

2020 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule Summary

On July 29th, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule for the 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP). The proposed rule covers diverse topics including Evaluation/Management (E/M) office visit services and a new participation framework in the Merit-based Incentive Payment System (MIPS). Comments are due on September 27, 2019. The AMA plans on sharing its draft comments to the federation prior to the due date.

Medicare Physician Fee Schedule

CY 2020 Conversion Factor

The proposed CY 2020 Medicare Physician Fee Schedule (PFS) conversion factor is \$36.09 (CY 2019 conversion factor was \$36.04). The conversion factor update of +0.14 percent reflects a budget neutrality adjustment for reductions in relative values for individual services in 2020. The AMA/Specialty Society RVS Update Committee's (RUC) recommendations to physician work relative values would have led to a 0.25 percent increase to the conversion factor, largely from reductions to cataract surgery. However, this amount was offset by the projected spending of \$125 million for the CMS proposed Principal Care Management services.

Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Updates

Physician Work RVU Updates

CMS has proposed to accept approximately 70% of the RUC recommendations. The RUC recommendations, voting report, and minutes are publicly available at <https://www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting>. AMA staff will work with the specialty societies to provide comments to urge that CMS will accept a greater number of these recommendations in the Final Rule.

Practice Expense RVU Updates

Updates to the direct practice expense inputs are proposed for individual codes based on recommendations from the RUC. CMS will continue to transition to updated pricing for medical supplies and equipment. Several updates are proposed for supplies and equipment based on invoices supplied by specialty societies.

Professional Liability Insurance (PLI) RVU Updates

CMS is required to update PLI premium data each five years. In 2020, CMS proposes to utilize new premium data and modify elements of the methodology. The impacts of these new data and methodology, range from +1% in payment to Emergency Medicine to -1% in payment to Neurosurgery. The RUC's PLI Workgroup will convene in August to consider this proposal and help formulate comments.

GPCI Updates

For CY 2020, CMS is conducting its statutorily required 3-year review of the GPCIs. The proposal does not include the 1.0 work GPCI floor, as the Balance Budget Act of 2018 (BBA) only extended the floor through December 31, 2019. CMS has also made available a [contractor report](#) on the 2020 GPCI update providing more detailed information than is available in the proposed rule.

E/M Office Visit Services

CMS proposes to align its E/M office visit coding changes with the framework adopted by the CPT Editorial Panel. The CPT coding changes will retain 5 levels of coding for established patients, reduce the number of levels to 4 for new patients, and revise the code definitions. A new CPT code for extended office visit time will also be implemented. The changes also revise the times and medical decision-

making process for the office visit codes. History and physical exams should continue to be performed as medically appropriate; however, these elements will no longer be a consideration for code level selection. Physicians can choose the E/M visit level based on either medical decision making or time.

CMS is also adopting the RUC recommended values, times, and practice costs for the stand-alone E/M office visits. The RUC recommendations for physician work, time, and direct practice expenses contribute to an approximate 5 percent redistribution between those physicians who routinely provide office visits and those physicians or other health care professionals who do not report office visits.

In addition to the CPT and RUC recommended changes, CMS proposes to implement a Medicare-specific add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient's single, serious, or complex chronic condition. CMS impact tables indicate that more than \$1.5 billion will be redistributed between specialties if this code is implemented.

The policy changes for the E/M office visits would be effective for services starting January 1, 2021.

CMS also seeks comments on whether it is necessary to make systematic adjustments to other services to maintain relativity between these services and E/M office visits, and whether it is necessary to make corresponding adjustments to E/M codes describing visits in other settings.

Visits Included in the Surgical Package

Although the surgical specialties participated in the RUC survey and their data were similar to other specialties, CMS proposes not to apply the office visit increases to the visits bundled into global surgery packages. Increasing the visits bundled into the surgical global packages, would increase spending by approximately \$450 million, approximately 0.5% of the Medicare conversion factor.

CMS is still in the process of gathering information on global surgery codes and does not propose modifying the values of visits into the bundled payment until it is assured that the number of visits is accurate. Physicians who work in practices with 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island are required to report using CPT 99024 on post-operative visits furnished during the global period for select procedures furnished on or after July 1, 2017. CMS encourages stakeholders to comment on the three RAND reports it released with this Proposed Rule regarding global surgery. The data RAND analyzed from the post-operative visits for the first year of reporting found that only 4 percent of procedures with 10-day global periods had any post-operative visits reported. While 71 percent of procedures with 90-day global periods had at least one associated post-operative visit, only 39 percent of the total post-operative visits expected for 90-day global procedures were reported.

Medicare Telehealth

CMS is proposing to add three new telehealth codes, which describe a bundled monthly episode of care for treatment of opioid use disorders (GYYY1, GYYY2, GYYY3). This treatment includes care coordination, individual therapy, and group therapy and counseling.

Scope of Practice

Physician Supervision Requirements for Physician Assistants (PAs)

CMS is proposing to change the current policy requiring general physician supervision for PA services to instead provide that the statutory physician supervision requirement for PA services is met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by

documentation in the medical record of the PA's approach to working with physicians in furnishing their services.

Ambulatory Surgical Centers (ASCs)

CMS proposes to allow either a physician or an anesthetist to examine the patient immediately before surgery for anesthesia risk and planned procedure risk to reduce regulatory burden. CMS also requests comments for other ASC requirements that could be revised to allow greater flexibility in the use of non-physician practitioners.

Hospice

CMS proposes to revise regulations to permit a hospice to accept drug orders from a physician as well as an NP or PA. The PA must be an individual acting within his or her state scope of practice requirements and hospice policy. Hospices may already accept drug orders from NPs. CMS also requests comments on the role of non-physician practitioners in hospice care and whether other non-physician practitioners should be considered on par with NP services.

Medical Record Documentation

CMS proposes to allow physicians, PAs, or Advanced Practice Registered Nurses (APRNs) who document and who are paid under the PFS for their professional services to review and verify (sign and date) rather than re-document notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team.

Care Management Services

Transitional Care Management (TCM)

CMS examined studies that conclude that patients who receive TCM services have lower hospital readmission rates, lower mortality, and incur lower costs. Based on these findings, CMS seeks to increase the utilization of TCM services and expand payment for care management. To incentivize additional utilization, billing requirements will be modified to allow TCM codes to be reported concurrently with other codes. CMS also proposes to increase payment for the two Transitional Care Management (TCM) codes as recommended by the RUC.

Chronic Care Management (CCM)

CMS is also proposing to adopt new add-on codes for CCM which will allow providers to bill incrementally to reflect additional time resources that are required in certain cases. CMS requests comment on whether to implement G codes for these expanded CCM codes for 2020 or wait for anticipated changes to CPT in 2021. CMS also proposes to clarify the language describing the comprehensive care plan required for CCM codes.

Principal Care Management (PCM)

CMS proposes to create two new codes for PCM services, which would pay physicians for providing care management to patients with a single serious and high-risk condition. The current CCM codes require patients to have two or more chronic conditions. As part of its rationale, CMS cites proposals submitted to the Physician-focused Payment Model Technical Advisory Committee for managing patients with one serious chronic condition. CMS estimates an additional \$125 million in annual spending for these services, offset by reductions to the Medicare conversion factor.

Remote Patient Monitoring (RPM)

CMS will implement a new CPT code to report time spent above and beyond the initial 20 minutes for evaluating patient generated health data obtained through RPM. For all RPM services, CMS proposes to change the current direct supervision requirements to general supervision which allows clinical staff to monitor patient data and interact with patients remotely. CMS also proposes to create six new non-face-

to-face codes to describe and reimburse for patient-initiated digital communications that require a clinical decision.

Opioid Use Disorder (OUD) and Opioid Treatment Programs (OTPs)

In the 2019 proposed rule, CMS sought comments on designing a new bundled payment for office-based management of patients with OUD. AMA comments were based on a [concept paper](#) jointly developed by the AMA and American Society of Addiction Medicine. In the current rule, CMS proposes new codes that would provide monthly payment for a bundled episode of care including development of a treatment plan, care coordination, individual and group therapy, and counseling for patients with OUD. The bundled payments would exclude medications approved by FDA for use in the treatment of OUD. There would be separate payments for the first month of treatment to cover induction and development of the treatment plan, payments for subsequent months of treatment (with no limit on duration of treatment), and an add-on code to cover patient circumstances that require substantial extra resources to manage.

CMS also provides an extensive and detailed proposal to implement the new Medicare Part B benefit for OTPs that was established by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT) for Patients and Communities Act including definitions of terms such as OUD and OTP, a methodology for determining Medicare payment for services and drugs provided by OTPs, and Medicare enrollment requirements for OTPs. The SUPPORT Act provides for payments to OTPs accredited by the Substance Abuse and Mental Health Services Administration to cover: medications used in the treatment of OUD, including oral, injected, and implanted buprenorphine, methadone, and naltrexone; medication dispensing and administration; counseling; individual and group therapy; toxicology testing; and other services deemed appropriate. While the new payments for office-based OUD treatment would be monthly, the OTP services would be defined on a weekly basis.

Open Payments

CMS is expanding the definition of “covered recipient” under Open Payments as required by the SUPPORT Act to include PAs, NPs, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives beginning January 1, 2022. CMS is also modifying payment categories to include debt forgiveness, long-term medical supply or device loan and acquisitions. CMS is proposing to require applicable manufacturers and group purchasing organizations to provide the device identifiers to identify reported devices.

Medicare Shared Savings Program (MSSP)

CMS is seeking comments on how to align the MSSP quality performance scoring methodology with proposed changes to the Web Interface measure set under MIPS and aligning the Shared Savings Program quality score with the MIPS quality score. Specifically, CMS seeks comment on replacing the Shared Savings Program quality score with the MIPS quality performance category score for ACOs in Shared Savings Program tracks that do not qualify as Advanced APMs. CMS is also seeking feedback on how to determine whether the ACO has met the minimum attainment level and how to utilize the MIPS quality performance category score to adjust shared savings and shared losses under the Shared Savings Program. CMS notes that one option is to no longer transition from pay-for-reporting to pay-for-performance during an ACO’s first agreement period.

Coinsurance for Colorectal Cancer Screening Tests

CMS has interpreted 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) of the Social Security Act to require that if during the course of a colorectal screening service that began as a screening service, but during which a polyp or other growth is found, it must be excluded from the definition of colorectal cancer screening. Instead, it is classified as a colonoscopy with such biopsy or removal. CMS notes that they repeatedly hear that beneficiaries, physicians, and members of Congress expressing surprise that a coinsurance

applies when they expected to receive a colorectal screening with no coinsurance and instead received what Medicare considers to be a diagnostic procedure. CMS seeks comments in this rule regarding whether it should require physicians and their staff to provide verbal notice with a notation in the record or a different approach to inform patients of the copay implications.

Opportunities for Bundled Payments under the PFS

CMS is requesting information on opportunities to expand the concept of bundling to improve payment for services under the PFS. Specifically, CMS seeks to explore options for establishing PFS payment rates or adjustments for services that are furnished together. CMS notes options could include a per-beneficiary payment for multiple services or condition-specific episodes of care. CMS specifically notes that it believes the statute, while requiring CMS to pay for physicians' services based on the relative resources involved in furnishing the service, allows considerable flexibility for developing payments under the PFS.

Advisory Opinions on Application of Physician Self-Referral Law (Stark)

CMS is proposing to add reasons that CMS will not accept a Stark advisory opinion request or issue an advisory opinion. CMS is also proposing to ease the restriction that prohibits the acceptance of an advisory opinion if CMS is aware of pending or past investigations involving a course of action that is "substantially the same" and instead allow CMS more discretion to determine, in consultation with OIG and DOJ, whether acceptance of the advisory opinion request is appropriate. CMS is proposing to establish a 60-day timeframe for issuing advisory opinions and proposing a \$220 hourly fee to prepare an advisory opinion. CMS is also proposing that it will not pursue sanctions against any individuals or entities (including non-requesting ones) that are parties to an arrangement that CMS determines is indistinguishable from an arrangement that was the subject of a favorable advisory opinion.

Quality Payment Program

MIPS Value Pathways (MVPs)

CMS outlines a new MIPS participation framework that would begin with the 2021 performance year. CMS describes the framework as incorporating a foundation that leverages promoting interoperability measures and a set of administrative claims-based quality measures that focus on population health priorities, which would limit the number of required specialty or condition specific measures physicians are required to report. The MVP framework would also provide enhanced data and feedback to clinicians.

CMS proposes that the MVP framework would include the following:

- Assigning available MVPs to clinicians and groups based on factors such as specialty designation or place of service;
- A base measure set of population health measures which would be included in virtually all the MVPs;
- A unified, smaller set of measures and activities around a clinical condition or specialty;
- Connecting measures and activities from the quality, cost, and improvement activities performance categories;
- Requiring completion of the promoting interoperability performance category;
- Providing timely quality and cost performance data feedback using administrative claims, registry, and electronically submitted data to enhance a clinician self-tracking to facilitate care improvement; and
- Enhancing information available to patients to inform decision making, including increasing patient-reported measures in MVPs.

CMS includes a request for information – Transforming MIPS: MIPS Value Pathways Request for Information – and a diagram and two examples explaining CMS' view on the future of MIPS. CMS seeks

comments on the development and structure of MVP generally. CMS provides a number of specific questions including:

- What should be the structure and focus of the Pathways?
- What criteria should we use to select measures and activities?
- What policies are needed for small and multi-specialty practices?
- Should there be a choice of measures and activities within Pathways?
- How should information be reported to patients?
- Should CMS move toward reporting at the individual clinician level?
- How to select measures for MVP?

The MVP framework would move away from the fragmented reporting rules of the current MIPS program toward an approach focused on clinical episodes of care, which the AMA and the medical community have discussed with CMS.

Performance Threshold

CMS proposes to increase the performance threshold from 30 points to 45 points in 2020 and 60 points in 2021. CMS also proposes to increase the exceptional performance threshold from 70 to 80 points in 2020 and to 85 points in 2021. CMS also provides estimates for future performance thresholds, when current law requires that they be set based on mean or median performance in previous years. It estimates that the performance threshold for 2022 will be 74.01 points, which was the mean score in 2017.

Performance Category Weights

CMS proposes to reduce the Quality performance category weight to 40 percent of the final MIPS score in 2020, 35 percent in 2021, and 30 percent in 2022. CMS also proposes to increase the Cost performance category weights by the same percentages – 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022.

Quality Performance Category

- CMS proposes to decrease the quality performance category weight to 40 percent in 2020 performance year.
- CMS proposes to add new specialty sets including Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition and Endocrinology.
- CMS is seeking comment on simplifying MIPS by implementing a core measure set using administrative claims-based measures that can be broadly applied to communities or populations and development measure set tracks around specialty areas or public health conditions.
- CMS proposes to increase the data completeness threshold to 70 percent.
- CMS proposes to remove measures that do not meet the case minimum or volumes required for benchmarking for two consecutive years.
- CMS proposes to modify the quality benchmark methodology to some of the outcome and high priority measures due to concern that meeting the benchmark under the existing methodology could result in inappropriate treatment.
- CMS proposes to eliminate 21 percent of the existing quality measures.

Qualified Clinical Data Registry (QCDR) Requirements

CMS is proposing to increase the QCDR measure standards for MIPS to require measure testing, harmonization and clinician feedback to improve the quality of QCDR measures available for reporting.

Beginning in 2021, QCDRs and Qualified Registries would be required to submit data for quality, improvement activities and promoting interoperability performance categories. Also beginning in 2021, CMS proposes that all QCDRs and Qualified Registries would be required to provide physicians feedback

on how participants compare to other providers within the QCDR or Qualified Registry who submitted data on the same measures. In addition, QCDRs would have to license their measures to other QCDRs and have measure testing completed at the time they submit their application to CMS.

Cost Performance Category

- CMS proposes to increase the cost category weight to 20 percent in performance year 2020.
- CMS would add 10 new episode-based measures.
- CMS proposes to revise the current Medicare Spending Per Beneficiary and Total Per Capita Cost measures.

Improvement Activities Performance Category

- CMS proposes to increase the participation threshold from a single clinician to 50 percent of the clinicians in the practice and require that at least 50 percent of a group's providers must perform the same activity for the same continuous 90 days.

Promoting Interoperability Performance Category

- As with the IPPS proposed rule, CMS is removing the Verify Opioid Treatment Agreement Measure and Query of PDMP measure would be optional for 2020. CMS is also eliminating the numerator and denominator for the Query of PDMP measure in 2019 and only requiring a yes or no attestation.
- Similar to the IPPS proposed rule, CMS is requesting feedback on several key areas including:
 - Potential opioid measures for future inclusion in the PI category;
 - Development of measures based on existing NQF and CDC efforts that measure the clinical and process improvements related to the opioid epidemic;
 - A metric to improve efficiency of providers within EHRs;
 - Activities that promote the safety of the EHR;
 - Issues related to standards-based API criterion in ONC's 21st Century Cures Act proposed rule with the goal of establishing an alternative measure under the Provider to Patient Exchange that would require providers to give patients their complete data contained within an EHR; and
 - Integration of patient-generated health data into EHRs using CEHRT.

MIPS Participation and Projected Incentive Payments

Table 113 of the proposed rule provides estimates of the number of clinicians who will be eligible to participate in MIPS during 2020, the number who will be excluded from MIPS by the low-volume threshold, and the number that could potentially be MIPS eligible or could be below the low-volume threshold but eligible to opt-in to MIPS on a voluntary basis. About 220,000 clinicians would be required to participate in MIPS based on individually exceeding the low-volume threshold and about 566,000 are MIPS eligible because their group exceeds the low-volume threshold. About 280,000 clinicians are excluded from MIPS eligibility due to either being below the low-volume threshold, new to Medicare, or being a type of health professional that cannot participate in MIPS. An additional approximately 386,000 clinicians could potentially be MIPS eligible but do not have a clear requirement to do so at this time.

MIPS penalties and incentive payments increase to a maximum of 9% in 2022, which is tied to the 2020 performance year. Based on its proposals, CMS estimates 87% of eligible clinicians who submit data will be eligible for a neutral payment adjustment or incentive payment of up to 1.82% and 53% will be eligible for an additional bonus for exceptional performance of up to 3.95%. CMS projects the maximum MIPS incentive payment would be 5.78%.

APM Proposals

CMS proposes certain changes to the way Other Payer APMs must be structured in order for physicians participating in a mix of Medicare APMs and Other Payer APMs to be eligible for the 5 percent incentive payments for Qualified APM Participants (QP). These proposals include establishing a new definition of Aligned Other Payer Medical Home models, consistent with the existing financial risk requirements for Medicaid medical homes, and modifying the marginal financial risk requirements for Other Payer APMs. The NPRM also includes an estimate that between 175,000 and 225,000 clinicians will achieve QP status during the 2020 APM participation period.