Medicare’s Quality Payment Program: 2020 and Beyond

Medicare’s Quality Payment Program (QPP) continues to evolve, with minor updates in 2020 and major changes in store starting in 2021. The Centers for Medicare & Medicaid Services (CMS) continues to chart a trajectory for clinicians moving to performance-based payments. As registered dietitian nutritionists (RDNs) who are Medicare providers continue to dip their toes into this new world, they can breathe a sigh of relief that for 2020 they don’t have to master significant changes. 2020 may be the year you want to take the plunge and “opt in”! Is it worth it? For 2019, 92.5 percent of clinicians who participated in the Merit-based Incentive Payment System (MIPS) received a neutral or positive payment adjustment. So, the odds are in your favor.

Read more to learn what’s in store for 2020 and beyond in the QPP of interest to RDNs. And if you’re not familiar with the QPP, visit the Academy website at: www.eatrightpro.org/payment/medicare/quality-payment-program.

What’s new under MIPS?

- New Nutrition/Dietitian Measure set created for quality reporting: The new measure set creates an easy way to locate the quality measures available for reporting by RDN eligible clinicians or RDNs who choose to opt-in to MIPS. The measure set includes a new measure, “Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents.” While this measure obviously is not relevant to the Medicare population, it is relevant for other payers and might be reported by RDNs as part of an all-payer alternative payer model option.
- Quality data completeness criteria threshold increased: MIPS eligible clinicians must report data on at least 70% of their Medicare Part B patients.

New Article Promotes the Value of RDNs in Orthopedic Practices

According to a recent article, Preoperative Weight Loss -Plan for Stepwise Incorporation of Registered Dietitian Nutritionists into an Orthopaedic Practice, co-authored by Academy Past President Lucille Beseler, MS, RDN, LDN,CDE, FAND and published in the International Journal of Orthopedics, orthopedic clinics may benefit from the incorporation of a registered dietitian nutritionist (RDN) into their practice in order to help patients achieve optimal weight loss prior to surgery and reduce postoperative complication rates. The article provides stepwise guidance for incorporating RDNs into orthopedic practices to address preoperative weight loss. RDNs looking to market medical nutrition therapy services to physicians to address weight loss can utilize this published article as a resource. To access the article as well as additional resources to promote coverage of medical nutrition therapy provided by RDNs, visit: http://bit.ly/33IH7XU.
• Improvement Activity adjusted:
  – If you are reporting as a group (including virtual groups), at least 50% of the NPIs billing under the group's TIN must perform each improvement activity during any continuous 90-day period within the performance year (January 1 – December 31).
  – New Improvement Activities: A new high-weight activity has been added to incentivize MIPS eligible clinicians to report Patient Relationship Codes on their claims using HCPCS modifiers. The codes were created to help CMS determine how to attribute care to clinicians for measuring costs. Reporting these modifiers has been optional since 2018, although at some point reporting will become mandatory. By including them as a high-weight Improvement Activity, CMS hopes providers will seize the opportunity to get into the habit of reporting them. RDNs should list HCPCS code modifier X5 – Only as Ordered by Another Clinician on line 24d of the CMS 1500 form.

• Performance thresholds increased significantly:
  – The performance threshold increases from 30 points to 45 points for the 2022 MIPS payment year (based on 2020 performance) and 60 points for the 2023 MIPS payment year (based on 2021 performance). That means in 2020 eligible clinicians need to get at least 45 points to avoid a penalty.
  – The additional performance threshold increases from 75 points to 85 points. That’s the number of points required to earn incentives from an additional incentive pool of $500m. While the bar is set higher, meaning fewer MIPS eligible clinicians will hit it, those who do have the potential for even greater payments.

• Overall stakes raised: The payment adjustment in 2022 for performance in 2020 increases to +/- 9% raising the overall stakes for MIPS participation.

What’s staying the same under MIPS?
• Eligibility: low-volume threshold, opt-in policy
• Data collection and submission
• Performance category weights:
  – Quality performance category weight remains at 45%.
  – Cost performance category weight remains at 15%. Currently RDNs are not scored in this performance category as the measures don’t apply to them. The category will continue to be reweighted to the Quality performance category.
  – Promoting interoperability performance category will continue to be reweighted to the Quality performance category for RDNs.

• Net result: For RDNs, Quality will continue to be weighted at 85% and Improvement Activities at 15%.

• Opportunities for bonus points: small practice, high priority measures, complex patient bonus
• The list of MIPS Alternative Payment Models: 2020 remains the same as 2019

Preparing for 2020
The Academy continues to encourage all RDN Medicare providers to opt-in to MIPS. While the program sounds complex, reporting for RDNs is easy. With payments under the Medicare Physician Fee Schedule stagnating, MIPS offers the opportunity to increase payments and demonstrate the contributions of RDNs to high quality, cost-effective care. Show CMS that access to MNT services is vital to Medicare beneficiaries and that RDNs are “players” in the Medicare program.

It will be “business as usual” for RDNs who participated in 2019 with one recommendation: start including Patient Relationship Codes on your claims and attest to Improvement Activity IA_CC_18. RDNs who want to participate in MIPS via a virtual group need to submit their selection to CMS via email (MIPS_VirtualGroups@cms.hhs.gov) by December 31, 2019. Learn more at https://qpp.cms.gov/mips/individual-or-group-participation#virtual-groups/.

New Medicare Card Transition Period Ending
Are you ready for the end of the transition period for utilizing old Health Insurance Claim Numbers (HICNs)? Beginning January 1, 2020, all Medicare transactions, such as claims, eligibility status and claim status inquiries, must include the Medicare Beneficiary Identifier (MBI). Claims and eligibility transactions submitted with an HICN be rejected, with a few exceptions. For more information about the MBI transition and for a list of exceptions, visit: https://www.cms.gov/Medicare/New-Medicare-Card/index.html.
Question Corner

**Q:** What is the Interrupted Stay Policy under the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)?

**A:** The Interrupted Stay Policy is a component of the SNF PDPM payment policy that sets out criteria for determining when Medicare will treat multiple SNF stays occurring in a single Part A benefit period as a single “interrupted” stay, rather than separate stays, for the purposes of the assessment schedule and the variable per diem payment schedule. To learn when is a stay considered “interrupted” and how the policy affect the assessment schedule and variable per diem, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v2_508.pdf.

**Q:** Will ICD-10 codes have different point values for scoring under the PDPM?

**A:** ICD-10 Codes are grouped into clinical categories which do drive reimbursement. Though the codes themselves may not have scoring attributed, the Non-Therapy Ancillary (NTA) comorbidities and Speech Language Pathology (SLP) components have many codes with points assigned to them that drive reimbursement. The ICD10 mapping to the Physical Therapy/Occupational Therapy (PT/OT) clinical categories determines rates as well. To learn more about SNF PDPM, read the special edition, September/October issue of the MNT Provider at: or visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM-101_Final.pdf.

**Q:** We often receive transfers from other LTC facilities wishing to admit to our facility. We would be doing a 5 day for our facility. The other facility already received the variable per diem rate adjustment. Does that preclude us from receiving the base rate adjustment? Or would we still be able to utilize the base rate adjustment?

**A:** The variable rate adjustments are based on Medicare stays. Since the resident would be new to your facility, this is considered a new Medicare Part A stay, requiring a new 5-day assessment. The variable rate adjustments would be reset to day 1.

**Q:** How will the interrupted stay policy affect the assessment schedule and variable per diem?

**A:** When the stay is considered “interrupted” under the Interrupted Stay Policy, both the assessment schedule and the variable per diem payment schedule continue from the point just prior to discharge. When the stay is not considered interrupted, both the assessment schedule and the variable per diem rate reset to Day 1, as it would in a new stay. For more information about the Interrupted Stay Policy, download the PDPM interrupted stay fact sheet, available at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet InterruptedStay_Final.pdf.

**Q:** Can a registered dietitian nutritionist (RDN) place a glucose sensor, educate, and bill for continuous glucose monitoring (CGM) under a physician?

**A:** Under Medicare, an RDN may perform the elements in CPT codes 95249 and 95250 if “incident to guidelines” are met, meaning the service is provided under the direct supervision of a physician, physician assistant, or nurse practitioner. The RDN can place and provide training on the use of a glucose sensor per facility protocol, assuming the protocol complies with state laws and regulations, the service falls within that individual RDN’s scope of practice, and the service is appropriate according to any facility protocols which may be in place. It is important to note that some states do not consider any services that break the skin under a RDN’s scope of practice. Commercial payers’ guidelines/requirements/restrictions must also be reviewed to determine appropriate credentialing/licensure/scopes of practice, etc. RDNs can self-assess their skills, education, training, and knowledge with Scope of Practice tools and resources available at: www.eatrightpro.org/practice/quality-management/scope-of-practice. For a detailed description of CPT codes 95249 and 95250, see the reference table below.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>description</th>
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<tbody>
<tr>
<td>95249</td>
<td>Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording.</td>
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<tr>
<td>95250</td>
<td>Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.</td>
</tr>
<tr>
<td>95251</td>
<td>Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.</td>
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**Q:** Can RDNs bill for diabetes self-management training (DSMT) on the same day as a CGM follow up visit?

**A:** Yes. RDNs providing DSMT as part of an accredited program may bill Medicare for the CPT code G0108 for diabetes outpatient self-management training services, individual, per 30 minutes, on the same date of service as the CPT code 95250 is billed for continuous treatment training (DSMT) on the same day as a CGM follow up visit.
Integrating RDNs into Primary Care Toolkit

Expand the role of the registered dietitian nutritionist (RDNs) and carve out your niche in team-based care in new models of health care delivery and alternative payment models. Demonstrate how services provided by RDNs contribute to a decrease in avoidable health care costs and add value through improved health outcomes. This toolkit is filled with practical information about population management, quality measurement, and tools to help get you started. To order your copy, visit: www.eatrightstore.org/product-type/toolkits/integrating-the-registered-dietitian-rd-into-primary-care--comprehensive-primary-care-initiative-cpc.

Question Corner, from page 3

Q: Where can I find an overview of the policies that were finalized by the Centers for Medicare & Medicaid Services (CMS) for the Merit-based Incentive Payment System (MIPS) 2020 performance period?

A: CMS offers an overview of the major policies finalized for the 2020 MIPS performance period in the calendar year 2020 Quality Payment Program (QPP) Final Rule Fact Sheet, which includes a table comparing the previous policy to the newly finalized policy. See the 2020 QPP Final Rule FAQs for a link to the fact sheet and answers to other commonly asked questions: https://qpp-cm-dev-content.s3.amazonaws.com/uploads/739/2020%20QPP%20Final%20Rule%20FAQs.pdf. Registered dietitian nutritionists (RDNs) can also visit the Academy’s web pages for an overview of the changes that are relative to RDN practice by visiting: www.eatrightpro.org/payment/medicare/quality-payment-program/mips-101-for-rdns.

MVPs and QDCRs Coming in 2021!

Are you ready for a new acronym? In 2021, the Centers for Medicare & Medicaid Services (CMS) will begin rolling out a new participation framework under the Merit-based Incentive Payment System (MIPS). MIPS Value Pathways, or MVPs, are designed to move away from siloed activities under the four performance categories of MIPS towards an aligned set of measures more relevant to a clinician’s scope of practice that is meaningful to patient care. MVPs will be created based on a medical specialty or condition (e.g., surgery or diabetes). The framework is intended to reduce reporting burden for MIPS-eligible clinicians and further drive participation toward alternative payment models. CMS plans to fully transform MIPS to this new framework over the next 3-5 years, with input from specialty societies, clinicians and patients. What MVPs mean for RDNs remains to be seen, but the Academy plans to be at the table as they are designed. Learn more by viewing CMS’ The Future of MIPS video available at: www.youtube.com/watch?v=ZhM3KiojPjY&feature=youtu.be and visiting the MVPs webpage: https://qpp.cms.gov/mips/mips-value-pathways.

In addition, beginning with the 2021 performance year, MIPS reporting may get easier. Qualified Clinical Data Registries (QCDRs) and qualified registries will become one-stop-shops for reporting as they will be required to support reporting for three performance categories: Quality, Improvement Activities, and Promoting Interoperability. MIPS eligible clinicians will not be required to report using a QCDR or qualified registry. And if they choose to do so, they will not be required to report all performance categories through it. Rather, they will just have the convenience of this option to do so. And beginning with the 2023 MIPS payment year (based on 2021 reporting), QCDRs and qualified registries will be required to provide performance feedback to their clinicians at least four times a year, including specific feedback on how they compare to other clinicians who have submitted data on a given measure within the QCDR or registry. Watch the January 2020 issue of the MNT Provider for additional details about QCDRs.