate E/M complexity of primary care and specialty care of ongoing complex conditions.
- The 2021 MPFS Proposed Rule requested comment to help clarify the definition of this code and was finalized as G2211.
  - **G2211**: Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition.
    - Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established
    - Not restricted to a specialty
    - Distinct from preventive and care management services

2021 Final Rule: New Codes (effective 01/01/21)

1. **99417:** Prolonged outpatient E/M beyond the total time of the primary procedure; each 15 minutes (starts at low end of range) (0.61 wRVU)
2. **G2212:** Medicare Prolonged outpatient E/M, beyond the top end of the range of total time.

CAA: New Codes (effective 01/01/24)

1. **G2211:** Add-on code for established patient outpatient E/M to account for complexity inherent to those services (0.33 wRVU)

2020 Final Rule: Time and RVU Changes
Effective 01/01/21 except G2211/G2212

TABLE 20: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU 2020	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

Source: https://www.cms.gov/files/document/12120-pfs-final-rule.pdf

Redistributive Impact

- E/M visit codes make up approximately 20% of total MPFS expenditures
- Significant redistributive adjustment was required to budget neutralize the increased RVU values
  - Paying more to manage beneficiaries means paying less to do things to beneficiaries
  - Physicians who primarily perform office visits will generate more revenue; physicians who are hospital-based or who primarily perform procedures will generate less

2021 MPFS/CAA

- Conversion factor impact
  - 2019 to 2020: 5¢ increase ($36.04 to $36.09) = 0.14% increase
  - 2020 to 2021 (Final Rule): $3.68 reduction ($36.09 to $32.41) = 10.20% reduction
    - If performed same number of RVUs in 2020 and 2021, would receive 10.20% less in reimbursement in 2021
  - 2021 (Final Rule) to 2021 CAA: $2.48 increase ($32.41 to $34.89) = 7.65% increase
  - **2020 to 2021 (Final/CAA): $1.20 decrease ($36.09 to $34.89) = 3.33% reduction**
    - **If performed same number of RVUs in 2020 and 2021, would receive 3.33% less in reimbursement in 2021**
    - **Different from the 3.75% positive adjustment in CAA, because of the work floor**

Disparate Impact

- **2020**
  - Greatest increase = 4% (clinical social worker)
  - Greatest reduction = 4% (ophthalmology)
  - Only 9 specialties saw more than a 1% change
- **2021**
  - Practitioners in 35 specialties would see 2% or more increase
  - Those in 5 specialties would receive 2% or more reduction
  - Practitioners in remaining specialties would see a -1 to +1% change in their reimbursement

Biggest Winners	Medicare Reimbursement Increase	Biggest Losers	Medicare Reimbursement Decrease
Endocrinology	14%	Radiology	-3%
Rheumatology	13%	Nurse Anesthetist	-3%
Hematology/ Oncology	12%	Pathology	-2%
Family Practice	12%	Interventional Radiology	-2%
Nephrology	11%	Cardiac Surgery	-2%
Allergy/ Immunology	8%	Vascular Surgery	-1%
Psychiatry	8%	Thoracic Surgery	-1%

Impact: Independent Medical Specialists

- Direct impact to bottom line
- Increase in Medicare reimbursement if primarily an E/M practice
- Potential increase in other payer reimbursement, if other payers utilize reference pricing
- Additional reimbursement could help expand capacity for high risk and rising risk patients, thus increasing ability to participate in value-based models

Impact: Independent Proceduralists

- Direct impact to bottom line
- Small change in Medicare reimbursement
- Potential change in other payer reimbursement, if other payers utilize reference pricing
- **3 options:**
    1. Do more procedures / grow market share
    2. Reduce expenses
    3. Pursue value-based payments

Impact – Employed or Contracted Physicians

Contractual conversion factor <u>does not change</u>
(unless contract subsequently amended or renegotiated)

- **Medical specialists**
  - Increased Medicare reimbursement for the physician's E/M services
  - The same amount of work now will produce more wRVUs
  - Employer will pay the physician more compensation for the same amount of work
  - The incremental financial impact is limited to the amount the contracted conversion factor exceeds the actual reimbursement per wRVU received

Impact – Employed or Contracted Physicians

- **Proceduralists**
  - Overall small change in Medicare reimbursement
  - Some increase in total wRVUs due to increase in the RVUs for office/outpatient E/M codes (but far less than medical specialists who provide these services more regularly), with an overall net decrease in wRVUs (depending on E/M volume).
  - Compensation would not be dramatically impacted
  - The incremental financial impact is limited to the amount the contracted conversion factor exceeds the actual reimbursement per wRVU received

Contract Review Challenges

- Benchmark survey data tied to the compensation conversion factor will not fully reflect these impacts for another 2-3 years given normal timing lags in survey data and the varied rate with which contract modifications occur
  - It may be 2023 (based on 2022 data) before benchmark surveys have stabilized from the impact.
- Documentation surrounding commercial reasonableness
- Consider compensation structure alternatives
  - Incentivize for managing high-risk and rising-risk patients
  - Reduce healthcare costs
  - Improve patient outcomes

4. Changes to Quality Payment Program

CAA Cancels APM QP Threshold Increases

Per MPFS:

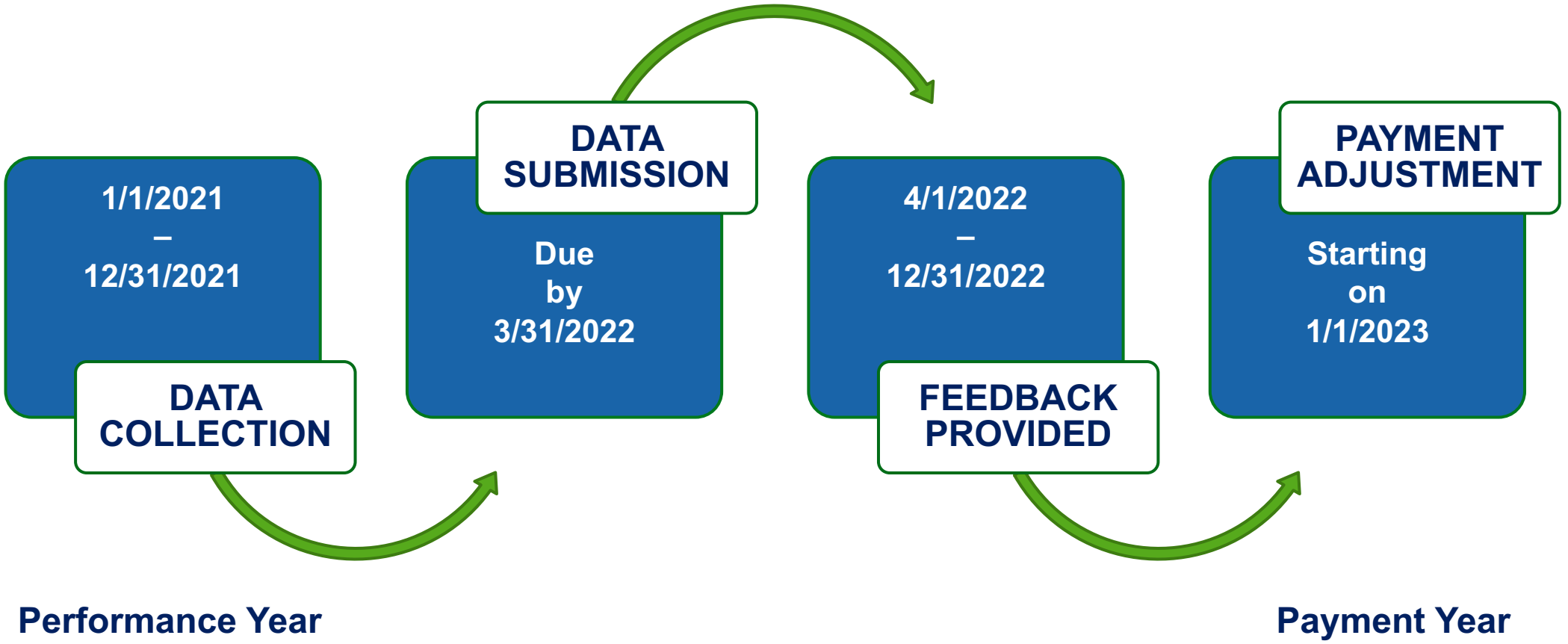
- For QP status, the thresholds for 2021 will be:
  - **Payment amount:** 75% of Medicare Part B payments, up from 50% in 2020; or
  - **Patient count:** 50% of Medicare patients through an advanced APM entity, up from 35% in 2020.
- For partial QP status, the 2021 thresholds are:
  - **Payment amount:** 50% of Medicare Part B payments, up from 40% in 2020; or
  - **Patient count:** 35% of Medicare patients through an advanced APM entity, up from 25% in 2020

Instead – 2020 percentages will carry forward through 2022

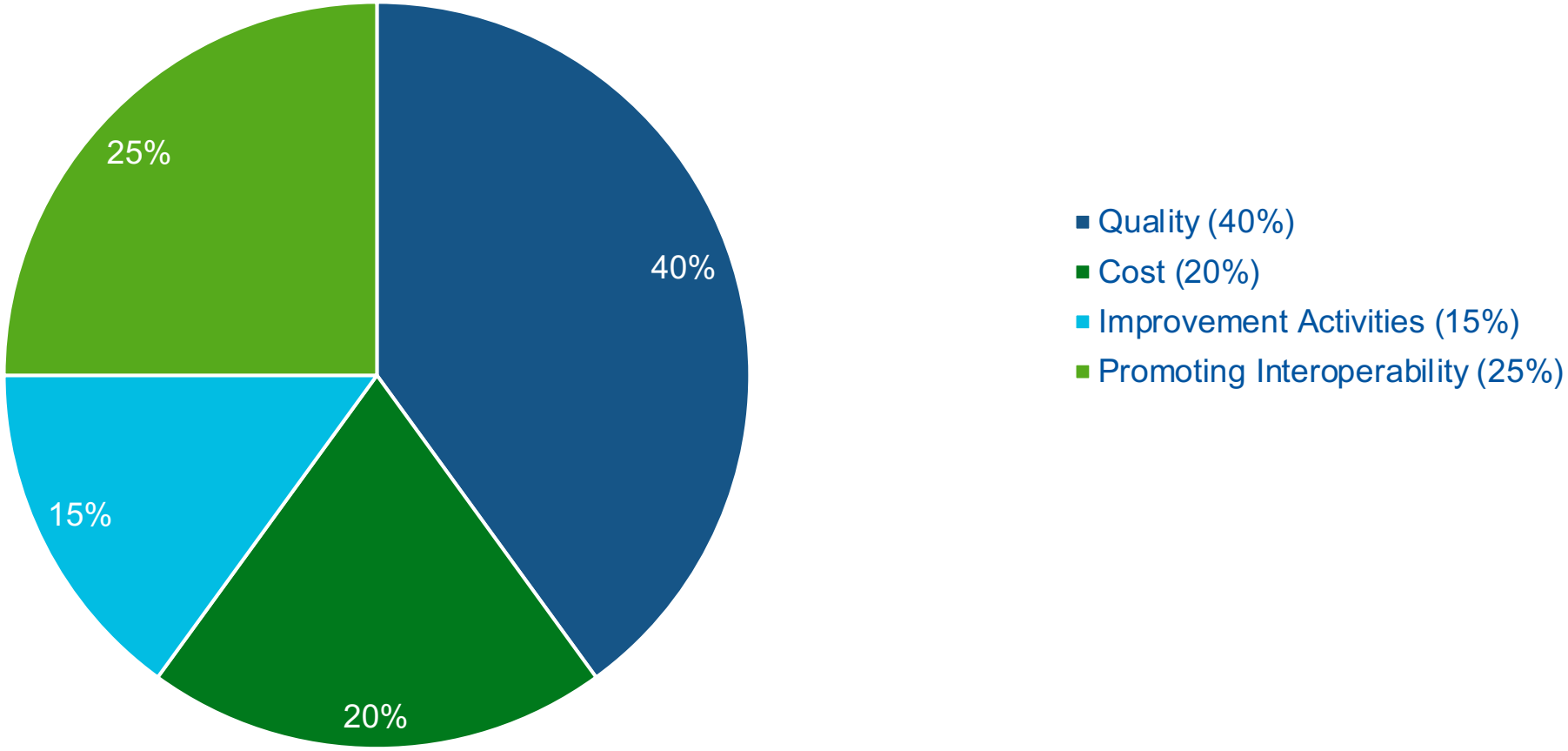
General MPFS Updates

- MIPS Value Pathways (MVPs) postponed until 2022
- Web-interface reporting ends after 2021 performance period
  - Special transition provisions for ACOs
- Complex patient bonus doubled for 2020 performance period only
- APM scoring standard is no longer available
  - Instead, New Alternative Payment Model begins with 2021 performance period
    - Quality category = 50% of final score based on APP Core Quality Measure Set
    - Cost category = 0%
    - Improvement Activity category = 20%
    - Promoting Interoperability = 30%

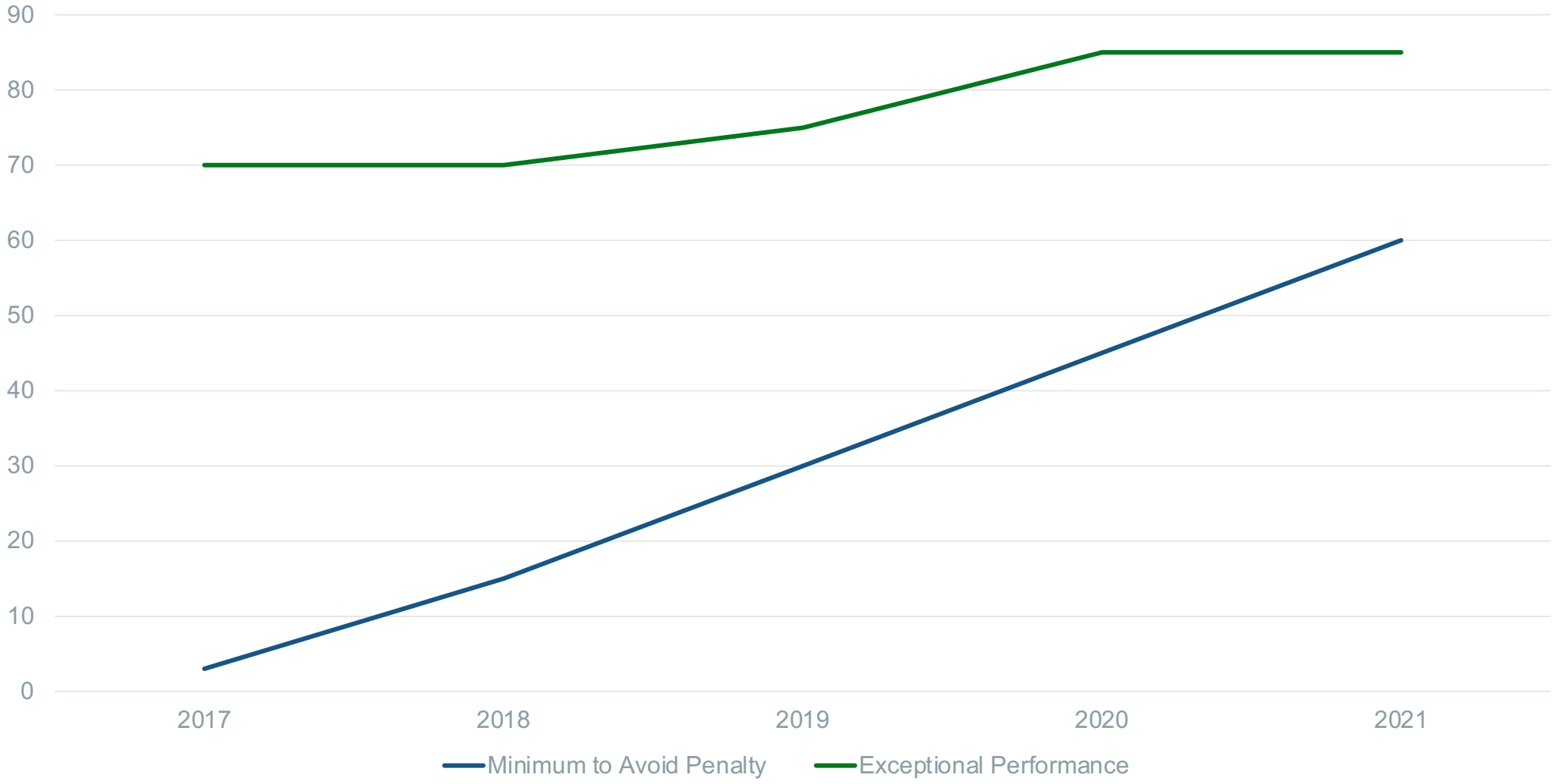
2021 MIPS Timeline



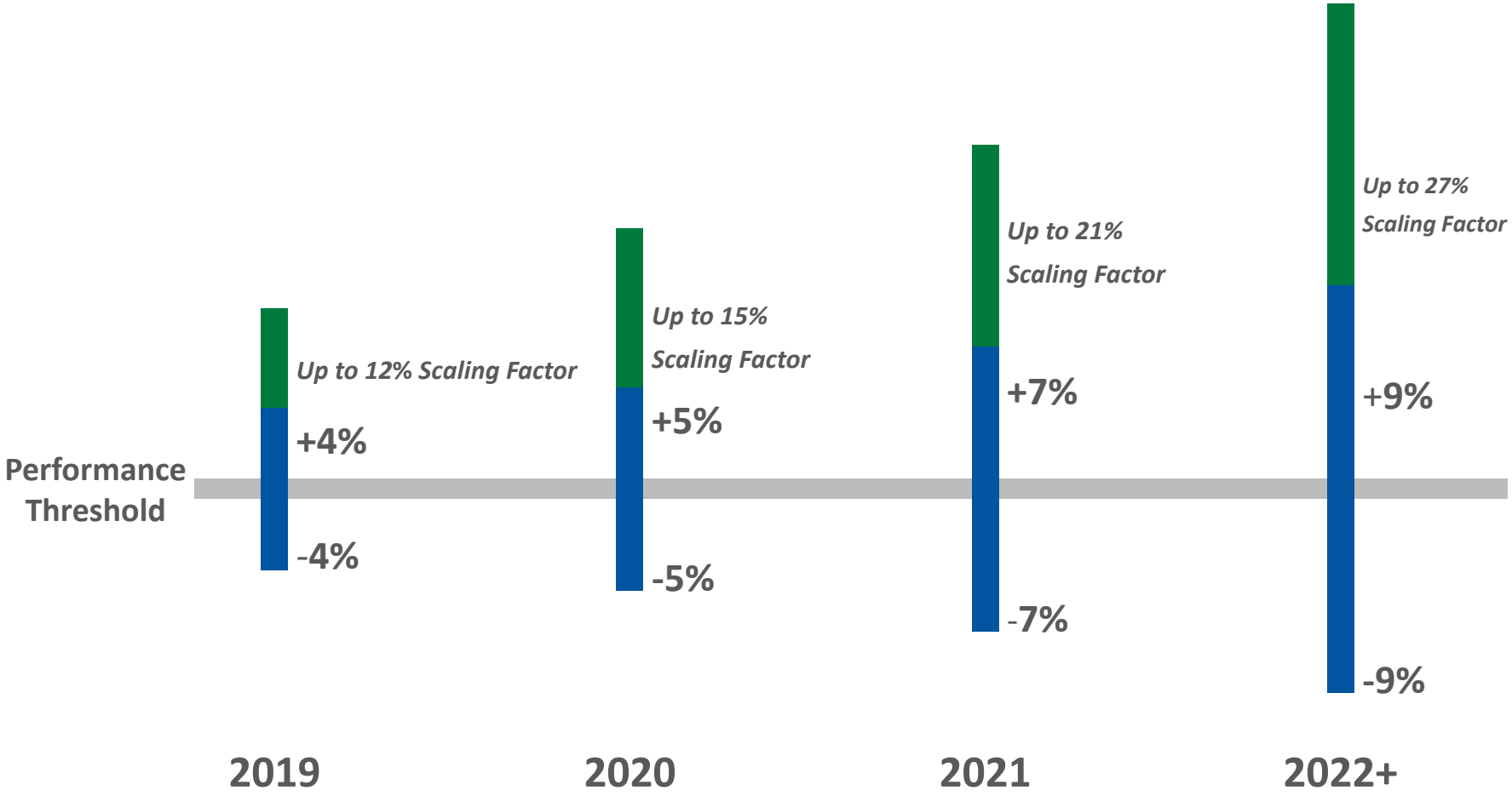
2021 Performance Category Weighting



MIPS Thresholds



MIPS Payment Adjustments



Top performers share in $500 million bonus pool (not to exceed 10% of allowed charges)

Quality Performance Category

- Worth 40% of final score
- Requires reporting of 6 measures for at least 70% of eligible patients for the entire year
  - Exception is for measures with specification or coding changes during the performance year – 9 months
- At least 1 measure should be an Outcome or High Priority measure
- 113 individual measures and several specialty measure sets modified
- 11 measures removed
- 2 new administrative claims quality measures added

Promoting Interoperability Category

- Worth 25% of final score
- Retained Query of PDMP as optional bonus measure worth 10 points
- Added HIE bidirectional exchange measure
- CEHRT Requirements: 2015 Edition/2015 Edition Cures Update/combo
- Automatic reweighting for

Nurse practitioners	Physical/occupational therapists
Physician assistants	Speech language pathologists
Clinical Nurse Specialists	Registered Dieticians/nutritionists
Audiologists	Clinical Psychologists
Certified Registered Nurse Anesthetists	

Cost Performance Category

- Worth 20% of final score
- Obtained through administrative claims
- Measures continue to include
  - Medicare Spending per Beneficiary (MSPB)
  - Total per Capita Cost (TPCC)
  - Episode-Based Measures (18)
- Telehealth services directly applicable to episode-based cost measures and TPCC measure

Improvement Activities Category

- Worth 15% of final score
- No material changes to structure
- Modified 2 IA activities and removed one IA activity related to patient portal
- COVID-19 clinical data reporting activity added in 2020 continues with modification

5. Direct Payment to Physician Assistants

PA Direct Payment Act (S.596/H.R. 1052)

- Current policy
  - Payment for PA services can only be made to PA's employer
  - PA cannot receive direct payment from Medicare unlike other provider types (MD, APRNs, physical therapists, psychologists, social workers, etc.) under their own name/NPI number
- New policy goes into effect January 1, 2022 allowing PAs to be paid directly for their services or reassign at their discretion consistent with reassignment rules

How can we HELP?