

2021 Medicare Outlook

Drew Voytal, MPA

Associate Director

Matt Devino, MPH

Associate Director

MGMA GOVERNMENT AFFAIRS

WASHINGTON, DC

dvoytal@mgma.org | 202.293.3450





Agenda

- **2021 Medicare Outlook**
 - Merit-based Incentive Payment System (MIPS)
 - Alternative Payment Models (APMs)
 - Medicare Physician Fee Schedule
 - Other Federal Regulations
- **COVID-19 Relief**
- **Congressional Agenda for 2021**
- **Advocacy and Member Engagement**



Medicare Payment Landscape

Merit-based Incentive Payment System (MIPS)

MGMA®



Quick note about 2019 MIPS performance / 2021 payment adjustment

FEEDBACK AND FINAL SCORES ARE NOW AVAILABLE

If you submitted 2019 MIPS performance data, you can view your performance feedback and MIPS final score on the Quality Payment Program website.

According to CMS

- 100% of 2019 MIPS participants avoided a penalty
- 96% will receive a positive adjustment (maximum possible adjustment: **+1.79%**)

COVID-19 Impact

- 65,237 (6.83%) of MIPS eligible clinicians received reweighting of one or more MIPS performance categories due to our MIPS Extreme and Uncontrollable Circumstances policy.
- Of those clinicians, 29,136 received reweighting of ***all*** their performance categories and were assigned a neutral score.

View the 2019 MIPS Performance Fact Sheet [here](#). Go to qpp.cms.gov/login for information on your score.

2020 Performance Year – 2022 Payment Year: COVID Update



CMS has announced that clinicians affected by the COVID-19 public health emergency may submit an [Extreme & Uncontrollable Circumstances application](#) to reweight one or more of the MIPS performance categories by **Feb. 1, 2021, at 8pm ET**.



If a group practice or individual clinician submits 2020 MIPS data for one or more performance categories, that data submission will override an approved application on a category-by-category basis.

[QPP COVID-19 Response Fact Sheet](#)
[2020 Exception Applications Fact Sheet](#)

Comparing MIPS Performance Policies – 2020 vs. 2021

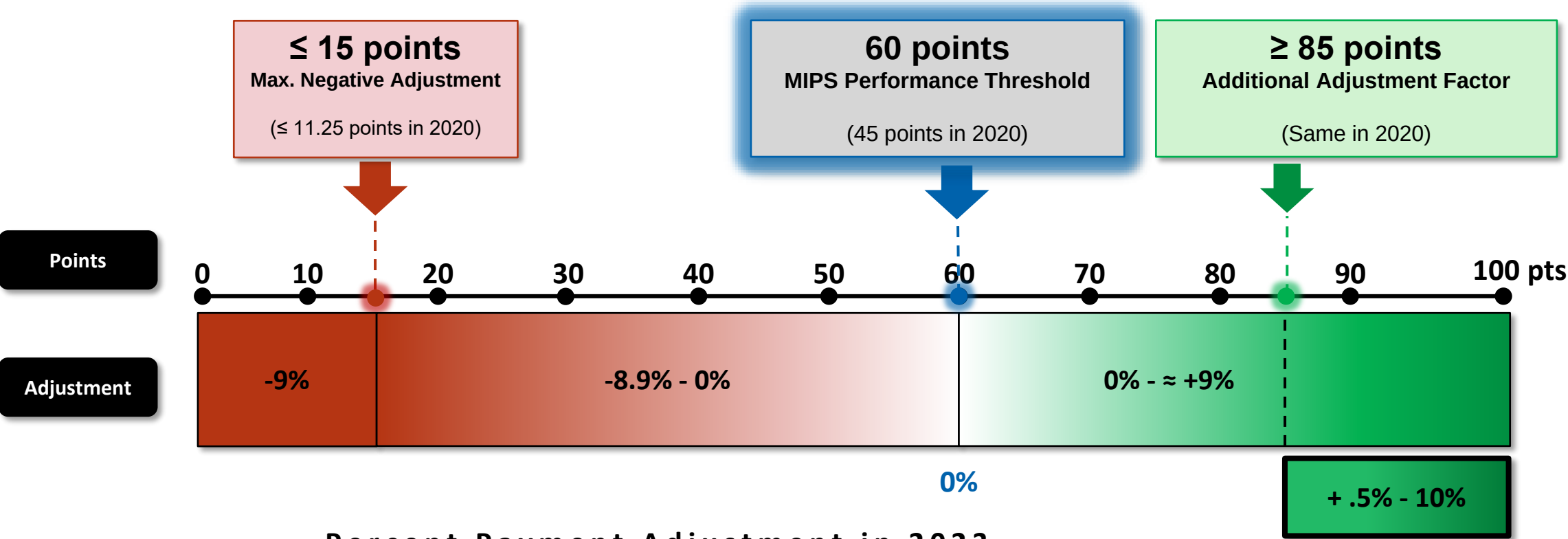
	2020	2021
Payment Adjustment	+ / - 9% (for payments made in 2022)	+ / - 9% (for payments made in 2023)
Reporting Period	Quality and Cost – Full Year PI and IA – 90 consecutive days	No change
Category Weights	Quality: 45% Cost: 15% PI: 25% IA: 15%	Quality: 40% Cost: 20% PI: 25% IA: 15%
Data Submission	Group practices can submit quality measure data using multiple data submission mechanisms, such as an EHR and registry.	No change*
Small Practice and Complex Patient Bonuses	Small Practice: 6 points included with Quality Complex Patients: up to 10 points**	Complex Patient Bonus back to 5 point maximum
Low-Volume Threshold	\$90,000 Medicare charges <u>and</u> 200 patients <u>and</u> 200 covered services	No change
CEHRT Edition	2015	No change

*From 2021 PFS final rule: CMS will end the CMS Web Interface as a quality reporting option for ACOs, APM entities, groups, and virtual groups in 2022

**From 2021 PFS final rule: for 2020 performance only, doubling the complex patient bonus to a maximum of ten points added to the overall MIPS performance score to account for additional complexities due to COVID-19

MIPS Point System and Adjustments

2021 PERFORMANCE / 2023 PAYMENT



Percent Payment Adjustment in 2023

Additional MIPS Payment Adjustment for Exceptional Performance above 80 points. These percentages are multiplied by a scaling factor to proportionally distribute statutorily allocated funds of \$500,000,000



Medicare Payment Landscape

Alternative Payment Models (APMs)



Advanced APMs in 2021

Advanced APM list	
	Bundled Payments for Care Improvement Advanced (BPCI-A)
	Comprehensive Care for Joint Replacement (CJR)*
	Comprehensive ESRD Care (CEC) Model*
	Medicare Shared Savings Program (MSSP) ACOs Tracks 1+, 2, and 3*
	MSSP Basic Track E and Enhanced Track
	Next Generation ACO*
	Oncology Care Model (OCM)*
	Maryland Total Cost of Care Model (Care Redesign Program & Primary Care Program)
	Vermont Medicare ACO Initiative
	Primary Care First (PCF) Model
	Direct Contracting (DC) Model Options
	Kidney Care Choices (KCC) Model
	Radiation Oncology (RO) Model

*model timeline extended due to COVID-19

Advanced APMs allow eligible clinicians to become a qualified participant (QP) and receive a 5 percent APM incentive payment and exclusion from MIPS.

2021 APM Proposal

To become a QP, a clinician must receive at least 75% of their Medicare Part B payments or see at least 50% of Medicare patients through an Advanced APM entity at one of the determination periods (snapshots).

New APMs in 2021

GEOGRAPHIC DIRECT CONTRACTING

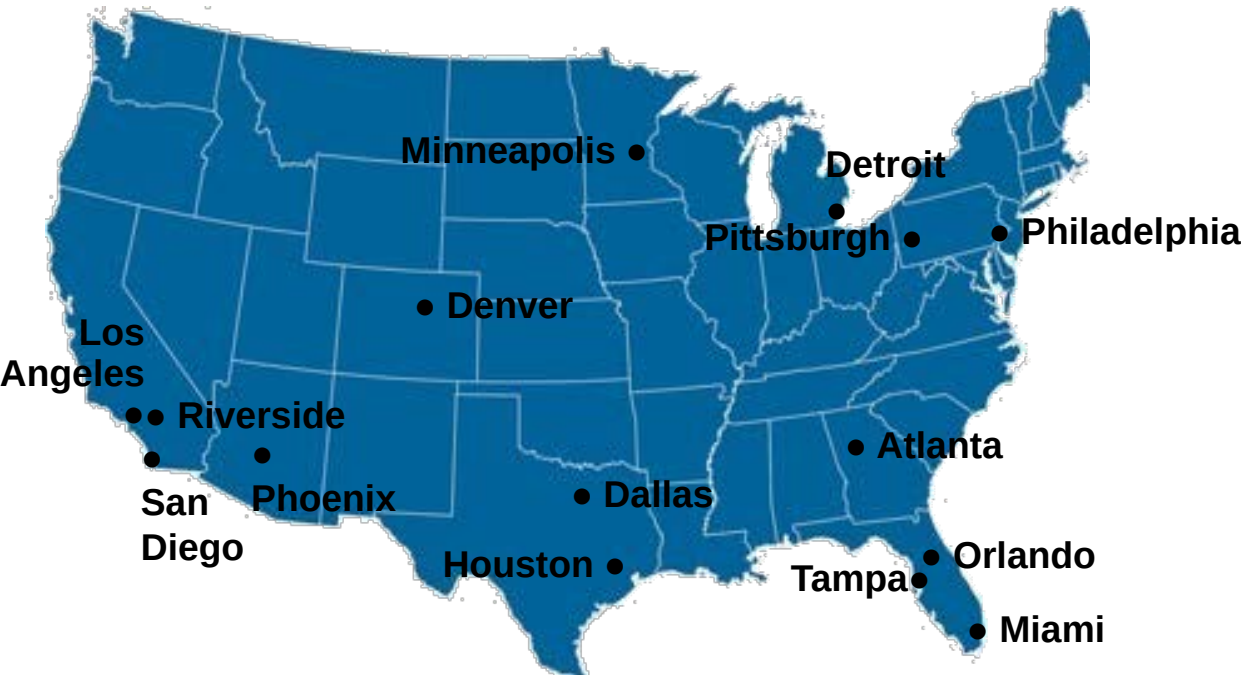
Voluntary
APM

The Geographic Direct Contracting Model requires participants to take full risk with 100% shared savings/losses for Medicare Parts A/B services for aligned Medicare FFS beneficiaries in a defined target region.

The Model will test whether a geographic-based approach to value-based care can improve quality of care and reduce costs for Medicare beneficiaries across an entire geographic region.

Participation:

- CMS is considering 15 Core Based Statistical Areas (CBSAs) and will select 4-10 CBSAs with 3-7 Direct Contracting Entities (DCEs) within each.
- There will be two three-year performance periods:
 1. Jan. 1, 2022 – Dec. 31, 2024
 2. Jan. 1, 2025 – Dec. 31, 2027



A non-binding [Letter of Interest](#) must be submitted to CMS by Dec. 21, 2020. CMS expects formal applications to be due in April 2021.

Learn more about the [Geographic Direct Contracting Model](#)

New APMs in 2021

RADIATION ONCOLOGY

MANDATORY
APM*

The RO Model will make prospective, episode-based (bundled) payments in a site-neutral manner for covered radiotherapy (RT) services furnished during a 90-day episode of care for the 16 included cancer types.

- Bundled payments will be split into two components – professional and technical – to allow for use of current claims systems;
- Model links payment to quality using reporting and performance on quality measures, clinical data reporting, and patient experience;
- Model qualifies as an Advanced APM.

Participation:

CMS is **requiring** participation from RT providers and suppliers that furnish RT services within randomly selected Core Based Statistical Areas (CBSAs). Participants will be physician group practices, freestanding radiation therapy centers, or hospital outpatient departments.

*This mandatory APM will go into effect July 1, 2021

Learn more about the [RO model](#)

New APMs in 2021

END-STAGE RENAL DISEASE TREATMENT CHOICES (ETC)

MANDATORY
APM*

The ESRD Treatment Choices (ETC) Model aims to test whether greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD will reduce Medicare expenditures, while preserving or enhancing the quality of care for ESRD beneficiaries.

- Expanded education and care choices for beneficiaries, including home dialysis
- Uniform positive payment adjustment for home dialysis, and either a positive or negative adjustment to both home and facility dialysis
- Payment adjustments for selected facilities and Managing Clinicians – a Medicare-enrolled clinician who furnishes and bills the monthly capitation payment.

Participation:

CMS is **requiring** select ESRD facilities and Managing Clinicians to participate in the model according to their location in randomly-selected geographic areas, to account for approximately 30% of ESRD facilities and Managing Clinicians across the country.

*This mandatory APM will go into effect January 1, 2021

Learn more about [ESRD Treatment Choices](#)

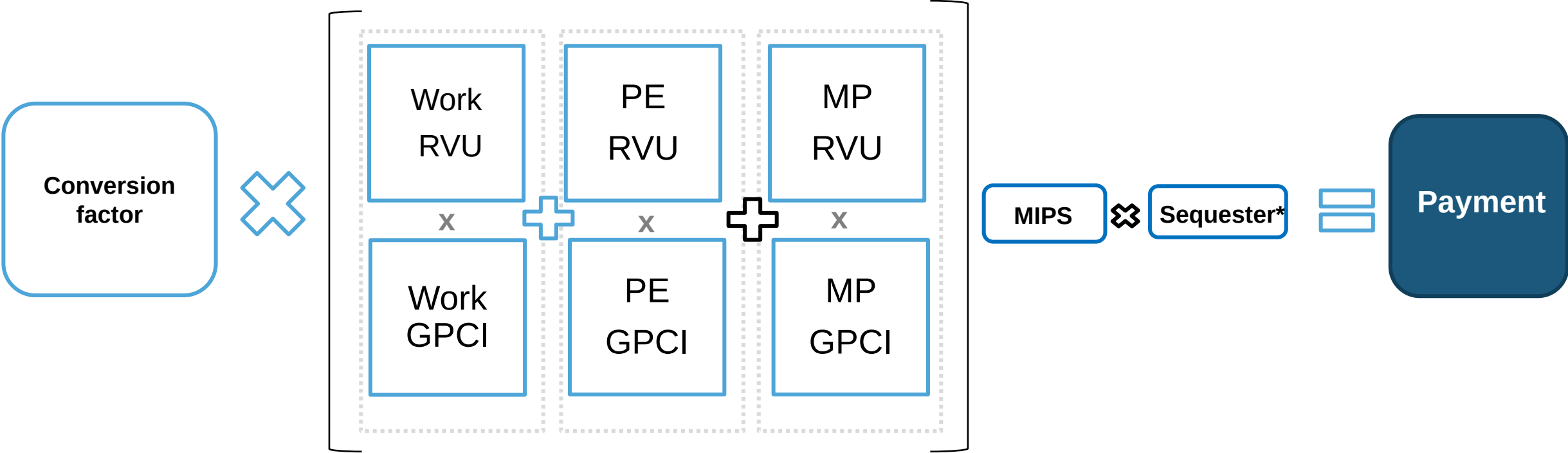


Medicare Payment Landscape

Medicare Physician Fee Schedule (PFS)



Medicare Service Payment Calculation



*Application of the sequester is suspended through Dec. 31, 2020 – an MGMA advocacy win!

Medicare Conversion Factors: 2021 Final PFS

PFS Conversion Factor		
CY 2020 Conversion Factor		36.0896
Statutory Update	0.00 percent	
CY 2021 RVU Budget Neutrality Adjustment	-10.20 percent (0.8980)	
CY 2021 Conversion Factor		32.4085

Anesthesia Conversion Factor		
CY 2020 Anesthesia Conversion Factor		22.2016
Statutory Update	0.00 percent	
CY 2021 RVU Budget Neutrality Adjustment	-10.20 percent (0.8980)	
CY 2020 Anesthesia Practice Expense and Malpractice Adjustment	0.59 percent (1.0059)	
CY 2020 Anesthesia Conversion Factor		20.0547

Evaluation & Management (E/M) Changes: 2021 Final PFS

CMS generally adopted the new E/M coding, prefatory language, and interpretive guidance framework issued by the AMA CPT Editorial Panel and will be effective January 1, 2021.
(see link below).

Level selection based on medical decision making (MDM) or total time by reporting practitioner on day of the visit (including both face to face and non-face to face).

History and examination can be used if medically appropriate but not used in code selection.

MDM elements include:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Level 2-5 for new patients
Level 1-5 for established patients
Deletion of CPT 99201

[AMA CPT information](#)

Evaluation & Management (E/M) Changes: 2021 Final PFS

NEW E/M ADD-ON CODES

G2211 (Visit Complexity (AKA GPC1X)) – Descriptor: Visit complexity inherent to evaluation and management 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 condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

G2212 (Prolonged Time (AKA 99417, AKA 99XXX)) – Descriptor: Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) “(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).

MGMA Resources:

[2021 Proposed physician fee schedule](#)
[2021 medical decision making for outpatient E&M resource](#)
[2021 physician E&M fee schedule analyzer](#)
[Preparing your practice for the 2021 E&M changes resource](#)

Additional Resources:

[AMA CPT E&M and Prolonged Services Code and Guideline Changes](#)
[AMA checklist for transitioning to 2021 E&M office visit changes](#)
[CMS Proposed PFS information for calendar year 2021](#)
[CMS MLN E&M services guide](#)

Evaluation & Management (E/M) Changes: 2021 Final PFS

COMMON QUESTIONS

Do you document total time or the time range in the record?

- The total time of the encounter (both face-to-face and non-face-to-face) should be documented in the record, not the time range. (I.e.— document “20 minutes” in the record for 99202 instead of “15-29 minutes.”) As a reminder, only count total time on the date of the encounter.

Does non-face-to-face time include work conducted by clinical staff?

- No, non-face-to-face time does not include clinical staff time. If the physician or qualified health practitioner (QHP) who is coding and reporting the service spends time with the clinical staff reviewing something they did, that could count towards the total time spent. The same rule applies for residents and medical students. Do not count clinical staff time if they are seeing the patient separately.

What kind of activities performed by physicians or QHPs can be counted towards total time?

- Preparing to see the patient (i.e.-reviewing tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

As a reminder, do not count time on separately reported services.

MGMA has released a comprehensive [E/M toolkit](#) with more information for members.

Medicare Telehealth Covered Services: 2021 Final PFS

Permanent Additions		Temporary Additions*
Visit complexity inherent to certain office/outpatient E/M services (HCPCS code G2211)	Domiciliary, rest home, or custodial care services, established patients (99336-99337)	Hospital discharge day management (99238-99239)
Prolonged services (HCPCS code G2212)	Home visits, established patient (99349-99350)	Inpatient neonatal and pediatric critical care, subsequent (99469, 99472, 99476)
Group psychotherapy (90853)	Emergency department visits, levels 1-5 (99281-99285)	Continuing neonatal intensive care services (99478-99480)
Psychological and neurobehavioral testing (96121)	Nursing facilities discharge day management (99315-99316)	Critical care services (99291-99292)
Cognitive assessment and care planning services (99483)	Psychological and neuropsychological testing (96130-96133; 96136-96139)	End-Stage Renal Disease monthly capitation payment codes (90952, 90953, 90956, 90959, 90962)
Domiciliary, rest home, or custodial care services (99334-99335)	Therapy services, physical and occupational therapy, all levels (97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)	Subsequent observation and observation discharge day management (99217; 99224-99226)
Home visits, established patient (99347-99348)		

CMS also finalized a technical refinement to its telehealth regulation to allow for the use of smartphones for telehealth visits. This does not mean that audio-only visits are allowed outside of the COVID-19 PHE. Synchronous audio and video must be used if a telehealth visit is conducted via smartphone.

***Temporary additions are covered during the public health emergency (PHE) for the COVID-19 pandemic and will remain on the list through the end of the calendar year in which the PHE ends.**

Other Medicare Coding Policy Changes: 2021 Final PFS

AUDIO-ONLY VISITS

In the final rule, CMS did not recognize 99441-43 for separate payment under PFS after conclusion of the COVID-19 public health emergency (PHE). CMS will not change their definition of "telecommunications system" to allow audio-only because they believe this longstanding regulatory definition reflects the intent of the statute.

HCPCS code G2252

- Same billing requirements as G2012.
- G2252 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion).
- wRVU of 0.50, direct PE inputs of 3 minutes of clinical labor code L037D, and 1 minute, 15 minutes, and 5 minutes of pre, intra and post service time, respectively.
- If this service originates from a related E/M service provided within the previous 7 days or leads to an E/M service or procedure within the next 24 hours or soonest available appointment it would be considered bundled into that in-person service.

Other Medicare Coding Policy Changes: 2021 Final PFS

COMMUNICATIONS-BASED TECHNOLOGY SERVICES (CBTS)

“Sometimes Therapy”

Finalized designating HCPCS codes **G2250**, **G2251**, **G2061**, **G2062**, and **G2063** as “*sometimes therapy*” services to facilitate billing of the CTBS by therapists.

Additionally, when billed by a private practice PT, OT, or SLP, the codes would need to include the corresponding GO, GP, or GN therapy modifier to signify that the CTB are furnished as therapy services furnished under an OT, PT, or SLP plan of care.

Finalized replacing G2061 – G2063 with CPT codes **98970** – **98972**.

Finalized allowing HCPCS codes **G2250** and **G2251** to be billed by certain NPPs.

Finalized allowing non-physician practitioners, such as licensed clinical social workers, clinical psychologists, PTs, OTs, and SLPs to bill HCPCS codes **G2061** through **G2063**, consistent with the definition of their respective benefit category.

Finalized to identically value HCPCS codes **G2250** and **G2251** to G2010 and G2012, respectively.

Did not propose to permanently allow billing for HCPCS codes G2020 and G2012 when furnished to new patients.

Other Medicare Coding Policy Changes: 2021 Final PFS

CPT 99072

- Finalized 99072 as a bundled service on an interim basis.
- **Definition:** *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory transmitted infectious disease.*
- Increasing on an interim basis several supply pricing increases:
 - \$0.43 for surgical mask (SB033)
 - \$3.40 for surgical mask with face shield (SB034)
 - \$2.36 for N95 mask (SD344)



Medicare Payment Landscape

Other Federal Regulations

MGMA®

Most Favored Nation Model

MEDICARE PART B DRUGS

CMS issued an interim final [rule](#) implementing a new **mandatory, nationwide** model for Medicare suppliers, including group practices. The Most Favored Nation (MFN) Model will operate for seven years, beginning on Jan. 1, 2021, and will include the following elements:

- Instead of paying providers that administer drugs based on the average sales price (ASP) in the U.S., Medicare will pay for Medicare Part B drugs based on a blended formula that includes the lowest adjusted international price (the “MFN Price”) and the ASP as well as a flat add-on amount per dose.
- The MFN Price will be phased in over the span of four years but is subject to an accelerated timeline if U.S. prices rise faster than the MFN Price and inflation.
- The MFN Model will focus on a list of 50 drugs (found in Table 2 of the rule) that encompass a high percentage of Medicare Part B spending.

The legality of the rule is currently being challenged in federal court.

Learn more about the [MFN Model](#)
and view [Supporting Documentation](#)

Stark Law Final Rule

PHYSICIAN SELF-REFERRAL

On Dec. 2, 2020, CMS finalized a [rule](#) updating the Physician Self-referral (Stark) Law. Changes under this final rule are effective Jan. 19, 2021, except for certain changes to the Stark Law group practice requirements, which will take effect on Jan. 1, 2022.

This final rule is generally organized into two parts:

1. CMS finalized three new exceptions for certain value-based compensation arrangements between or among physicians, providers, and suppliers.
2. It also includes several new rules and clarifications to existing Stark Law regulations, intended to address some of the more challenging aspects of Stark Law compliance.

The Stark Law prohibits a physician from making a referral to an entity for the furnishing of designated health services (DHS) if there is a financial relationship between the referring physician and the entity, absent an exception.

Stark Law Final Rule: Value-based Exceptions

CMS finalized three new exceptions for arrangements that facilitate value-based care delivery and payment reform. Exceptions can apply to both APM and non-APM participants, and one of the exceptions applies even if a group practice does not assume any financial risk.

New exceptions can apply to arrangements between group practices, hospitals, and other healthcare entities that have a “value-based purpose,” which means coordinating patient care, improving quality, reducing costs, or transitioning away from a volume-based FFS system.

Examples of arrangements that may be permissible under one of the new exceptions, that previously may have been impermissible, include:

- Entering into gainsharing or shared savings arrangement with a hospital;
- Providing/receiving financial or infrastructure support, such as data analytics, IT upgrades, care coordination tools
- Sharing/leasing employees, like care coordinators, behavioral health professionals, nurses

Other revisions under the final rule include updates to key terminology, such as fair market value, commercial reasonable, and taking into account volume or value of referrals. These terms are critical to meeting many of the existing exceptions to the Stark Law, such as the in-office ancillary services exception.

Group practices should consult their attorneys or compliance experts to discuss if changes impact compensation plans or existing arrangements.

View MGMA's [Memo](#) outlining key revisions to the Stark Law

MGMA AUC Toolkit

MGMA Government Affairs has developed this toolkit to assist practice leaders better understand and implement the Centers for Medicare & Medicaid Services (CMS) Appropriate Use Criteria (AUC) program.

Medicare Appropriate Use Criteria (AUC) Program

ADVANCED DIAGNOSTIC IMAGING

Legislation created the AUC program to “reduce overutilization” of advanced diagnostic imaging.

- Requires ordering professionals to consult clinical decision support (CDS) software prior to ordering image (CDS reports green, orange, or red “light” code)
- Rendering professionals to report code on claim, or face a rejection
- CMS will calculate “outlier” ordering professionals
- Up to 5% of those ordering clinicians will be required to get PA
- An “Educational and Operational Testing Period” began in January 2020 and has been extended through CY 2021
- **Full implementation begins January 1, 2022**

[Download MGMA's AUC Toolkit](#)

Key Provisions of the ONC and CMS Final Health Information Technology and Interoperability Rules

MGMA Government Affairs has developed this toolkit to assist practice leaders better understand and implement the Department of Health and Human Services HIT and Interoperability final rules.



Implementing 21st Century Cures

ONC/CMS PRIORITIES TO INCREASE INTEROPERABILITY AND REDUCE BURDEN

New Regulations that:

- Combat information blocking (**compliance deadline extended to April 5, 2021**)
- Accelerate data exchange between health information networks
- Require hospitals to supply admission, discharge, and transfer (ADT) feed to practices
- Promote open, accessible APIs-application programming interfaces (leveraging FHIR)

[Download MGMA's 21st Century Cures toolkit](#)



COVID-19 Relief

Provider Relief Fund

MGMA®

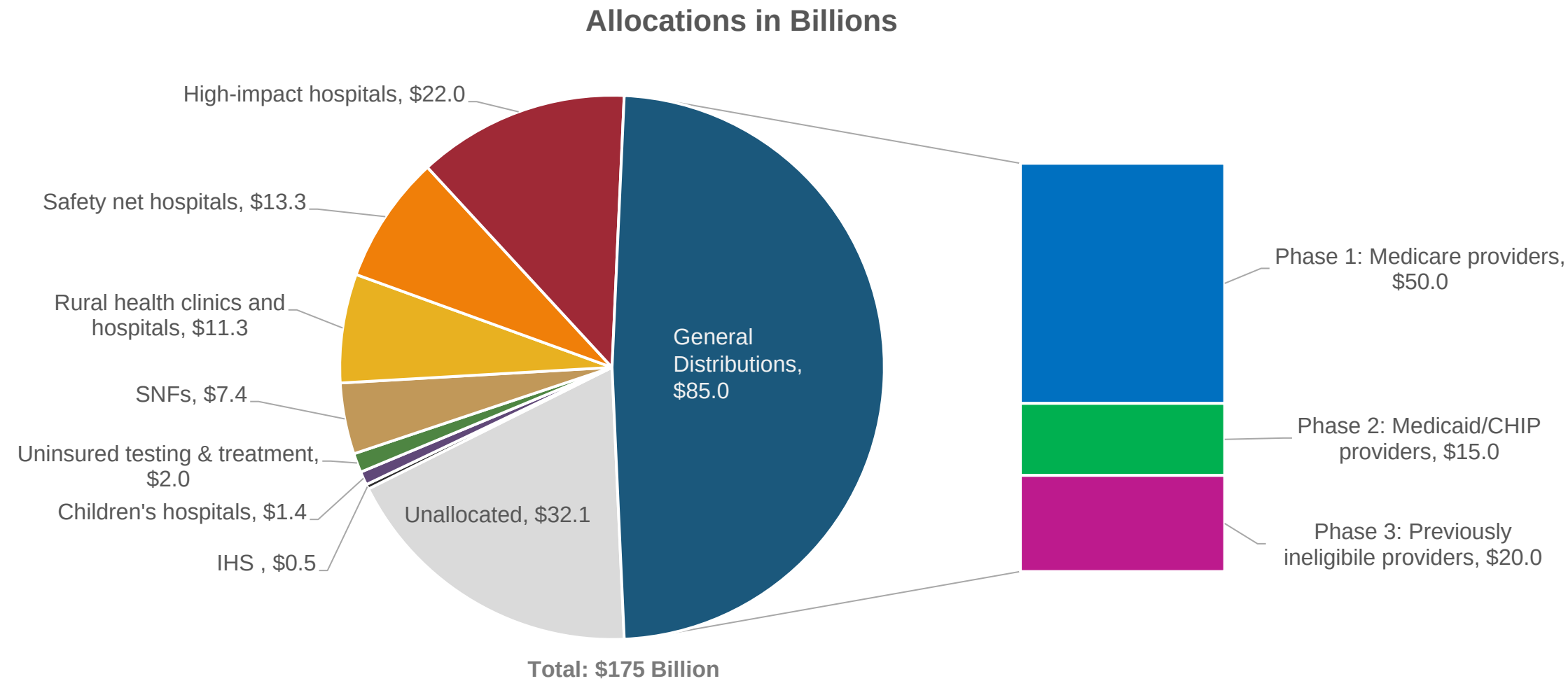
A grayscale photograph of a person's hand pointing at a computer monitor. The monitor displays a website with various sections and text. The hand is in the foreground, and the monitor is in the background.

Provider Relief Fund: Overview

- Through the CARES Act and other legislation, Congress appropriated a total of \$175 billion to the Department of Health & Human Services (HHS) to distribute to eligible healthcare providers for healthcare related expenses or lost revenues that are attributable to COVID-19 via the Provider Relief Fund (PRF).
- Payments under the PRF are grants and do not need to be paid back if a recipient complies with the program's terms and conditions (T&C).
- Since April 10, HHS has been distributing these funds in the form of both general and targeted distributions.

[Download](#) the MGMA Federal COVID-19 Financial Assistance Programs resource

Provider Relief Fund: Announced Allocations to Date



PRF: Reporting, Recordkeeping, and Auditing Requirements

Providers Receiving >\$10k

Recipients that received one or more payments exceeding \$10,000 in the aggregate from the PRF will be required to demonstrate compliance with the T&Cs, including use of funds for allowable purposes, for each PRF payment.

HHS posted a detailed list of [data elements](#) to be collected in the reporting process. The PRF reporting portal is expected to be open **Jan. 15 – Feb. 15, 2021**.

Providers Receiving >\$150k – Quarterly reports

The T&Cs for all PRF payments require recipients who receive at least \$150,000 in the aggregate from any statute primarily making appropriations for the coronavirus response to submit quarterly reports to HHS and the Pandemic Response Accountability Committee.

However, HHS clarified in an [FAQ](#) (pg. 15) that recipients of PRF payments do not need to submit a separate quarterly report at this time. HHS will develop a report containing all information necessary for recipients of PRF payments to comply with this provision and will post the names of recipients and their amounts on a [public website](#).

Providers Expending >\$750k in a year – Single audit

Due to longstanding regulations, any organization that receives federal grant funding and expends more than \$750,000 in federal dollars in any given year is required to undergo a single audit to ensure compliance with the grant's rules and regulations. Funding issued under PRF is catalogued as CFDA 93.498 Provider Relief Fund and CFDA 21.019 Coronavirus Relief Fund.

It is called a single audit because it is a standard used by all federal agencies that covers financial statements and records, expenditures and internal controls, as well as requirements specific to the grant itself. A single audit reviews a targeted funding source for allowable costs incurred within the allowable time period and proper reporting to HHS.

PRF: Resources Checklist



HHS has been rolling out guidance and making announcements through its [Provider Relief Fund](#) landing page.

- ✓ Guidance includes [FAQs](#), which have been consistently evolving since HHS began making payments to providers.



Group practices with questions should call the Provider Relief hotline at **(866) 569-3522**.

- ✓ When calling, providers should have ready the last four digits of the recipient's or applicant's Tax Identification Number (TIN), the name of the recipient or applicant as it appears on the most recent tax filing, the mailing address for the recipient or applicant as it appears on the most recent tax filing, and the application number (begins with either "DS" or "CR") if they have submitted an application in the Provider Relief Fun Payment Portal.



HHS has published a tentative [timeline](#) for reporting requirements.

- ✓ All recipients must report within 45 days of the end of calendar year 2020 on their expenditures through the period ending Dec. 31, 2020.



Within 90 days of receiving a payment, providers must sign an attestation confirming receipt of the funds and agreeing to the [conditions](#) of payment. Access the [attestation portal](#) for more information.

- ✓ Providers must submit separate attestations for each payment received.

Download the [MGMA PRF resource](#)



COVID-19 Relief

Paycheck Protection Program

MGMA®



Paycheck Protection Program: Overview

The CARES Act, passed on March 27, established the Paycheck Protection Program (PPP) to help small businesses maintain payroll and stay financially viable by accessing forgivable PPP loans.

On June 5, the Paycheck Protection Program Flexibility Act was signed into law, making critical adjustments to the program. The legislation:

- lowers the SBA's requirement that 75% of the loan be spent on payroll costs to 60% to qualify for loan forgiveness;
- extends the Covered Period to 24 weeks (up until Dec. 31, 2020);
- allows PPP borrowers to defer payroll tax payments;
- establishes a minimum maturity term of five years for the balance remaining after forgiveness; and
- provides greater flexibility for borrowers to rehire employees that would otherwise reduce the amount forgiven.
- [Download](#) the MGMA Federal COVID-19 Financial Assistance Program overview resource.

PPP: Timeline of Major Actions

Date	Description
March 27, 2020	CARES Act signed, appropriating \$349 billion for PPP
April 3, 2020	First round of PPP launches
April 16, 2020	First round of PPP ends, original \$349 billion exhausted
April 24, 2020	Paycheck Protection Program and Health Care Enhancement Act signed into law, authorizing an additional \$320 billion for PPP
April 27, 2020	Second round of PPP launches with \$320 billion in new funding
June 5, 2020	PPP Flexibility Act passed
June 30, 2020	With money remaining, Congress extends second round application period to August 8
August 8, 2020	Second PPP application period closes with nearly \$140 billion remaining in reserve
October 2, 2020	SBA begins processing loan forgiveness applications

PPP: Loan Forgiveness Guidance

The Small Business Administration released three PPP loan forgiveness applications:

1. The standard [application](#).
2. An abbreviated application called “[Form EZ](#)” for borrowers who meet at least one of three [conditions](#), and
3. A [simpler application](#) for recipients of \$50,000 or less.

The Borrower may elect a Covered Period or Alternative Payroll Covered Period that is either:

1. 24 weeks (168 days) in length, or
2. 8 weeks (56 days) in length, if the Borrower received its PPP loan before June 5, 2020.

For each individual employee, the total amount of cash compensation eligible for forgiveness may not exceed an annual salary of **\$100,000**, as prorated for the Covered Period.

- For a 24-week Covered Period, that total is **\$46,154**.
- For an 8-week Covered Period, that total is **\$15,385**.

Borrowers may be eligible for loan forgiveness if the funds were used for eligible payroll and non-payroll costs during either an 8- or 24-week covered period. Borrowers should contact their PPP lender to complete the correct forgiveness form. Borrowers must apply for forgiveness within 10 months after the last day of their covered period to avoid interest accrual. At that point, any unforgiven amount will be subject to a 1% interest rate.

Borrowers will only need to report items like tax filings, bank statements, and payment receipts as part of the loan forgiveness process. Otherwise, formal reporting on the use of funds is not required.

Download the [MGMA PPP resource](#)
Review the SBA's PPP Loan Forgiveness [FAQ](#)

PPP: Looking ahead



Congress would like to see additional changes made to the PPP, and almost every COVID relief proposal since the program's inception has included bills to further modify it. We expect to see at least some of these changes included in whichever COVID relief package ends up passing, including:

- Allow borrowers to deduct additional business expenses (including PPE and other safety equipment)
- Allow 501(c)(6) non-profits to apply for PPP loans
- Allow certain employers to apply for a second PPP loan
- Clarify that the Covered Period can be between 8 and 24 weeks in duration
- Streamline the loan forgiveness process for recipients of up to \$150k
- Expand forgivable expenses



Borrowers must apply for loan forgiveness within 10 months after the last day of the borrower's covered period. Any unforgiven amount will be subject to a 1% interest rate.

COVID-19 Relief

CMS Accelerated and Advance Payment (AAP) Program



CMS Accelerated & Advance Payment (AAP) Program

- The CARES Act amended the existing AAP Program, giving successful applicants access to upfront loans based on historic Medicare billing. While an important financial relief program, the original provisions included harsh repayment terms.
- Following MGMA advocacy urging improvements, Congress revised the repayment conditions of the AAP by:
 - ✓ Postponing the recoupment of disbursed funds until 365 days after the advance payment has been issued to a physician practice;
 - ✓ Extending the repayment timeline so that the loan balance is not due until September 2022;
 - ✓ Reducing the per-claim recoupment amount from 100 percent to 25 percent for the first 11 months and then 50 percent of claims withheld for an additional six months; and
 - ✓ Lowering the interest rate from 10.25 percent to 4 percent for loans not repaid in full by September 2022.

CMS subsequently [announced](#) that the recoupment process will begin *automatically* one year after payment was issued. The Agency plans to issue further guidance on the recoupment process at a later date.

COVID-19 Relief

Medicare Telehealth

The MGMA logo is displayed in a bold, white, sans-serif font. The letters 'M', 'G', and 'M' are connected, and the 'A' is separate. A registered trademark symbol (®) is located at the bottom right of the 'A'.

MGMA®

Medicare Telehealth During the COVID-19 PHE

CMS has implemented several new Medicare telehealth billing flexibilities for group practices during the COVID-19 public health emergency (PHE). **The PHE was [renewed](#) by Secretary Azar and is now set to expire on Thursday, Jan. 21, unless it is renewed again.** If the PHE is not renewed, the Medicare telehealth waivers authorized by the PHE will also expire on that date.

Distant site practitioner requirements relaxed
Modality flexibilities*
List of covered codes expanded**
Payment parity for telehealth and audio-only codes
HIPAA penalties waived for good-faith efforts
Frequency of services rules waived***

Geographic limitations and originating site restrictions waived
Beneficiary cost-sharing and consent flexibility from HHS OIG
Audio-only E/M codes covered (99441-3; 98966-8)
Audio-only allowed for behavioral health/education telehealth codes
Physician licensure flexibilities
Established patient requirements relaxed

*CMS finalized a technical refinement to its telehealth regulation to allow for the use of smartphones for telehealth visits. This does not mean that audio-only visits are allowed outside of the COVID-19 PHE. Synchronous audio and video must be used if a telehealth visit is conducted via smartphone.

**CMS finalized temporary additions to be covered during the public health emergency (PHE) for the COVID-19 pandemic and will remain on the list through the end of the calendar year in which the PHE ends (see slide 19).

***CMS finalized a policy to allow subsequent nursing visits to be furnished via Medicare telehealth once every 14 days in the NF setting.

Download the MGMA Commercial Health Plan COVID-19 Policies [resource](#)
Download the MGMA [resource](#) on Medicare telehealth/telemedicine waivers during the COVID-19 PHE



Congressional Agenda for 2021

MGMA®

Medicare Budget Neutrality



MGMA is advocating against Medicare cuts during COVID-19

H.R. 8702

Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020

Legislation to avoid Medicare cuts while also supporting the corresponding increases for a duration of two years.
View our support letter [here](#).

H.R. 8505

Amendment to SSA to provide for a one-year waiver of budget neutrality adjustments under the Medicare physician fee schedule

Legislation to provide a 1-year waiver to the Social Security Act's Medicare budget neutrality requirements.
View sign-on letter [here](#).

MGMA.com/CONTACTCONGRESS

Medicare Telehealth



MGMA supports important updates to Medicare telehealth post COVID-19

H.R. 8727

Telehealth Modernization Act

Legislation to extend certain flexibilities that were initially authorized during the PHE. The bill allows (1) rural health clinics and federally qualified health centers to serve as the distant site; (2) removes originating site and geographic restrictions, allowing patients to be located at home to receive telehealth services; and (3) all types of practitioners to furnish telehealth services, as determined by CMS.

H.R. 7663

Protecting Access to Post-COVID-19 Telehealth Act of 2020

Legislation to modify requirements relating to coverage of telehealth services under Medicare. The bill (1) authorizes CMS to generally waive coverage restrictions during national emergencies, (2) allows rural health clinics and federally qualified health centers to serve as the distant site, (3) removes restrictions that require the originating site to be in a rural area, and (3) allows the home of a beneficiary to serve as the originating site for all services.

Additionally, CMS must report on the utilization of telehealth services specifically during the public health emergency relating to COVID-19.

[MGMA.com/CONTACTCONGRESS](https://mgma.com/CONTACTCONGRESS)

Remainder of 2020: Future COVID Legislation?

Current government funding only extends through Dec. 11, so Congress has a dual focus on passing COVID relief legislation and funding the government.

- Democrats and Republicans have resumed negotiations on a COVID relief/stimulus package, but it is unclear whether a compromise will be reached.
- If no compromise is reached on a full COVID relief package, attention will pivot to fund the government in the form of a Continuing Resolution (CR) in order to avoid a government shutdown beginning Dec. 12.
- As with the CR passed on Sept. 30, certain COVID relief provisions could be wrapped into a bill funding the government into the new year. This would likely be the last package passed before 2021.
- New members of the 117th U.S. Congress will be sworn in on Jan. 3, 2021, and further negotiations will likely continue as early as that afternoon.

Healthcare Outlook in 2021

Regardless of the balance of power between Capitol Hill and the White House, we expect these healthcare issues will be priorities next year:

Surprise Billing

Protecting patients from high cost out-of-network care has received significant attention in Washington, despite little progress on a solution.

Drug Pricing

This was a priority with bipartisan support prior to COVID and will likely continue to demand attention.

Preexisting Conditions

Whether through the ACA or some other authority, protecting those with preexisting conditions has bipartisan support.

MGMA Advocacy and Member Engagement

MGMA[®]

MGMA Advocacy During COVID Pandemic

Advocacy Wins

- ✓ Expanded telehealth coverage
- ✓ Audio-only telehealth codes
- ✓ Automatic MIPS hardship for 2019
- ✓ Suspension of Medicare sequester until 2021
- ✓ Extension of the PHE
- ✓ Improved repayment conditions for Medicare AAP Program
- ✓ Delayed start to mandatory RO APM
- ✓ Financial relief for group practices:
 - ✓ PRF
 - ✓ PPP
 - ✓ Expansion of AAP

Outstanding Asks

- ☐ Address Medicare reimbursement cuts stemming from E/M office visit increases
- ☐ Extend telehealth flexibilities beyond expiration of PHE
- ☐ Automatic MIPS hardships for 2020, 2021
- ☐ Continue suspension of sequester
 - ☐ [Send a letter](#) to your Congressperson!
- ☐ Continue PRF distributions, address tax treatment, and clarify reporting requirements
- ☐ Amend PPP (i.e., simplify loan forgiveness, include PPE as an eligible cost, etc.)



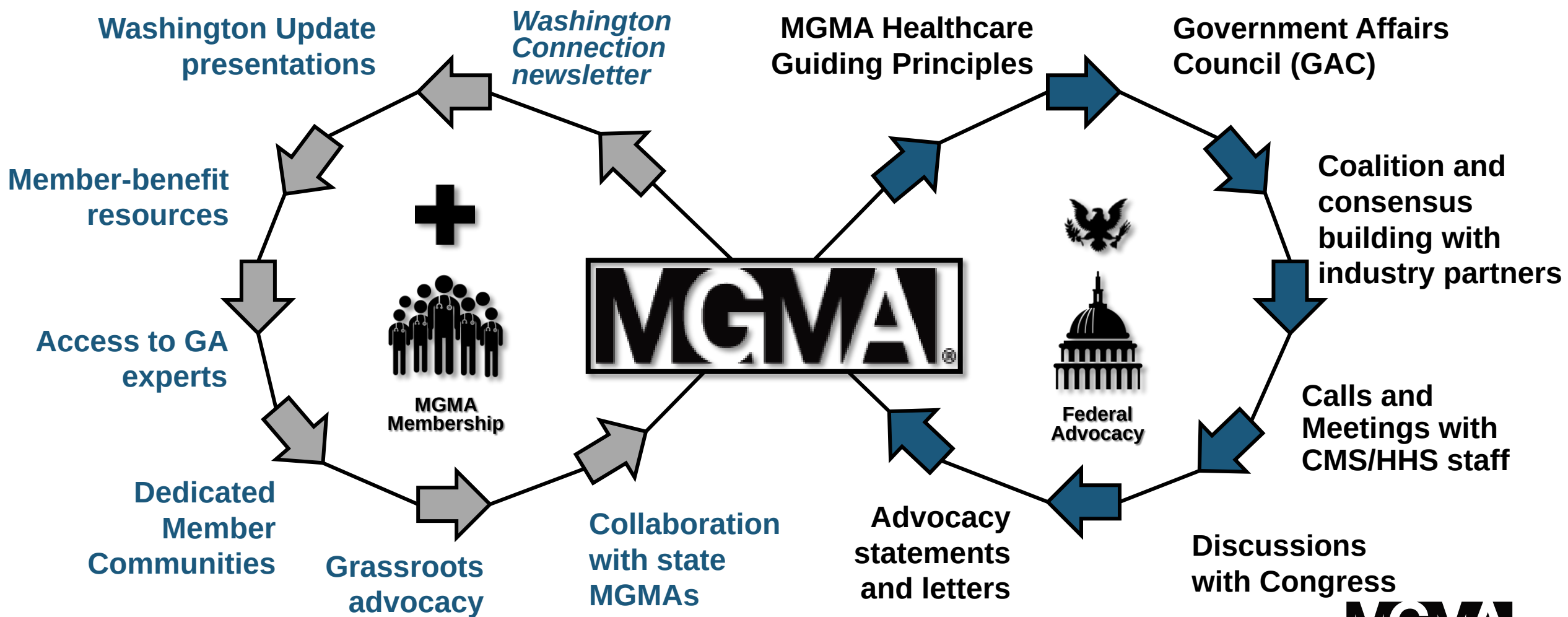
Help advocate for medical practices!

[MGMA.com/CONTACTCONGRESS](https://mgma.com/contactcongress)

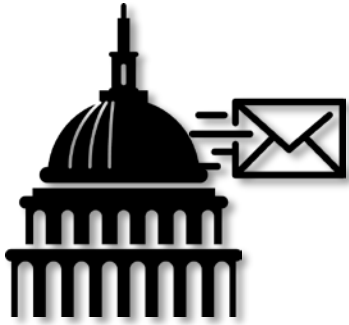


MGMA Government Affairs

ADVOCACY “FEEDBACK LOOP”



Resources from MGMA Government Affairs



Washington Connection ([link](#))

Subscribe to receive our weekly e-newsletter with breaking updates and everything you need to know from our nation's capital.



Speak directly with MGMA Government Affairs experts

We would like to hear from you!

202.293.3450 | govaff@mgma.org



Dedicated member e-groups ([link](#))

National members can discuss a wide variety of regulatory issues with 3,400 MGMA peers and MGMA Government Affairs staff on the GovChat e-group.

Your national advocacy team in Washington, DC



Anders Gilberg, MA
Senior Vice
President



Robert Tennant, MA
Health IT Policy
Director



Mollie Gelburd, JD
Associate Director



Drew Voytal, MPA
Associate Director



Claire Ernst, JD
Associate Director



Matt Devino, MPH
Associate Director



Chad Clinton, BA
Associate Director,
Public Affairs

MGMA®

Questions?

Drew Voytal, MPA

Associate Director

MGMA GOVERNMENT AFFAIRS

WASHINGTON, DC

dvoytal@mgma.org | 202.293.3450



@DrewVoytal

Matt Devino, MPH

Associate Director

MGMA GOVERNMENT AFFAIRS

WASHINGTON, DC

mdevino@mgma.org | 202.293.3450



@matt_devino

MGMA[®]

APPENDIX



MGMA®

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
ALLERGY/IMMUNOLOGY	\$247	5%	4%	0%	9%
ANESTHESIOLOGY	\$2,020	-6%	-1%	0%	-8%
AUDIOLOGIST	\$75	-4%	-2%	0%	-6%
CARDIAC SURGERY	\$266	-5%	-2%	0%	-8%
CARDIOLOGY	\$6,871	1%	0%	0%	1%
CHIROPRACTOR	\$765	-7%	-3%	0%	-10%
CLINICAL PSYCHOLOGIST	\$832	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	\$857	0%	1%	0%	1%
COLON AND RECTAL SURGERY	\$168	-4%	-1%	0%	-5%
CRITICAL CARE	\$378	-6%	-1%	0%	-7%
DERMATOLOGY	\$3,767	-1%	0%	0%	-1%
DIAGNOSTIC TESTING FACILITY	\$748	-1%	-2%	0%	-3%
EMERGENCY MEDICINE	\$3,077	-5%	-1%	0%	-6%
ENDOCRINOLOGY	\$508	10%	5%	1%	16%
FAMILY PRACTICE	\$6,020	8%	4%	0%	13%
GASTROENTEROLOGY	\$1,757	-3%	-1%	0%	-4%
GENERAL PRACTICE	\$412	5%	2%	0%	7%
GENERAL SURGERY	\$2,057	-4%	-2%	0%	-6%
GERIATRICS	\$192	1%	1%	0%	3%
HAND SURGERY	\$246	-2%	-1%	0%	-3%
HEMATOLOGY/ONCOLOGY	\$1,707	8%	5%	1%	14%
INDEPENDENT LABORATORY	\$645	-3%	-2%	0%	-5%
INFECTIOUS DISEASE	\$656	-4%	-1%	0%	-4%
INTERNAL MEDICINE	\$10,730	2%	1%	0%	4%
INTERVENTIONAL PAIN MGMT	\$936	3%	3%	0%	7%
INTERVENTIONAL RADIOLOGY	\$499	-3%	-5%	0%	-8%
MULTISPECIALTY CLINIC/OTHER PHYS	\$153	-3%	-1%	0%	-3%
NEPHROLOGY	\$2,225	4%	2%	0%	6%
NEUROLOGY	\$1,522	3%	2%	0%	6%
NEUROSURGERY	\$811	-4%	-2%	-1%	-6%
NUCLEAR MEDICINE	\$56	-5%	-3%	0%	-8%
NURSE ANES / ANES ASST	\$1,321	-9%	-1%	0%	-10%
NURSE PRACTITIONER	\$5,100	5%	3%	0%	7%
OBSTETRICS/GYNECOLOGY	\$636	4%	3%	0%	7%
OPHTHALMOLOGY	\$5,343	-4%	-2%	0%	-6%
OPTOMETRY	\$1,359	-2%	-2%	0%	-4%
ORAL/MAXILLOFACIAL SURGERY	\$79	-2%	-2%	0%	-4%
ORTHOPEDIC SURGERY	\$3,812	-3%	-1%	0%	-4%
OTHER	\$48	-3%	-2%	0%	-5%
OTOLARNGOLOGY	\$1,271	4%	3%	0%	7%
PATHOLOGY	\$1,265	-5%	-4%	0%	-9%
PEDIATRICS	\$67	4%	2%	0%	6%
PHYSICAL MEDICINE	\$1,164	-3%	0%	0%	-3%
PHYSICAL/OCCUPATIONAL THERAPY	\$4,973	-4%	-4%	0%	-9%
PHYSICIAN ASSISTANT	\$2,901	5%	2%	0%	8%
PLASTIC SURGERY	\$382	-4%	-3%	0%	-7%

CY Final 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
PODIATRY	\$2,133	-1%	0%	0%	-1%
PORTABLE X-RAY SUPPLIER	\$95	-2%	-4%	0%	-6%
PSYCHIATRY	\$1,112	4%	3%	0%	7%
PULMONARY DISEASE	\$1,654	0%	0%	0%	1%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	\$1,809	-3%	-3%	0%	-5%
RADIOLOGY	\$5,275	-6%	-4%	0%	-10%
RHEUMATOLOGY	\$548	10%	5%	1%	15%
THORACIC SURGERY	\$352	-5%	-2%	0%	-8%
UROLOGY	\$1,810	4%	4%	0%	8%
VASCULAR SURGERY	\$1,293	-2%	-4%	0%	-6%
TOTAL	\$97,008	0%	0%	0%	0%

To see a list of the proposed RVUs click [here](#).