April Faulkner:

The Quality Insights QPP Support Center Team welcomes you to today's webinar, the *Medicare 2021 Physician Fee Schedule Final Rule*. We'll take just a moment to review a few items before we begin the presentation. All participants entered today's webinar in a listen-only mode. Should you have a question during today's presentation, please type it into the chat or the Q&A box at the bottom or your screen. If time permits we will address questions at the end of the presentation. If we do run out of time, all submitted questions will be collected and attendees will be provided with a Q&A document after the event. Today's webinar is being recorded. The recording, along with the slide deck and a transcript of the webinar, will be posted on the Quality Insights QPP Support Center website within the next few days. These resources can be found on the archived events page. We have posted a link to that webpage in the chat box.

At this time I would like to introduce our presenter. Kem Tolliver holds dual Bachelor of Science degrees in healthcare administration and organizational management with certificates as a certified medical practice executive, certified professional coder and certified medical office manager. She is the author of *Revenue Cycle Management: Don't Get Lost in the Financial Maze*, published by MGMA.

April Faulkner:

Kem has provided strategic and operational leadership to hospitals and independent practices over 20 years, as well as legislative expertise in the Maryland State General Assembly. Miss Tolliver is President of Medical Revenue Cycle Specialists, which provides practice management and revenue cycle improvement, new practice startup, payer contracting, medical coding, training and education and practice transformation efforts that include optimizing technology and leverage innovate revenue cycle strategies. And now I will turn the presentation over to Kem to get us started.

Kem Tolliver:

Hello everyone. This is Kem. I'm so excited to be here today. Thank you so much for attending. Let me first start off by saying that there's a ton of information in today's program and I certainly don't expect you to remember everything. Please use the chat box to ask a question. We may not be able to get to all of the questions as we mentioned during the housekeeping session, but we definitely want those questions so we can create a Q&A document for you to have access to a few days after the program.

Kem Tolliver:

So we're going to be covering some of the major changes that happened with Medicare. However, what you and your organization or region or specialty might consider a major change may not be discussed. We're going to talk about a lot and we have about an hour together. So if your specialty isn't necessarily discussed, please, please, please check out the Medicare website and I'd like to just also thank Quality Insights for the opportunity to provide this program to you, so that you don't have to read the over 500-page Federal Register with all of these changes. However, you can certainly go to the Federal Register and see these 2021 updates. There is a search menu in the Federal Register that you can type in your specific topic to get to what you're looking for.

Kem Tolliver: (slide 4)

So let's talk about our learning objectives. We're going to talk about the coding changes and E&M changes. That's one of the big updates and we're going to also talk about telehealth services. We're going to talk about the Medicare fee schedule, and we're going to talk about the conversion factor in relative value units.

We're also going to talk about some of the administrative changes that were made by Medicare. One of those administrative changes is scope of practice, and there are quite a few of them. We're going to talk about some updates to the value based programs. However, I want to let you know that Quality Insights will be presenting another very comprehensive program on the Quality Payment Program on February 3rd, so look out for that invitation.

Then finally we're going to talk about optimizing all of these updates within your organization and I definitely want to leave quite a bit of time for that because I want to make sure that you have actionable items that you can take away for your practice.

Kem Tolliver: (slide 5)

Let's start off with the coding updates. Now, I don't endorse any particular resource but I gave you pictures of these books because I highly recommend that you purchase CPT, ICD-10 and HCPCS books for 2021. Let me tell you why. If you're using an electronic health record practice management software, these codes are available to you to search in your software. However, there are a ton of descriptors that are in your coding books that are not going to be in your EMR software.

The other thing is once your EMR vendor has updated their search lists, those old codes are gone. So if you ever need to go back and maybe appeal a denial or justify the use of a specific CPT, HCPCS or diagnosis code, you want to have that book. So it's a good idea to have it, especially for 2021. I got my books not too long ago and I was like a kid in a candy store, I guess because I'm a nerd and a coder, but again, I do highly recommend, even if you're not a coder, make sure that you get your organization to purchase these books for 2021. Lots of great information.

Kem Tolliver: (slide 6)

We're going to start off talking about the COVID-19 diagnosis code, the ICD-10 clinical modification codes. That's probably what you're all using since we're focused on ambulatory services. So the U07.1 is a confirmed positive COVID-19. Now there's a couple of things that I hope that you take away from today's discussion. One is that you want to think about making sure that you do not diagnosis someone with COVID-19 if they have not tested positive. So if you have a patient who is being seen and they're presenting with certain signs and symptoms, maybe a cough or a fever or shortness of breath, if they have not tested positive for COVID, you want to assign the appropriate codes for the symptoms that they're presenting for.

The other thing is when you are diagnosing a patient with COVID-19, the first thing that you want to do is assign your U07.1 diagnosis code. That will be your primary diagnosis, and then the secondary related diagnosis goes after that. Again, your ICD-10 book is going to be very helpful for you for 2021.

Kem Tolliver: (slide 7)

Let's talk about some of the other changes. Let me just also preface this by saying that my team member, Denise Walsh, presented a fairly comprehensive coding update and the slide deck for that program, which was November 24th, is available on the Quality Insights webpage. I'm going to give you a brief refresher, but there have been some changes since Denise's program and we're going to talk about a few of those changes.

- There's been some **removals**. So you probably all have heard that 99201 has been deleted. 99211 has not been deleted. So only the new patient level 1 E&M has been deleted. You want to make sure that the 99201 is not available for selection in your practice management software. Hopefully the vendors have gotten that updated, but whatever you do, make sure that you have some type of an edit or check in your organization's workflows to not allow a 99201 to slip in. The second removal is history exam being excluded from the scoring for CPT. Now this does not mean that you don't need to document the HPI, the history and physical. If it's medically appropriate, you should continue to document that. The other thing that has been removed is for time based coding, the requirement that you have to have greater than 50% face-to-face time spent on counseling and/or care coordination. So that's been removed and we're going to go through some of the updates for time based coding.
- Now some of the **revisions** are going to be the time criteria and we have a table for you. I'm going to show you that table of what the new times look like for our impacted E&Ms. Now the impacted E&Ms are 99211 through 99205. So all of the other E&Ms are not necessarily impacted by the changes that we're talking about here, it's just the 99211 through the 99205. Some of the other revisions have been the medical decision making process and we're going to go into a little bit more detail. The code definitions and the guidelines for those codes, there've been revisions there. This is another reason why you want to purchase those coding books, because all of those definitions and guidelines and descriptors are listed in your coding books. Another revision is that in the past, the history or present illness was not able to be documented by care team members but now it can be. So they can collect this information and the patient or the caregiver can supply this information directly to your care team. However, we want to make sure that all of that information is being reviewed by the recording provider.
- The areas that have **not changed**, and again, I mentioned this already, but I'll stress again, 99211 may still be billed. It's very unlikely that a physician or an NPI level provider would bill for a 99211. This is going to be your nurse visits. So just keep that in mind. The medical decision making levels, the levels have not changed and we're going to go through and you'll see that information.
- So some **new** additions are going to be prolonged service codes and we'll talk about those in more detail. I mentioned that your staff, your ancillary staff, may collect HPI and there are some revisions to telehealth services, so we're going to talk about that as well.

Kem Tolliver: (slide 8)

Just to go into a little more detail here, the history and exam, as I mentioned, it's removed from E&M scoring. You've probably heard that before, but what does that mean to you in your organization? There are several components that go into the decision making as to which level of CPT code you are going to select, and history and exam were a part of that scoring. Removing history and exam from part of that scoring now leaves us with medical decision making and time or time to be used to determine your CPT

score level. There are a ton of resources available to help you understand the new scoring methodology. A few places that I would recommend, and again, Quality Insights is not endorsing any particular one, but your MAC, your Medicare Administrative Carrier, may have a scoring tool for you. AAPC and AHIMA, the coding organizations, will have excellent coding tools and I've used a few of them already for 2021 and they're really helpful. I believe the AMA has one, as well as MGMA. So take a look at those scoring tools, they're going to really help you.

In terms of the exam we talked about this already, but we want to make sure that you document it if it's necessary. For most standard of care it is, and the goal that I think CMS had with removing HPI and removing history and exam from the scoring is to help with the reduction of burden of documentation for providers. For some providers this might be helpful, so I think it's really going to depend on your organization.

For medical decision making, there are a couple things you want to be aware of, such as that you must address the elements of MDM during the particular encounter that you're billing for. So if you're just pulling in old elements and those elements are not addressed at the date of the encounter, they don't qualify. So you want to make sure that you are addressing those elements within that encounter.

April Faulkner:

Kem, sorry to interrupt. I did get two questions that came to me in chat. I didn't know if you wanted me to ask those now. I think they pertain to the section you are presenting.

Kem Tolliver:

Okay.

April Faulkner:

One of them is, "H&P provider must review. What does that mean?" She's saying, "I'm sure reading the HPI is not enough to say he reviewed. How should this be documented?"

Kem Tolliver:

I'm trying to make sure I understand the question. We need to make sure that the provider signs off that they have reviewed it, and Denise, I believe what we need to do is make sure that the provider has reviewed it. I don't know that they need to go back and redo it again. Is that what the question is?

April Faulkner:

I did get a little bit more clarification. The provider signs the chart.

Denise Walsh:

Kem, this is Denise. In my experience, now that ancillary staff can do that documentation, as long as the provider is adding to that documentation and it is his note and the provider is signing the documentation, that is enough to clarify that. It's inferred that the provider has reviewed and agrees with the documentation by ancillary staff.

April Faulkner:

The person who submitted it said, "Thank you," so I think that answers that.

Kem Tolliver:

Thanks, Denise.

April Faulkner:

Yes, thank you both. One other comment I got is, "Would you kindly list the scoring tool resources here that were mentioned?"

Kem Tolliver:

Absolutely. If you give us that permission we're happy to put that in the chat. It is aapc.com, ama.com, and mgma.com. So all the .coms: AAPC, AMA, and MGMA. You would probably want to search their websites and I would search audit tools. From my experience, AAPC has one of the best audit tools so far.

Kem Tolliver: (slide 8)

So with our medical decision making we want to list the amount of and/or the complexity of the data that's been reviewed during that encounter and then we also want to list the number and complexity of problems that were addressed in that encounter. So this is all really about making sure that we're not just pulling over old information, that we're actually addressing these elements and these problems within that encounter.

Kem Tolliver: (slide 9)

We're going to talk more about time in this slide right here. We have a list of all of the acceptable activities that can count toward total time, again, on the date of the encounter and that's been a running question. This is all on the date of the encounter. One thing that we recommend, both Denise and I, is that you make sure that you wait until the end of the day to see if there's anything else that has been done for that patient that can be added to their time. I'm not going to read these things to you, but I want to add some thoughts here. You do not count clinical staff time with the patient when it's separate from the billing provider. So if they're having a separate conversation with the patient, that's not billable, but you can count provider time with the clinical staff when they're reviewing something that the staff did. So that can be counted. You do not count time that can be separately reported and billed for other services. So if there are other CPT or HCPCS codes for services, you don't want to count that. Don't count time that's separately reported and billable within that particular encounter. The other thing is that you do want to document the total time within the encounter. For example, the CPT has published certain ranges of time. What you want to do is document how much acceptable time was spent within that encounter and I'm going to show you the CPT's published ranges of time. Again, Denise went into quite a bit of detail on time based coding in the November 24th program, so you definitely want to take a look at that. The other thing that we want to do, looking at the items here, is remember what you can and cannot include in your time calculations. Again, it needs to be on that date of service. You will get these slides, they'll be posted on the Quality Insights website for you.

Kem Tolliver: (slide 10)

Our new add-on codes for 2021. The 99417, that's our prolonged service code that was the placeholder 99XXX. This is to be billed to non-Medicare payers. Again, this is only supposed to be used when you're factoring time alone as the basis of the code selection. This is an add-on code, so that means that this needs to be added with another CPT code. Again, this is going to be time personally spent by the physician or the qualified healthcare provider and it does not include time for activities that will be done by your clinical staff. Again, you cannot bill Medicare for the 99417.

April Faulkner:

Kem, I've gotten two more questions in the chat box. "Our physician will interpret a sleep study and discuss results and recommendations at the office visit. Does that discussion time count towards the visit?"

Kem Tolliver:

Yes, if they are because I understand when they're having the discussion about the sleep study and the results, a part of that is going to be inclusive in coming up with an assessment and a treatment plan. So yes, that would be included. Can you keep that in the chat so I can look at it because I believe there's a sleep study interpretation code. I just want to make sure that that time is not separately billable before I confirm.

April Faulkner:

Okay. I have sent that in the chat to the panelists. Then one other question came in. "Can you go over time documentation and how a physician should enter their notes?"

Kem Tolliver:

That will definitely be a part of our Q&A follow-up. That's going to go into quite a bit more detail and we're at slide 10 and we have 30 minutes left, so we'll definitely put that in the Q&A document.

April Faulkner:

Okay, that's all I have for now. Thanks.

Kem Tolliver: (slide 10)

Okay, perfect. The G2211, this is the visit complexity code. We have learned that this code has been delayed. We're not able to use this code until December of 2023. That timeline may change, but for now it's been delayed. Now we can use the prolonged service code G2212 for Medicare, it has the same guidelines as the 99417 and the G2212 code for Medicare can be an in-person or a telehealth service. So again, the 99417 is for everyone excluding Medicare and the G2212 is our prolonged service code for Medicare, and the G2211 has been delayed, so we can't use that for Medicare until 2023.

Kem Tolliver: (slide 11)

Now, everyone who wants to bill or has being billing for telemedicine, we all need to understand the two forms of telemedicine, which are synchronous and asynchronous telemedicine services. I wanted to

make sure that you had this documentation for yourselves because there are times when even I get a little turned around about the difference between the two of these. So synchronous is going to be live, it's going to be two-way. You have to have audio and visual communication at the same time between the provider and the patient. Live, interactive, two-way, audio and visual. That is synchronous. Anytime you hear synchronous, just know live, interactive communication with the patient and the provider, audio and visual. Asynchronous is going to be the type of communication that happens over a certain period of time. It allows the patient and the provider to interact on their timeline. So this isn't real-time. It also gives us the ability to upload and share images. So this is not happening simultaneously and it's not happening real-time between the provider and the patient.

Kem Tolliver: (slide 12)

The other thing that I want to mention about telehealth services is the use of technology and structured data. So everyone who is participating with MIPS or some other advanced alternative payment model, will need to have structured data. Structured data is in a format that allows it to be clipped and then brought into a dashboard or a report. So you know when we give providers the option to free type in their notes? That information is not structured. So that information doesn't get pulled into your MIPS and your quality reporting dashboards in your EMR and it doesn't get pulled into your reports. So all of that great information is missing. So if you're using telehealth technology that's outside of your EMR, please make sure that there is some process to convert that text into structured data back into your EMR, so that it is viewable in your dashboard and in your MIPS reports.

Kem Tolliver: (slide 13)

The other thing that I want to talk about before we get into telehealth is the HIPAA Security Risk Assessment. It's required for covered entities on an annual basis and if you transmit, share, and store protected health information, you are a covered entity. This is something that we need to do and we need to prioritize, especially now that care delivery is shifting to virtual platforms. We need to protect our PHI, we need to protect our patients' privacy and security. Yes, we've had some temporary waivers and we'll talk about those in a few minutes, however, when you think about brand management, if your organization has a breach of 500 or more, they're going to be reportable breaches still. So we want to make sure we're protecting our brand and we're doing the right thing here.

The Security Risk Assessment is a MIPS and an APM measure, so in order to get that credit, you definitely need to make sure you're doing your Security Risk Assessment. Now as you're doing the Security Risk Assessment, make sure that when you get your vulnerability list back from your vendor or whoever is doing this for you, you can actually do this yourself. NIST has an updated Security Risk audit tool. * Make sure that you take your vulnerability seriously and that you take corrective actions on those vulnerabilities. *Link to Security Risk Assessment tool: https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

Kem Tolliver: (slide 14)

So let's talk about some of the key telehealth service changes. Before I do that, I just want to remind you that many E&M services can be billed out as telehealth. Check the CPT book, but many of the current E&M codes can be billed as telehealth, you still need to use the necessary CPT guidelines for those services.

We're going to talk about two tracks here. We're going to talk about some of the permanent changes and some of the changes that expire when the Public Health Emergency expires. Group psychotherapy has been added as a permanent change. So this means that patients can do group psychotherapy services virtually. The 99483, the cognitive assessment and care planning, that's permanently going to be admissible as a telehealth service and then your home visits, your 99347 and your 99348s, those home visits are going to be permanently available to bill through telehealth.

Now some of the services that are going to expire are the ER visits, critical care visits and there's a ton of therapy visits that I will add to a Q&A document for you. Now we want to keep in mind here that the Public Health Emergency, as we know, keeps getting extended and we have to be on the lookout for that and we want to urge Congress to make some of these telehealth services permanent. Our audio only services, these are the services that we can still bill. The G2252 is that virtual check-in, it has the same billing requirements as what you're billing right now, the G2012. Just keep in mind that the telephone services, the 99441 through 43, those aren't right now being recognized by CMS, and if you purchase your CPT books there's a star beside the CPT codes that can be billed through telemedicine. Again, another reason why you would want to buy those books.

Please keep those questions coming in to the chat box. We want to make sure you get your questions answered, either hopefully if we have some time at the end or we'll send you a Q&A document.

Kem Tolliver: (slide 15)

So our temporary telehealth waivers. I was mentioning the Public Health Emergency. It expires on Thursday, January 21st. If it's not renewed, all of these waivers are gone. So the penalties for HIPAA, those are waived right now if you can prove good faith efforts in trying to protect PHI. Our established patient mandate, some services that typically we were only allowed to bill if it was an established patient and that's been expanded to new patients, will expire. For physician licensure, there's been some waivers to expand telehealth and allow physicians to do certain services that maybe that didn't have originally board certification or licensures for, but one thing I want to say about that licensure is to check with your state Board of Physicians because every state is not accepting these federal waivers. So you want to check with your state's Board of Physicians.

Another great thing here is patients can use smartphones right now for synchronous, real-time telehealth service. Luckily the originating site, the distance site, all of that stuff right now is waived. That really makes a huge impact, keeping that waiver, because if it goes away then we go back to only rural health organizations being able to provide telehealth services. Then beneficiary cost sharing is where you have the option for Medicare patients to waive their coinsurance. You are not allowed to waive coinsurance for Medicare beneficiaries unless you are using this waiver. So again, these waivers will expire on January 21st.

Kem Tolliver: (slide 16)

As promised, this is a table of the E&M code changes. I've listed CPT codes that are impacted by these changes. I've given you the work RVUs. So if your organization is using RVUs for compensation, this gives you some more leverage to see what the RVU looks like and then what I've also done is given you the time. You can see the 2021 time changes. Then your medical decision making. This lists what that looks like for your medical decision making. Again, you'll have this slide deck so you'll be able to study this and review it and take some action on it within your organization.

Kem Tolliver: (slide 17 title page and slide 18)

So let's shift gears and start talking about reimbursement. Now technically the codes that are published, these changes are published annually and many practices and organizations are going to be impacted by the conversion factor. I'm going to show you a formula after we talk about the conversion factor, but I want you to be aware that when the Final Rule was published in late December, we were told that the conversion factor was going to be $32.4085. As of last night, and I sit on a National Government Affairs Committee, we were told by CMS that they are actually bumping that up to $34.8931. It's still a decrease from 2020, but it is a bump up. So you'll be excited to know that we've gone up a little bit. The anesthesia conversion factor has gone down and that's definitely going to impact that specialty. So just keep that in mind.

Kem Tolliver: (slide 19)

What I also want to talk about here is when we're thinking about all of this, there is a formula. I remember when I was in college I was dealing with my final exam and this was on the final exam and I was biting my nails off, but this is the formula to Medicare physical reimbursement. I won't bore you going through the formula, but I want you to be aware that your RVUs and your conversion factor play a big role in what your overall physician reimbursement is going to look like, and all of that is going to be impacted by our sequestration cuts. So these are things that you want to understand. There is an RVU workbook that CMS publishes, so that you can see what the work RVUs look like for your particular specialty.

Kem Tolliver: (slide 20)

Here's the Medicare fee schedule. Now I have listed Maryland Medicare Administrative Carrier, my MAC's fee schedule, but we all need to go to our own MAC and if you don't know what your MAC is, you can Google it based on your region, but you want to use the fee schedule specific to your region. So if you're in Delaware, if you're in Pennsylvania, in whatever state that you're in, you want to know what your Medicare fee schedule is going to look like for your jurisdiction because every jurisdiction is going to be different. In my case, we have multiple jurisdictions for our one MAC. We have D.C., Maryland and Virginia and each one of them has different localities. So you want to dig deeper to make sure that you know which locality you're getting your rates from. This is actually a good sample of what you can expect typical reimbursement to be. Now I don't know that Delaware and Pennsylvania are too far off from the DMV, D.C., Maryland and Virginia, however, I've given you a pretty good snapshot of what you can expect your reimbursement to look like for the impacted CPT codes.

As you can see here, the new patient reimbursement has definitely decreased. Someone asked whether or not the fee schedule has been released for 2021. It depends on your MAC. My MAC released their 2021 fee schedule, however, it was down for construction over the weekend. So you want to check with your MAC. Please, please, please don't use the general CMS fee schedule because it's not going to be accurate for your locality. You want to get your fee schedule directly from your Medicare carrier.

The CPT reimbursement for a new patient has gone down, but if you look at the established patient, code 99215, has increased by almost $30, for my MAC. That's a huge change. So what you want to take away from this guide is to make sure you do an annual coding review and you're documenting to the fullest potential. You may be leaving money on the table by not actually reviewing and updating your templates to make sure that you're capturing everything that's applicable to that date of service.

Something else I want you to think about here is that this is Medicare's fee schedule. Now we know that the industry typically bases their reimbursement on Medicare, but this doesn't mean that every single commercial insurance, Medicaid payer, Workers Comp, is going to use Medicare. Many of them are going to use Medicare as a benchmark, but you definitely want to touch base with your individual commercial insurance companies to see what their reimbursement is going to look like.

Kem Tolliver: (slide 21)

Now earlier I mentioned a sequestration cut. That cut has been delayed until March 31st, 2021, and it's going to be a 2% cut. So what action you want to take here is to make sure that your billing team starts checking EOBs in March and April to start looking for this adjustment, this cut. The other thing to think about is creating an adjustment code for your sequestration write-offs, so that you keep track of them and account for them in your practice management software.

Kem Tolliver: (slide 22)

Let's talk about key regulatory and legislative initiatives. Lots of updates, lots of administrative operational and compliance changes. There's so much to be aware of.

- The **CARES Act** has a small business aid portion that allows you to be eligible for loans for certain expenses. It allows you to apply for new loans. I recommend that you do some research on the CARES Act because there's definitely some updates that have happened that allow for employers to get a tax credit, a tax credit within the CARES Act and it's an employee retention tax credit. So if you were able to keep certain employees, it gives you some tax savings there.
- The **Surprise Billing Act**. As we all know this has been a big factor for this administration, but what was going to happen was that providers would have been given a strict timeframe to bill patients for services and if they didn't, they would face a $10,000 penalty per incident. Well that was scrapped and has not happened because providers don't control all of the patient statements. It's takes time for primary and secondary adjudication and there are many other factors. However, hospitals do have a price transparency requirement now that they need to be on board with.
- There is another initiative to expand telehealth services in minority entities, so there's a **Minority Broadband Initiative** that allows some financial support to provide services and additional funding for those who are minorities and need some additional funding.
- The **21st Century Cures Act** is really going to help us with interoperability. There's certain EMRs and practice management software that cannot speak to each other and that's called not having an open API. The 21st Century Cures Act is looking to solve that by making it mandatory for certain software to be interoperable and being able to talk to each other. So this is something that's going to be really helpful to us as we're being required to coordinate care and share information securely.
- **Colorectal Cancer Screening Cost Sharing**. Medicare is looking at reducing or waiving certain copays for colorectal cancer screening.
- There's permanent expansion for **Tele-Mental Health** services that are going to be available for Medicare beneficiaries that's going to be past the expiration date of the Public Health Emergency. So if you're in behavioral health services, this is a huge win for you.
- **Rural Health Clinics** are getting pay increases. They're definitely going to get a bump up in reimbursement. CMS has seen how the rest of the country has been using telehealth services and the shortfalls that they've had in reimbursement for Rural Health Centers.

- The **Paycheck Protection Program** is going to be very helpful to your organization if you need additional funding.
- **Medicaid** is going to pay for **non-emergent medical transportation**. This is going to be a huge shift, so this is something you definitely want to be aware of.

Kem Tolliver: (slide 23)

Now, some other changes involving scope of practice. I'm excited about this. Medicare will start paying physician assistants directly in 2022. This is part of the Final Rule so I don't see it going away. However, we will need to keep our eyes on the legislation over the next few years. Medicare has not reimbursed for PAs in the past, but I think with the expansion of telehealth services and a need to get more patients seen, Medicare realizes that they need to change their payment methodology and include physician assistants. So if you've ever thought about hiring physician assistants, stay on the lookout for this legislation. Direct supervision is no longer just an in-person option. Direct supervision can be done via telehealth. The public health waivers may not be applicable to your state when it comes to that scope of practice. When the time comes, you will need to check whether or not your state is going to allow PAs to be paid directly and maybe not have a collaboration agreement. In most states right now collaborative agreements with PAs and physicians are requirements. So some of those things may not change.

Kem Tolliver: (slide 24)

Value based payments. The way that I see value based payments, it's really about deciding which track makes sense for your organization and then how you are going to fulfill the obligations of the track that you select. Especially when you're choosing your quality measures. Don't choose quality measures that are going to be hard for you to meet. Make sure that you're choosing quality measures that make sense for your specialty and after you've participated for a few years and you see what works and what doesn't work, make readjustments. It's really going to be about screening your patients, care coordination and your processes and reporting your outcomes.

Kem Tolliver: (slide 25)

So these are the changes for the MIPS categories for 2021. Again, on February 3rd, Quality Insights is going to host a QPP webinar that goes into a lot more detail, but I wanted you to be aware that Quality is 40%, Improvement Activities is 15%, Promoting Interoperability is 25%, and look what has happened, Cost has gone up to 20%. Now, in 2020 we were given 10 additional points for complex patients, that's gone down to 5 points for 2021.

Kem Tolliver: (slide 26)

Now looking at the performance measures over time, in order for you to avoid the penalty, the performance threshold has gone up, but to get the exceptional performance bonus, it has stayed the same from last year. One thing that you'll notice on this graph is that between 2020 and 2021, the Quality category has gone down and the Cost category, if you look over time, continues to go up. So what does that mean? That means that Medicare is very interested in tying our reimbursement to cost. They're seeing that we're getting the whole quality thing, so they're not increasing Quality anymore, but we're still struggling with cost, and that's where these alternative payment models come in.

Kem Tolliver: (slide 27)

Looking at our allowed charges, in order for you to be exempt from participating in MIPS, you need to bill more than $90,000 for Part B professional services. The other exemption is the number of beneficiaries that you have, you need to treat 200 Part B beneficiaries. And in addition, you must provide 200 or more services. So it's not an 'and/or', it's an 'and/and'. More than 200 Part B patients and more than 200 Part B services. So that would be more than one service per beneficiary essentially.

Kem Tolliver: (slide 28)

When you think about APMs, we've completely shifted from fee-for-service, and it's really now about pay for performance. What we want to think about is what an Advanced Alternative Payment Model is. Why do you need to participate and how is it going to impact your organization? Well, it impacts your organization, first of all, by at least allowing you to demonstrate, and it's not that you're not already doing this because we've been providing quality care, it's now about demonstrating outcomes and getting financial incentives to backfill the removal of fee-for-service.

Why we should participate is because we're feeding data into the overall healthcare system. So when you don't participate, the rest of us don't get the benefit of seeing that data. We're all doing really great work, so it's crucial for us to report that great work. Really this is about incentivizing us to demonstrate quality of care and decrease cost of care by proper utilization.

Kem Tolliver: (slide 29)

Now there are a ton of Advanced Alternative Payment Models and I've listed them here for you. What I want to show you and demonstrate here is the different types of AAPMs. You have Joint Replacement, ESRD and Radiation Oncology, which by the way, is going to be effective in 2022. You have different tracks of the Medicare Shared Savings Program and Next Generation ACO. There is also Comprehensive Primary Care Plus and Bundled Payments for Care Improvement. What all of this boils down to is that our payments are being linked to the types of outcomes that we're able to provide and these different AAPMs are focusing on some of those high risk, high cost disease management tools. ESRD is very expensive. Joint replacement is very expensive. When you're in an Accountable Care Organization, you pool together all of your data so you want to make sure that everyone in your ACO understands the group's goals, and those goals are aligned by Medicare's Shared Savings Program. I want you to be aware of this so that you can start thinking about if there are any particular AAPMs that are going to be of interest to your organization.

Kem Tolliver: (slide 30)

The other thing I want to show you is that there are state-based AAPMs. In my state of Maryland, we have Total Cost of Care, which really is pretty fascinating. We are able to do our own Medicare rate settings for our hospital services and our HSCRC does our rate settings for Medicare. Yes, we do our own rate settings for Medicare. However, it's a double edged sword because once we set a rate, we are locked into providing Medicare with millions of dollars of savings. So it takes an enormous effort, not just with the hospitals, but with the community physicians to work together to prevent readmissions, perform preventative services, screenings, chronic care management and transitional care management. We actually have funded CTOs and these are organizations that come out and help the primary care practices with meeting these initiatives and they do it for free. I'm bringing this up to you to start

thinking about what this landscape is going to look like in your area, and start thinking about the relationship that you can start building collaboratively with other organizations and your hospitals.

Kem Tolliver: (slide 31)

There are three new APMs that you can definitely research: Direct Contracting, Primary Care First, and Kidney Care Choices. So again, we're looking at those high dollar areas.

Kem Tolliver: (slide 32)

When I mentioned the collaboration with other entities, this is where the Stark Law exceptions come in. So the Stark Law exceptions for 2021 allow us to do so much more than we were able to do previously. Now we can enter into shared savings arrangements with hospitals. So if you haven't done that already, don't wait for the hospitals, start thinking about what you can do because the hospital needs you, and if you are a community physician organization, they need to make sure that they're working with you to let you know when your patients have been discharged, so that they don't come back into the hospital again. You're also eligible to get financial assistance from other entities for IT improvement. So your hospitals are able to help you financially with this and other entities that you want to coordinate care with, and then you can also share staff. So if you are doing some type of a value based care coordination activity with other entities, you can actually share staff and pay for them together. So this was a really big help.

Kem Tolliver: (slide 33 title page and slide 34)

I'm going to leave you with areas that you want to review in your organization to optimize these rules. First, make sure that you prioritize seeing who has chronic illnesses in your organization. You can run CPT reports, you can run diagnostic reports. You want to start outreach to patients who are going to be high risk and high cost. Now that we've gotten some E&M changes, it's also a good idea to work with your software vendor to update your favorites list, your providers' favorites list, making sure that your templates are removing certain factors that you might not be using anymore.

The other thing that you want to do is please, please, please stay in touch with your MAC on the regional Medicare updates. Please do not use the national CMS fee schedule, look for your regional fee schedule, download that fee schedule and start analyzing the 2021 updates. Look at your commonly billed CPT codes, maybe your top 30 or 40 CPT codes. If your MAC hasn't released it yet because of this new update, keep checking that website.

Kem Tolliver: (slide 35)

These are other areas that you want to consider looking at in your organization. Look at your liability coverage. If you are doing telehealth services, you want to look at cyber liability. You also want to look at Workers Comp for COVID-19 and want to keep that going. For most of us, we do our OSHA training on a regular basis, but think about using your waste management organization to provide your OSHA training. A lot of them are bundling OSHA training online for free with the waste management services. The other thing is to check the NPPES database. Make sure that your taxonomy codes are up to date, make sure your practice information on the NPI database is updated, something that you want to do at the beginning of every single year. Then take advantage of those preventative care services. Look at the

reimbursement for a TCM versus a regular E&M. If you're going to see a patient in the office within 7 to 14 days after discharge, why bill a 99213 when you can bill your TCM codes and get paid more?

Kem Tolliver: (slide 36)

Other areas to review. If you are participating with multiple QPP or value based programs, consider mapping the program measures out so that you're not reporting duplicate measures. Do that mapping for yourself. Consider doing annual coding reviews. Do that internally or maybe hire someone. Whatever you do, please, please, please start thinking about HCCs, the hierarchal condition categories. This is your risk adjustment. Basically what you want to do is make sure that your providers are documenting their ICD-10s to the highest level of specificities. We need to show and we need to demonstrate that we are treating very ill patients. If we use unspecified, that doesn't show the complexity, the true nature of the mortality and morbidity of that patient.

Kem Tolliver: (slide 37)

Another thing to think about is to decide whether or not your EMR templates need to be modified. I wouldn't recommend removing E&M from your templates, but think about what your templates need to look like going forward. Also think about your appointment templates. So the E&M times have changed. Were your appointment templates based on the old E&M timeframe? Then think about getting your providers some additional guidance on scoring their medical decision making.

Kem Tolliver: (slide 38)

Professional development. It's something that Quality Insights takes very seriously, which is why, again, I'm very appreciative of them for bringing us together today, but these are some professional development considerations that you may want to look at within your organization. So for your ancillary staff, even though they don't necessarily do front office or they probably are now with COVID, think about where additional resources can be given to them. I always include medical assistants in any coding updates because they are assisting the providers with their documentation and they're really on the front lines right now.

Kem Tolliver: (slide 39)

Shameless plug. This is a resource for you, a book that I wrote. The link is here if you're interested in learning more about revenue cycle management and getting more detail into that process to streamline. Please make sure that you put any additional questions you have in the chat box so that we can get them answered and give you a Q&A sheet. Thank you so much for attending today. I hope you learned some great things and that you're able to take some information back to your organization. I'll turn it back over to you, April.

April Faulkner:

All right, thank you so much, Kem. Thank you everyone for joining us today and just a quick reminder, when you close out of today's session you will automatically be directed to a very brief evaluation. Please take just a moment to complete it. We really appreciate your feedback and comments. Also, please note that registration is open for the next edition of *QPPLive!* and that will be held on Thursday,

January 21st. There is a link in the chat box for registration for that upcoming webinar. Thank you again, everyone, for joining us and have a great rest of the day. The session has now concluded.

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