May 2022 Reimbursement Update

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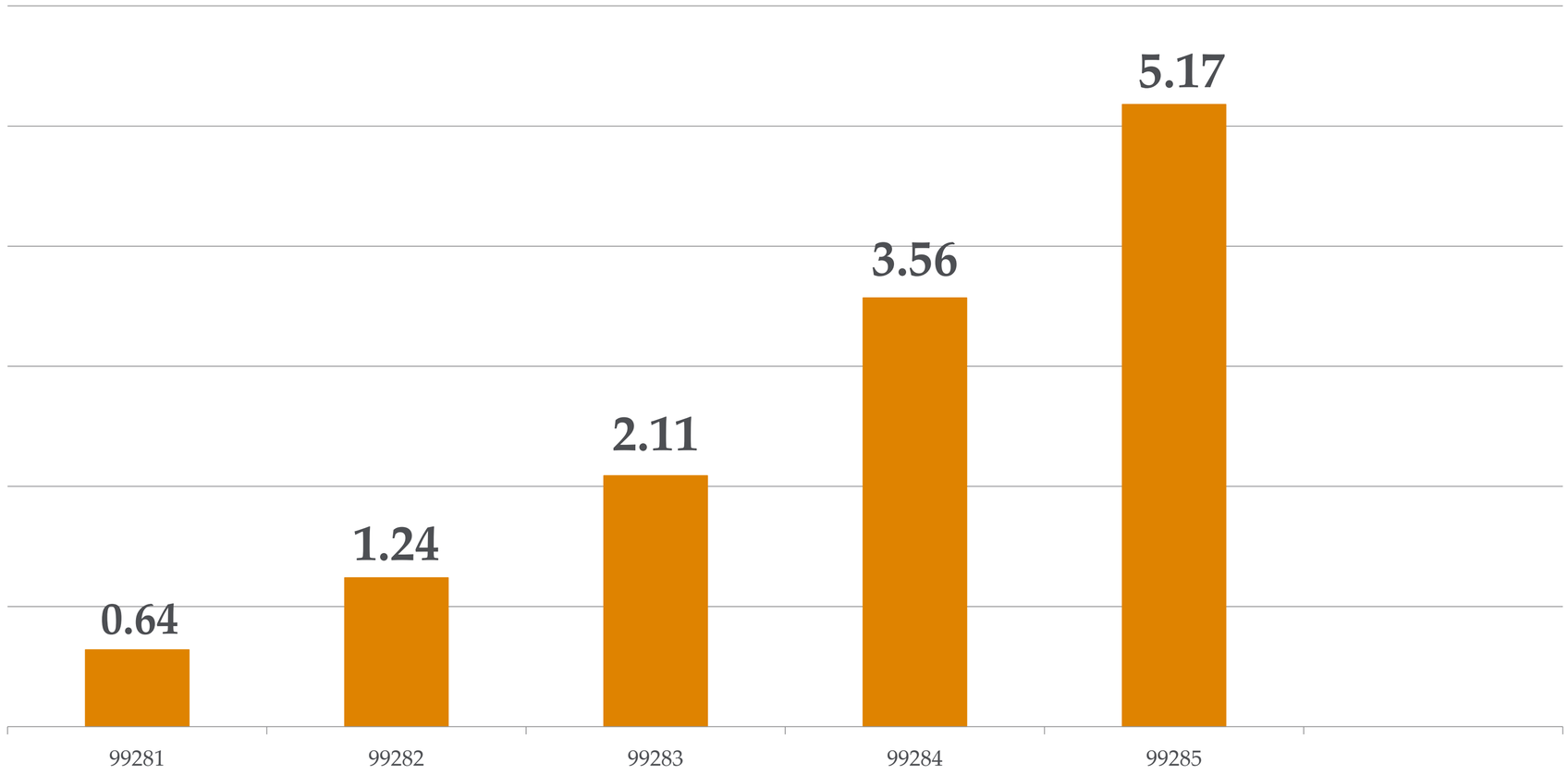
Topics Covered

- 2023 RVUs where we stand
- 2023 Conversion factor projections
- Future ED Documentation Guidelines
- 2022 MIPS Update and 2023 MVPs
- Telehealth regulatory developments
- No Surprises Act

Future RVUs

2022 Total RVUs

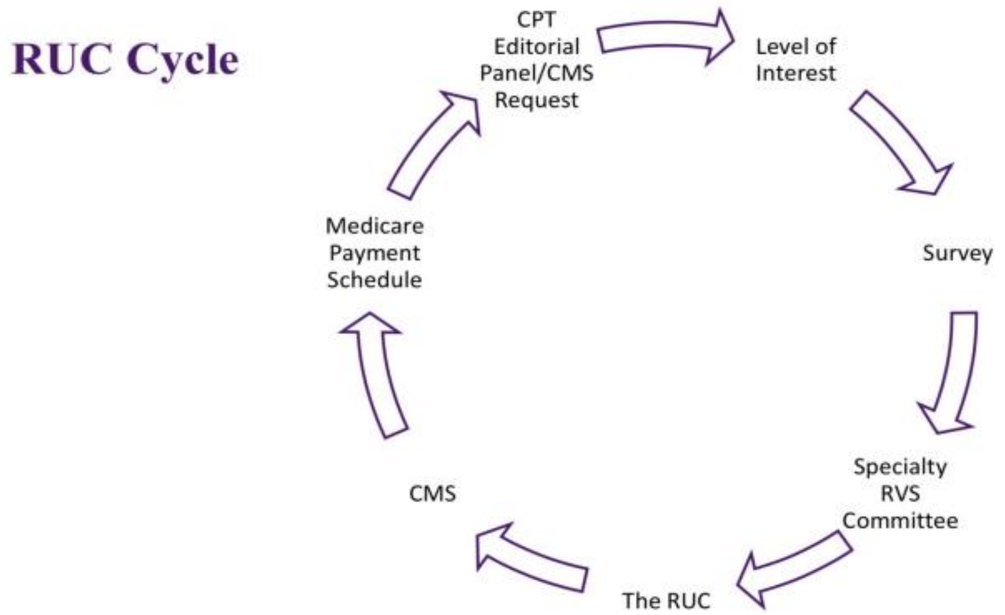


ED RVU Components and RUC Increases

- Emergency Medicine Total RVUS
  - Work RVUs 77% (RUC)
  - Practice Expense 16%
    - Non physician clinical labor, supplies , and equipment
      - Doesn't apply much to the ED
  - Liability 7%
    - Actual claims data

- ED RUC Work RVU History
  - 2007 big increases
    - (99285 wRVU 3.06 - 3.80)
  - 2020 5% increase
    - (99283 wRVU 1.34 - 1.42)
  - 2021 5% increase
    - (99284 wRVU 2.60 - 2.74)

The Timeline for Updated RVUS: 9928x Codes Currently Being Scored By CMS



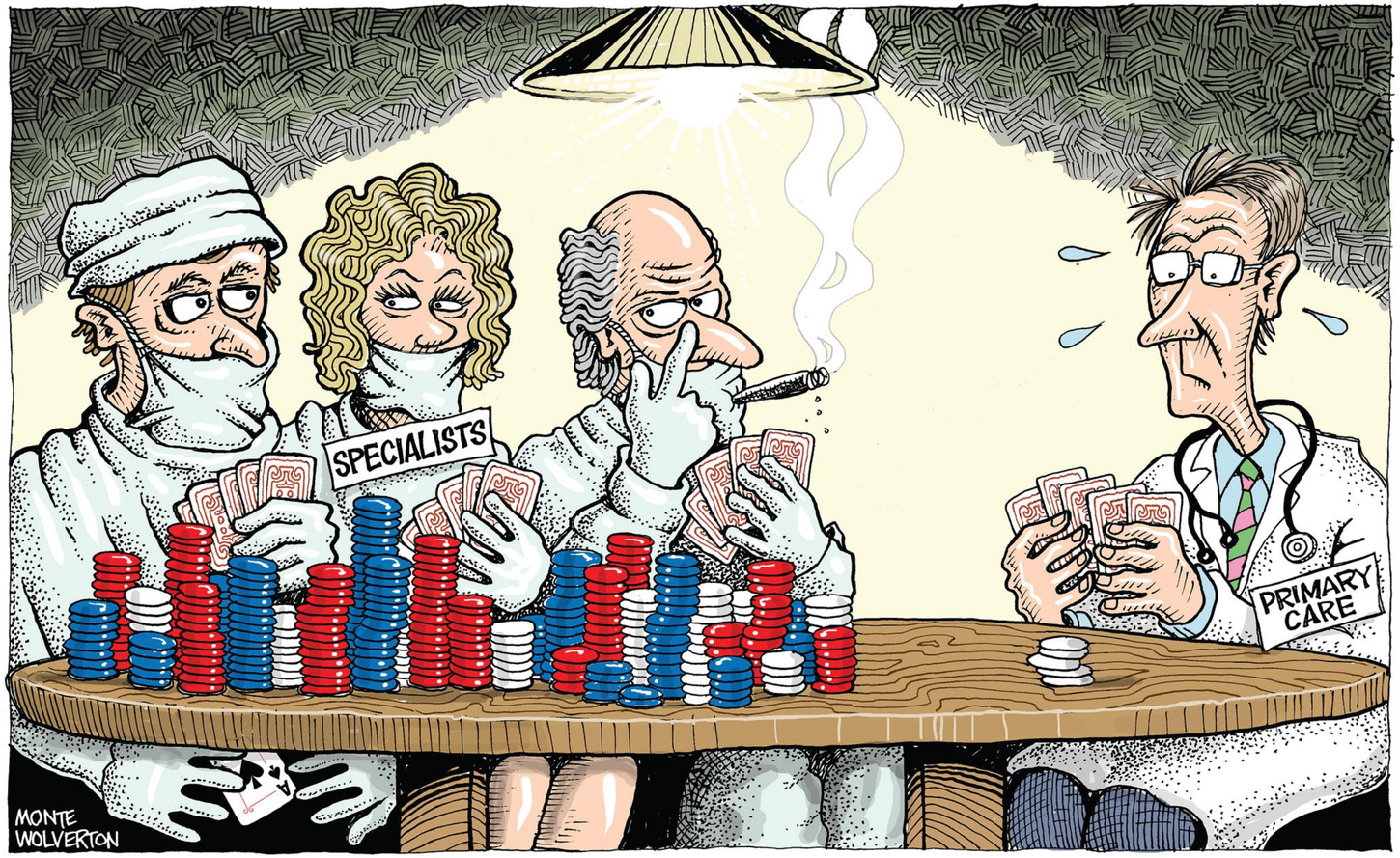
- April 2021 ACEP Team presentation
- RUC recommendations to CMS
- July 2022 Proposed Rule
- November 2022 Final Rule
- January 1 2023 dates of service new RVUs

Factors Determining Work RVUs

Surveys sent to specialty society members to gauge:

- The time it takes to perform the service
- The technical skill and physical effort
  - Vascular anastomosis
- The required mental effort and judgment
  - Complex oncologic condition
- Psychological stress due to the potential risk to the patient
- Example of intensity variation
- Critical Care: Highest intensity E/M service
    - 30 minutes and 4.50 work RVUs
- 99214 established Office code 30-39 minutes 1.92 Work RVUs

The RUC and A Shift To Primary Care



Primary Care Gaining Strength

- New seats on The RUC
- Annual wellness visits
- Transitional care management
- Complex care coordination
- RVU increases to Office codes

Amidst this back drop and with ED RVU increases 2020/2021
ACEP must advocate for E Med.
Anticipate stable RVUs for 2023!

2023 Conversion Factor

Conversion Factor Issues We Face

- We are starting from a 2022 CF of $34.6062
  - +3% new money (2022) as opposed to 3.75% (2021)
- 2% sequester – phased in Q2 2022 goes until 2031
- 4% pay as you go – $1.9T American Rescue Plan, OMB scorecard calculation pushed to 2023
- Primary care complexity code -3% resurfaces 2024
- Statutory Update from MACRA 2026 (based on 2024 performance)
  - +0.25% if you're in MIPS
  - +0.75% in you're in an APM
- Back to the SGR days with a roughly 10% annual headwind to the CF

2022 Conversion Factor: Where You Are Now and What's Ahead

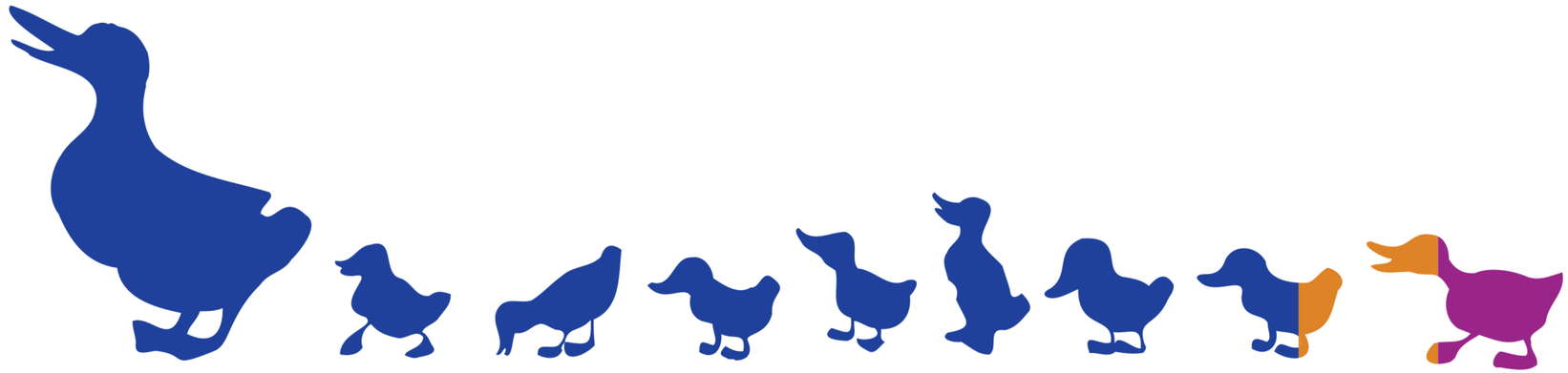
2022 CF Compared to 2021

CY 2022 Quarter (Q)	PFS Conversion Factor (CF) Cut	Sequestration Cut	2022 vs. 2021 Total Cut
Q1 (Jan-Mar)	0.75%	0%	0.75%
Q2 (Apr-Jun)	0.75%	1%	1.75%
Q3 (Jul-Sep)	0.75%	2%	2.75%
Q4 (Oct-Dec)	0.75%	2%	2.75%
Year Average	**0.75%**	**1.25%**	**2.00%**

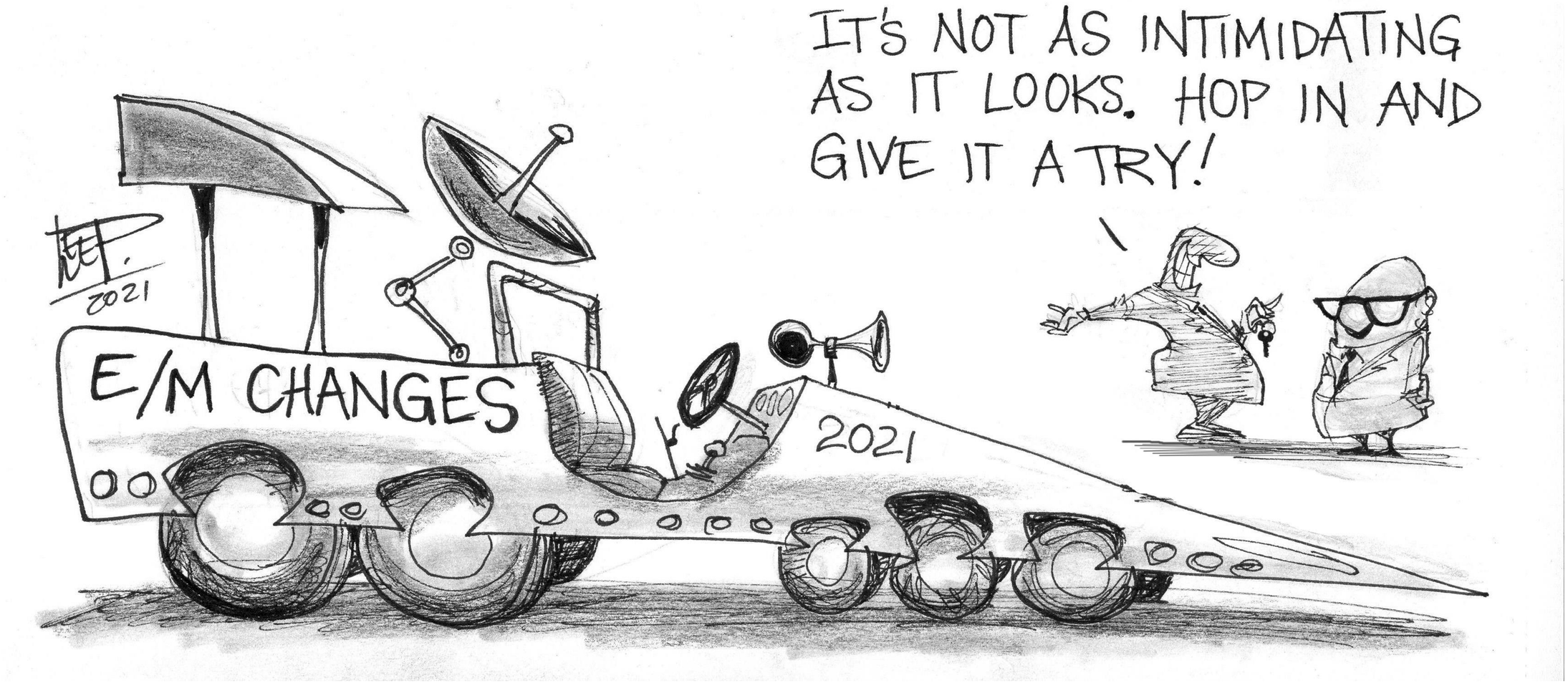
2023 Documentation Guidelines

Where Are The RVUs?

- 83% of typical ED doc's RVUs from 99281-99285
- 8% from critical care
- 9% from procedures



Office Code New Documentation Guidelines 2021



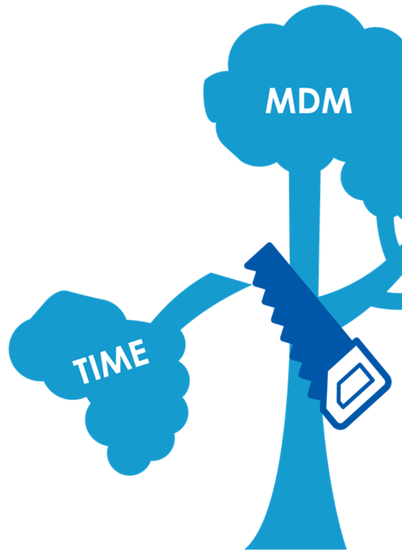
ED Implications:
2023 Documentation Guideline Changes

CPT 2022: ED and Time

Time not a factor in ED 9928x code selection

*"Time is not a descriptive component for the **emergency department levels of E/M services (99281-99285)** because emergency department services are typically provided on a variable intensity basis, involving multiple encounters with several patients over an extended period of time."*

AMA CPT 2022 Professional Edition



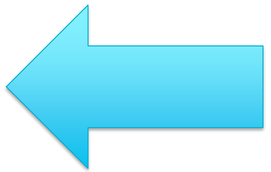
Leaves the ED with MDM

2023 Forecast ED E/M Code, MDM Construct

- Office New Patient level One (99201) deleted
- Office Est. Patient level One (99211) nursing only visit – not assoc. with any MDM

2022 Overview of Office MDM

- No MDM 99211
- Straight forward Office level 2
- Low Office level 3
- Moderate Office level 4
- High Office level 5



?99281-99285
MDM Construct
For 2023

Forecasting ED MDM
Using Scoring Grid for The Office Codes

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

99203
99213
	Low	Low
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• Any combination of 2 from the following:
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

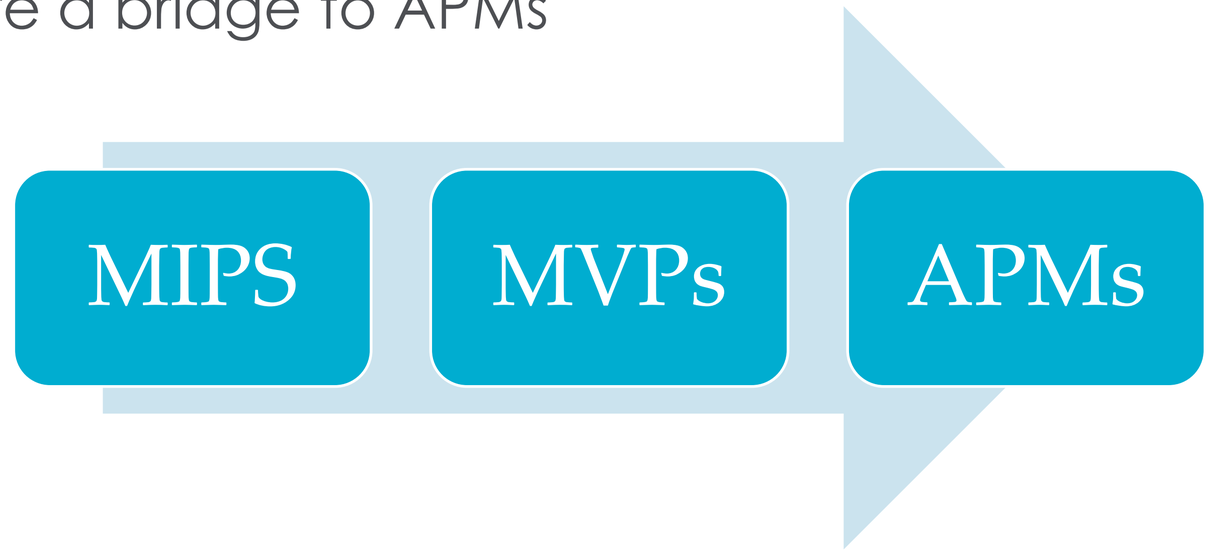
Future ED Medical Decision Making

- Decision regarding hospitalization
- Testing considered if not performed (CT Scan)
- Treatment considered if not performed (Antibiotics)
- Review of external notes (NH, EMS, DC Summary)
- Independent historian (parent, guardian, spouse)
- Independent interpretation of test
  - EKG, Rhythm strip, X-ray, CT
  - Especially if not billing

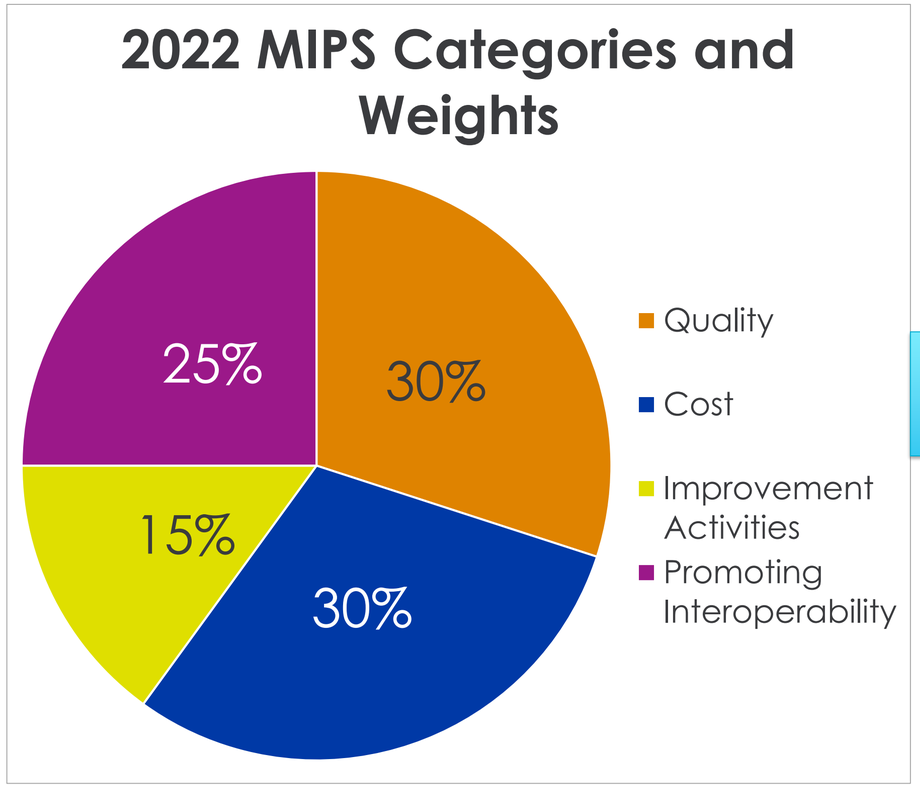
2022 MIPs Update

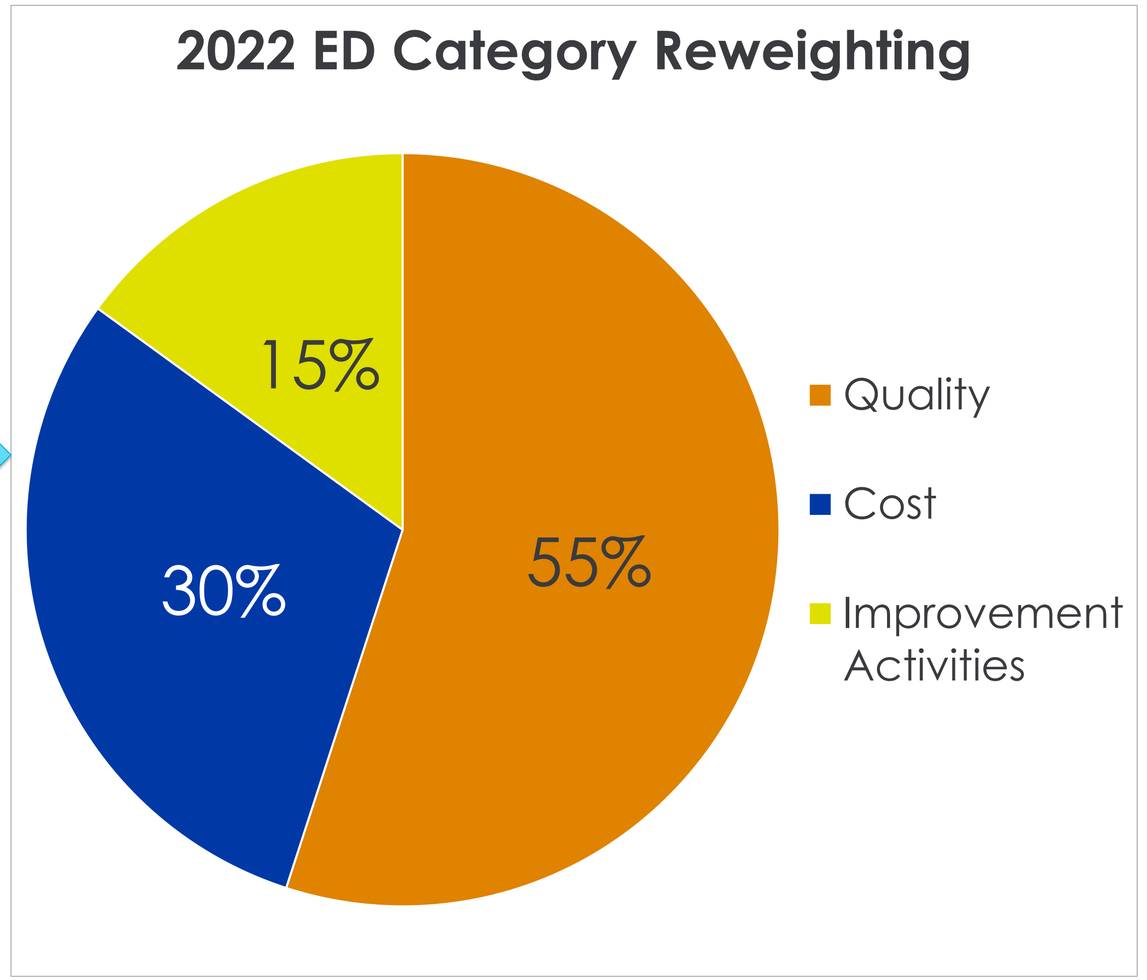
2022 MIPS Update

- 2022 is the 6th year of MIPS
- CMS continues to modify the program:
  - Make it more meaningful and less burdensome for clinicians
    - Mixed results
- MIPS intended to serve as a glide path to Alternative Payment Model (APM)
- MIPS Value Pathways (MVPs) are a bridge to APMs



2022 MIPS Category Weightings





2022 MIPS Requirements

Quality

- 6 measures, including 1 outcome or high priority measure
- Report each measure for at least **70%** of applicable patients across all payers
- Performance Period**:** Full calendar year

Cost

- Total Per Capita Cost (TPCC) Measure (20 case minimum)
- Medicare Spending Per Beneficiary (MSPB) Measure (35 case minimum)
- 23 episode-based cost measures

Improvement Activities (IA)Performance Category

- Activities that improve clinical practice
- Inventory of 100+ activities to choose from: high/medium weight
- Attest to 2-4 activities to receive full credit under this category.
- Does not require submission of performance data
  - Attestation process
- For group reporting, at least 50% of clinicians in the practice must perform the same IA during any continuous 90-day period.
- Examples:
  - Collection and follow-up on patient experience and satisfaction data, including development of improvement plan [HIGH]
  - Completion of an accredited CME program that addresses performance or quality improvement [MEDIUM]

Facility-Based Measurement

- Facility-based measurement offers "facility-based" groups opportunity to receive scores MIPS quality and cost categories
  - Based on the Hospital Value-Based Purchasing (VBP) Program score earned by your assigned facility
- 2022 physician MIPS facility-based measurement tied to FY 2023 Hospital VBP Program scores
- CMS recently announced it is unable to calculate a hospital VBP score for 2023 due to impact of COVID on suppressed measures
- If finalized, CMS would not be able to apply facility-based measurement under MIPS in 2022, similar to 2021

2022 MIPS Final Score & 2024 Payment Adjustments

2022 Final Score	2024 Medicare Payment Adjustment
89 – 100 points [up from 85 points, 2021]	• Positive adjustment • Eligible for exceptional performance bonus on linear sliding scale (last year)
75.01 – 88.99 points	• Positive adjustment on linear sliding scale • Not eligible for exceptional performance bonus • Budget Neutral
75 points [up from 60 points, 2021]	• **Neutral payment adjustment (0%) Performance Threshold**
18.76 – 74.99	• Negative adjustment of 0% to -9% on linear sliding scale
0 – 18.75 points	• Negative payment adjustment of -9%

MIPS Bonus Amounts Have Been Small

	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year
Performance threshold	3 points	15 points	30 points	45 points
Overall national mean score	74 points	87 points	86 points	89 points
Maximum upward payment adjustment	1.88%	1.68%	1.79%	2.2%

2021 and 2022 COVID Extreme Circumstance Available

MIPS Value Pathways (MVPs)

New for 2023 MIPS Value Pathways

- CMS feedback, including ACEP's, MIPS reporting should be more meaningful to clinicians
  - Quality, Improvement Activity, and Cost measures nothing to do with each other
- MVPs are sets of existing MIPS measures/activities focused on a specific specialty, clinical condition, or procedure
- Aims to break down silos between performance categories, reduce reporting burden, provide better glide path to APM participation
- Initially due to the COVID-19 CMS postponed MVPs but has now finalized the first set of seven for 2023 reporting including Emergency Medicine

MVP General Reporting Requirements

Quality	• Select **4 quality measures (instead of 6)** • 1 outcome measure if available
Improvement Activities	• Select **2 medium-weighted** improvement activities **OR** • **1 high-weighted** improvement activity (instead of 2 high)
Cost	• **Cost measures included in the MVP**
Foundational Component (same for every MVP)	
Population Health Measures	• MVP Participants select **1 population health measure** (out of two available). For the 2023 performance period, CMS anticipates that 2 population health measures will be available for selection.
Promoting Interoperability	• **Most emergency physicians are exempt**

ACEP's MVP Proposal–Accepted by CMS!

- The first batch of MVPs moving forward including ACEP's!
- ACEP developed an emergency medicine-focused MVP called: **"Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP"**
- Help transition emergency physicians to:
  - Value-based care
  - Bridge to Alternative Payment Models (APMs)

Emergency Medicine MVP Concept

- The MVP attempts to capture most common undifferentiated high-risk conditions that may occur within the ED, including chest pain, abdominal pain, headache, and back pain.
  - Significant variation in clinical decision making
  - Clinical decisions high impact on quality and cost
- Additional opportunities for headache and back pain,
  - Significant clinician variation in opioid prescribing and imaging

MVP Detail

MVP Policies

- MVPs are available but optional for 2023
- Can still use regular MIPS process
- MVP registration April 1 – November 30 of 2023
- Qualified Clinical Data Registries (e.g., CEDR) required to support
- CMS forecasting a transition from MIPS to MVPs
  - Sought comment re sun setting traditional MIPS transitioning to MVPs
    - After 2027 performance period

MVP Scoring

- Same scoring rules as traditional MIPS, with some exceptions:
  - Scored on 4 highest scoring quality measures instead of 6 highest
  - Mandated reporting on population health measures
- MVP Participants will receive a final score based on their MVP reporting
  - Unless higher final score from another reporting option

Emergency Medicine MVP Quality Measures: QPP Subset

- QPP116: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- QPP254: Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
- QPP321: CAHPS for MIPS Clinician/Group survey (Survey Vendor)
- QPP331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis
- QPP415: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

Emergency Medicine MVP Quality Measures: Registry Measure Subset

ACEP CEDR

- ACEP21: Coagulation studies in patients presenting with chest pain with no coagulopathy or bleeding
- ACEP50: ED Median Time from ED arrival to ED departure for all Adult Patients (OUTCOME MEASURE)
- ACEP52: Appropriate Emergency Department Utilization of Lumbar Spine Imaging for Atraumatic Low Back Pain

VITUITY

- ECPR46: Avoidance of Opiates for Low Back Pain or Migraines

Emergency Medicine MVP Quality Measures: Foundational Quality Measure

- Foundational measures: population-based administrative claims measures
  - CMS calculates, nothing to submit
- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate
  - Assesses each group's unplanned all-cause 30-day readmission
  - Patients have an index admission hospitalization and the following:
    - Medicare Part A for 12 months prior to the date of admission
    - Aged 65 or over
    - Discharged alive from a non-federal short-term acute care hospital
    - Not transferred to an acute care facility

Emergency Medicine MVP Cost Measures

- Medicare Spending Per Beneficiary (MSPB) Clinician Measure
  - Each MSPB episode has a window 3 days prior to the index inpatient admission through 30 days after discharge
  - Attributes all Medicare Part A and B costs occurring in the episode window to the clinician(s) responsible for care
    - Medical MS-DRGs through the use of an E&M threshold
    - Surgical MS-DRGs by identification of the physician performing the core procedure of the stay

Emergency Medicine MVP: High Weighted Improvement Activities

HIGH WEIGHTED MEASURES

- IA_BE_6: Regularly Assess Patient Experience and Follow Up on Findings
- IA_CC_14: Practice improvements that engage community resources to support patient health goals
- IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program

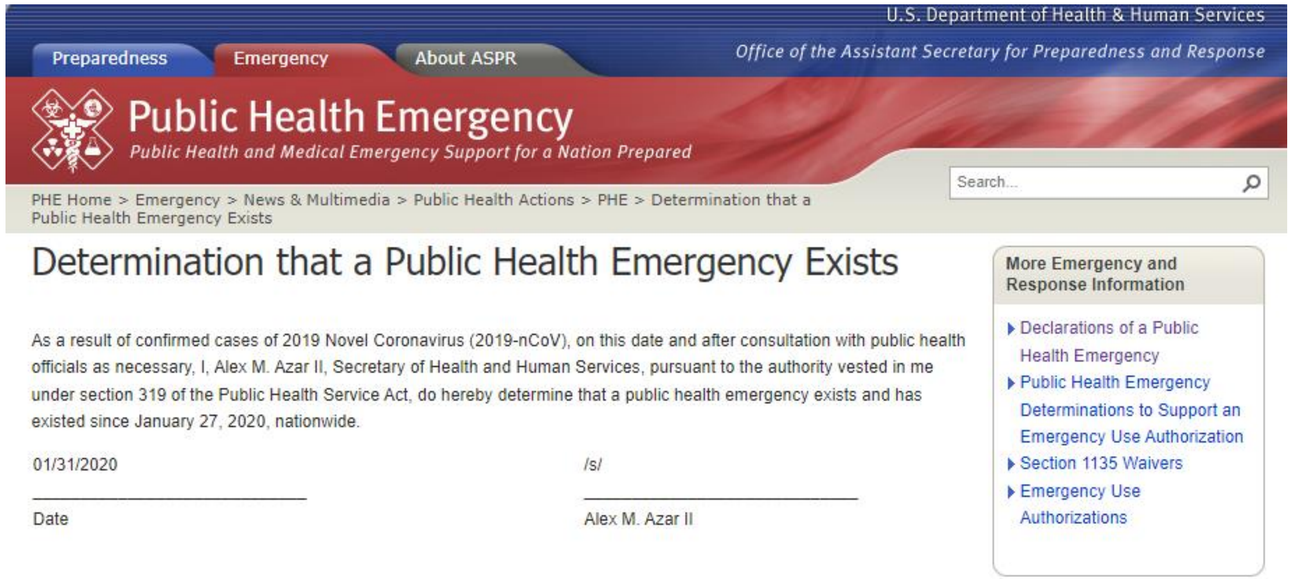
Emergency Medicine MVP:
Medium Weighted Improvement Activities

MEDIUM WEIGHTED MEASURES

- IA_BE_4: Improvements in patient portal engagement
- IA_CC_2: More timely communication of test results
- IA_PSPA_1: Participation in an AHRQ-listed patient safety organization
- IA_PSPA_7: Use of QCDR data for ongoing practice assessment
  IA_PSPA_15: Antimicrobial Stewardship Program (ASP)
- IA_PSPA_19: Implementation of formal quality improvement methods, practice changes or other practice improvement processes
- IA_PSPA_20: Leadership engagement in guidance and commitment for implementing practice improvement changes

COVID Regulatory Update

The Public Health Emergency



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Determination that a Public Health Emergency Exists

As a result of confirmed cases of 2019 Novel Coronavirus (2019-nCoV), on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby determine that a public health emergency exists and has existed since January 27, 2020, nationwide.

01/31/2020 — Date

/s/ — Alex M. Azar II

More Emergency and Response Information

- Declarations of a Public Health Emergency
- Public Health Emergency Determinations to Support an Emergency Use Authorization
- Section 1135 Waivers
- Emergency Use Authorizations

- Extended for another 90 days beyond April 16th expiration
- Now April 16- July 15th
- Pledged 60 day notice before ending
- November mid term election creates pressure related to additional renewals

The Public Health Emergency and Telehealth

- In response to COVID-19, CMS and Secretaries of HHS PHE-granted authorities to make health services safer and more easily accessible

- New policies allowed for delivery and claims submission for ED E/M services that are furnished via telehealth regardless of geographic area or patient location

- Expected to continue in the near term, Congressional action will be needed for this expansion to continue in the longer term

ED Relevant Telehealth Update

- ED and other key codes approved through 12.31.2023
- ED 99281-99285 Critical care 99291-99292
- Subsequent observation (99224-99226) and Obs discharge (99217)
- After the PHE ends CMS extended the HPSA geographic waiver and the patient home location waiver for 151 days.

Telehealth Additional Hurdles To Overcome

- During the Public Health Emergency 99281-99285 on the approved list as part of category 3 through 12.31.2023
  - Need data and use cases to convert to permanent approval
- PHE ends potentially July or October 2022 calendar year
  - Health Professional Shortage Area (HPSA) Congressional action
  - Patient location of home require Congressional action
  - Congress added an allowance regarding the HPSA and patient location issues for 151 days after the PHE

No Surprises Act Update

Federal No Surprises Act

- Effective Jan 1, 2022
- Changed reimbursement process for out of network (OON) services
  - What is the “fair payment” when:
    - Service is provided (e.g., a plumber or an ER doc caring for a STEMI)
    - No agreed to rate in advance
- Patient taken out of the middle
  - Prohibits “balance billing” the patient

Federal No Surprises Act

Payment now determined in three steps:

- Step 1: Initial payment to the provider:
  - 2019 median in network rate (QPA- Qualified Payment Amount)

- Step 2: Open negotiation period:
  - must be requested within 30 days of initial payment)

- Step 3: Final payment determined via arbitration
  - must be requested in 4-day window of 31-34 days after request for open negotiation

Step 1: Initial Payment from Health Insurer
QPA Determination

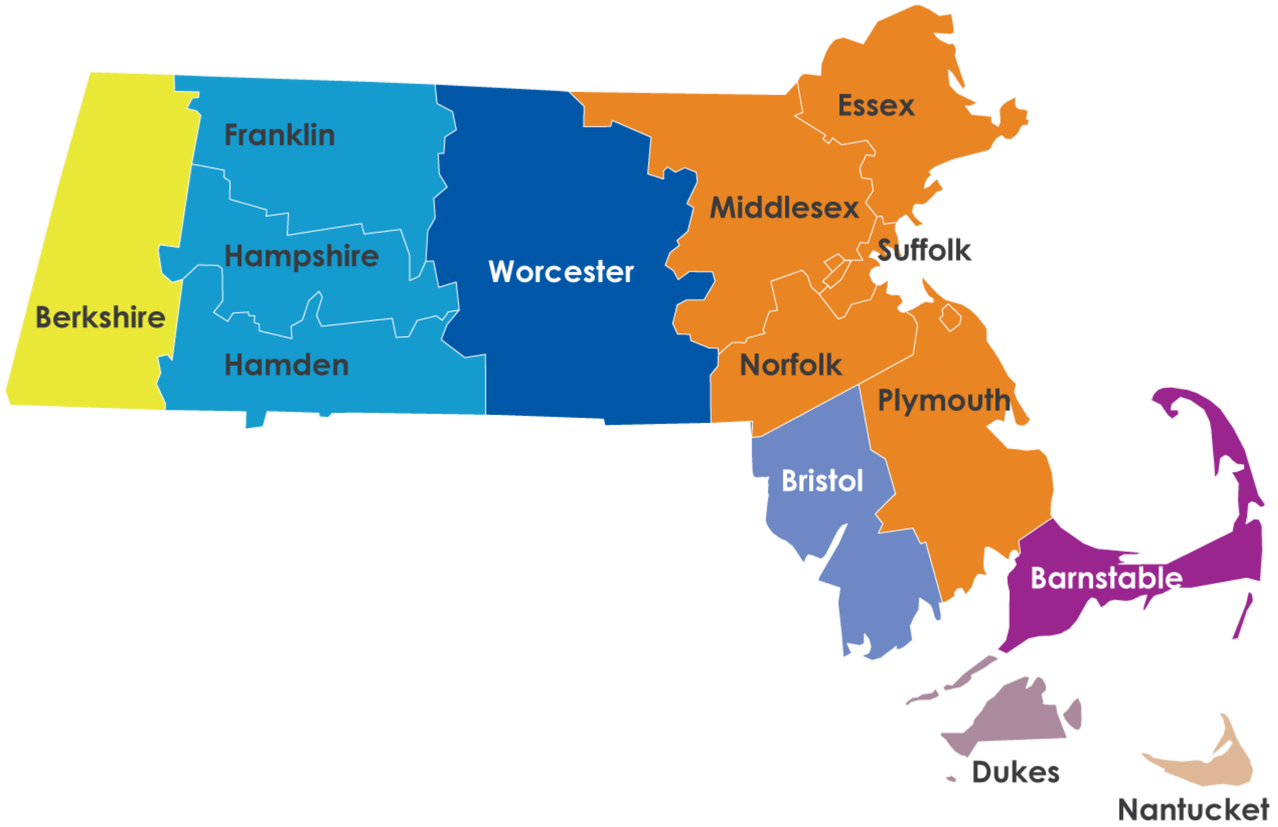
The QPA is simply defined as, for each payer, the median in network payment:

- As of January 31, 2019
- Same insurance market
- Same or similar service
- Same or similar specialty
- Same geography (MSA- Metropolitan Statistical Area)
- Increased by CPI-U (Consumer Price Index Urban) annually

- QPA Purpose:
  - Patient cost sharing determination (will not change downstream)
    - Deductible, co-insurance, co-pay will not change
  - Initial timely payment to providers
  - Data point for consideration later in arbitration

Massachusetts: 6 Metropolitan Statistical Areas

- Barnstable Town, MA MSA
- Boston-Cambridge-Newton MA-NH MSA
- Pittsfield, MA MSA
- Providence-Warwick, RI-MA MSA
- Springfield, MA MSA
- Vineyard Haven, MA μSA
- Worcester, MA-CT MSA



Step 2: Open Negotiation

- 30 days to request after receiving the QPA payment
- No standardized process
  - Snail mail, email, portal, some no process
- May not be any acknowledgment
- Date of request is important
  - 31-34 business day window for arbitration request
- Example:
  - 99284: Charge is $600
  - Initial QPA payment $125
  - Group opens negotiation with offer of $540
    - May or may not be any response
    - If you don't like the offered amount or no response … go to arbitration

Step 3: Arbitration Process and Considerations: Factors IDR Will Consider to Determine Best Offer

- $50 non-refundable filing fee from both parties
- Loser pays fees to the IDR entity ~ $650 for batches
- Baseball-style arbitration:
  - Each party gives best offer and arbitrator picks one or the other
    - NOT in the middle
    - Incentive to make a reasonable offer

Arbitrator Considers:

- Qualifying payment amount (2019 median in network)
- Market share
- Acuity of the patient
- Teaching status
- Demonstration of good faith to be in-network
- If applicable contracted rates in past 4 year

Step 3: Arbitration Process Under Legal Review

- Final Regs: “Arbitrator shall consider…”
  - Qualifying payment amount (2019 median in network)
- Government final regs over emphasized using just the QPA
- Texas Medical Association argued the designated menu of factors should be considered.
- Government was appealing to use just QPA (now on hold)
- Portal opened in April to request arbitration

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Educational Appendix

MIPS Cost Category Detail

Measure Name	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	Assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	• Medicare Parts A and B claims data
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient	35 episodes	• Medicare Parts A and B claims data
13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (18 measures)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures, 10 episodes for procedural episode-based measures	• Medicare Parts A and B claims data

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