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Special Bulletin

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CMS Releases CY 2020 Proposed Rule for Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) July 29 issued a proposed rule that would update physician fee schedule (PFS) payments for calendar year (CY) 2020. The rule also included several proposals to implement year four of the quality payment program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

AHA Take: The AHA is closely evaluating CMS's proposals. We are pleased that the agency proposed a new approach to paying for and documenting evaluation and management (E/M) visits, rather than the problematic policy finalized last year. We also appreciate CMS's proposal to establish a bundled payment and a Part B benefit for the treatment of opioid use disorder (OUD) to better account for the need for a multifaceted approach to care management for patients with substance use disorders (SUDs). We will further analyze this proposal to determine if the specific provisions will sufficiently support providers treating OUD and SUDs.

The AHA also is closely evaluating CMS's proposal to create Merit-based Incentive Payment System (MIPS) "Value Pathways" to determine whether they achieve the goals of reduced burden and fair evaluation. However, we are concerned by its proposal to increase the weight of the MIPS cost category and to add additional problematic cost measures.

CMS will accept comments on this rule through Sept. 27. Highlights of the PFS proposed rule follow. Watch for a detailed Regulatory Advisory in the coming weeks.

Key Takeaways

CMS proposes to:

- Update the PFS conversion factor by 0.14% for CY 2020.
- Set separate payment rates for all levels of E/M visits rather than using the blending payment rate for certain levels that was finalized last year.
- Increase existing payment or introduce new payment for certain care management services and simplify billing requirements for these services.
- Allow physicians and certain nonphysician practitioners to review and verify, rather than re-document, notes made in the medical record by other members of the medical team.
- Increase the weight on MIPS cost measures.
- Increase performance standards for earning positive payment adjustments under MIPS.
- Introduce a new "MIPS Value Pathways" framework intended to streamline and align MIPS reporting requirements.
- Implement the new, statutorily required Part B benefit for OUD treatment in opioid treatment programs.
- Establish bundled payments for treatment of OUD, including eligible telehealth codes.
- Revise several elements of CMS's advisory opinions on compliance with the Stark law.

CY 2019 Proposed Payment Update

CMS proposes a total increase in payment rates of 0.14% in CY 2020. This reflects the zero percent update factor as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), in addition to a budget neutrality adjustment. These adjustments result in an estimated conversion factor of $36.0896 for CY 2020, a nominal increase from the CY 2019 conversion factor of $36.0391.

Payment for Evaluation and Management (E/M) Visits

In the CY 2019 PFS rule, CMS finalized several changes to documentation of and payment for E/M visits, many of which were scheduled to go into effect on Jan. 1, 2021. However, the agency continued to receive significant feedback on these changes, including from the "Joint AMA CPT Workgroup on E/M," which was developed to create an alternative solution to CMS's policy. In this rule, CMS proposes to adopt the workgroup's policy, which was also adopted by the CPT Editorial Panel.

Among others changes, this approach would include the following changes:

- Rather than paying a blended rate for Levels 2 through 4 E/M visits as finalized last year, CMS proposes to assign separate payments to all E/M visit levels for new and established payments. As part of this proposal, CMS would do away with the requirement it finalized last year for providers to meet only those documentation requirements currently associated with a Level 2 E/M visit.

- Instead of using the history and exam elements of E/M visits traditionally used to select the appropriate E/M level, CMS proposes to require histories and exams only when medically necessary and instead have clinicians use medical decision making (MDM) or time with the patient to determine the appropriate level of E/M visit.

- As a corollary, because the only difference between Level 1 and Level 2 visits for new patients are related to the history and exam elements, CMS proposes to eliminate Level 1 for new patients. This would result in four visit levels for new patients (Levels 2 through 5) and five levels for established patients (Levels 1 through 5).

- CMS also proposes to adopt the new code descriptors, prefatory language and interpretive guidance framework developed by the AMA CPT Workgroup. Part of this language includes changes in the description of time for certain levels of E/M visits and thus, CMS proposes to delete the add-on code it finalized last year for extended visits and replace it with a new CPT add-on code for prolonged office/outpatient E/M visits.

- Finally, CMS proposes to consolidate into a single HCPCS code the two add-on codes it adopted in the CY 2019 PFS rule for visit complexity associated with

certain primary care and specialty care visits. CMS proposes to increase the valuation of this consolidated code above what each add-on code would have been paid and to allow it to be billed with any level of E/M visit.

CMS also proposes to adopt the AMA RUC-recommended valuations for all E/M codes and the proposed prolonged services add-on code (subject to a minor exception), which would increase payment for the codes above the payment amount that would have resulted from the blended rate, had it gone into effect.

Payment for Care Management Services

CMS proposes several changes related to care management services, including:

- Removing the restriction on 14 HCPCS codes that prohibits providers from billing them concurrently with transitional care management (TCM) services and increasing the payment amounts for TCM codes;

- Adopting new G codes to identify additional time increments for noncomplex chronic care management (CCM) services;

- Replace the current CPT codes for complex CCM services with new codes that would remove certain elements of the billing requirements and clarify what must be included in the "typical care plan" required to bill for complex CCM services; and

- Introduce new coding and payment for "principal care management" (PCM) services, which would describe care management services for a single serious, chronic condition.

Review and Verification of Medical Record Documentation

Among other documentation changes finalized in the CY 2019 PFS rule, CMS finalized a requirement that medical records need only document a teaching physician's presence during the time the service was furnished, not that the information must be documented by the teaching physician him or herself. Through transmittals issued in 2018, CMS further eased burdens on teaching physicians by allowing them to review and verify (i.e., sign and date) notes made by a student in a patient's medical record for E/M services, rather than having to re-document the information.

In this rule, CMS proposes to extend these flexibilities to other practitioners. Specifically, CMS proposes to allow physicians, physician assistants and advance practice registered nurses (included nurse practitioners, clinical nurse specialists and certified nurse-midwives) who furnish and bill for their professional services to verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team.

QUALITY PAYMENT PROGRAM (QPP)

As mandated by MACRA, the QPP includes two tracks – the default MIPS and advanced alternative payment models (APMs). The rule proposes updates to what eligible clinicians must report during the QPP's 2020 performance period and beyond. There is a lag of two years between the QPP's performance period and the payment year; for example, CY 2020 performance will affect PFS payments in CY 2022.

MIPS Policy Updates. As required by MACRA, eligible clinicians will receive positive or negative payment adjustments of up to 9% in CY 2022 based on CY 2020 performance. This is the maximum adjustment allowed under the MACRA. Key proposed MIPS policy changes include the following:

- **Quality Category.** Currently weighted at 45% of the MIPS final score, CMS proposes to lower the weight of the quality category by 5% each year starting with the CY 2020 performance period until it reaches the statutorily mandated 30% in CY 2022. CMS also proposes to increase data completeness requirements for submitted quality data.

- **Cost Category.** Currently weighted at 15% of the MIPS final score, CMS proposes to increase the weight of the cost category by 5% each year starting with the CY 2020 performance period until it reaches the statutorily mandated 30% in CY 2022. CMS also proposes to add 10 new condition and treatment-specific episode-based cost measures, and to modify the methodology used to calculate the two overall cost measures (Medicare spending per beneficiary and total cost per capita).

- **Promoting Interoperability.** CMS proposes changes to the category's measures that parallel the changes it recently proposed for the hospital Promoting Interoperability Program. This includes removing the verification of opioid treatment agreement measure, and retaining the query of prescription drug monitoring programs (PDMPs) as an optional measure with a simplified "yes/no" response.

- **MIPS Final Score Thresholds.** Eligible clinicians receive scores of between 0 and 100 points based on their performance across all four MIPS categories. CMS proposes to increase the MIPS performance threshold (i.e., the minimum score to avoid negative payment adjustments) from the current 30 points to 45 points for CY 2020 and 60 points for CY 2021. The exceptional performance threshold (i.e., the minimum score to receive exceptional performance bonuses) would be raised to 80 points in CY 2020 and 85 points in CY 2021.

MIPS Value Pathways (MVPs). For CY 2021, CMS proposes to begin implementing MVPs that it believes would align and reduce reporting requirements across the four MIPS performance categories. The rule does not propose any specific MVPs, but proposes a general framework, provides some examples and includes a request for information on how CMS could structure MVPs in future rulemaking. Built over time, the

MVPs would organize the reporting requirements for each MIPS category around specific specialties (e.g., ophthalmology), treatments (e.g., major surgery) or other priorities (e.g. preventive health). CMS envisions that MVPs would eventually replace the current structure of the MIPS program, and that clinicians/groups would choose – or be assigned to – a particular MVP. CMS indicates it would reduce reporting burden for those participating in MVPs by using a smaller number of quality and cost measures, and is exploring mechanisms of enhancing its mechanisms of sharing data with providers.

Advanced APM Changes. MACRA provides incentives for clinicians who participate in advanced APMs, including a bonus payment of 5% of payments for professional services in 2019 through 2024 and exemption from MIPS reporting requirements. Among other updates, CMS proposes to include "aligned other payer medical home models" in its definition of medical homes that qualify as advanced APMs. CMS would apply its existing financial risk and nominal amount standards to the other payer medical homes.

MEDICARE SHARED SAVINGS PROGRAM (MSSP) QUALITY MEASUREMENT

To support its previously finalized policy of aligning the MSSP's quality measure set with the MIPS web interface reporting option, CMS proposes to remove one MSSP quality measure (ACO 14 – Preventive Care and Screening Influenza Vaccination) and to add another (ACO 47 – Adult Immunization Status). CMS also solicits input on whether and how to align the MSSP quality scoring approach with the MIPS quality category.

MEDICARE PAYMENTS FOR OPIOID USE DISORDER (OUD) TREATMENT

Section 2005 of the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 established a new Part B benefit category for OUD treatment and services furnished by an opioid treatment program (OTP) beginning on or after Jan. 1, 2020. OTPs are healthcare entities that focus on providing medication-assisted therapy, including methadone, for people diagnosed with OUD, and were not previously able to receive payment from Medicare. In this rule, CMS proposes several regulations to govern Medicare coverage of and payment for OUD treatment services furnished in OTPs, including definitions and details regarding:

- What services and medications are covered;
- Requirements an OTP must meet to be eligible for Medicare payment, including enrollment in the Medicare program;
- The methodology for determining Medicare payments for the drug and non-drug components of the bundled payment, including the duration of the bundle, the requirements for an episode and adjustments for additional therapy services;
- Appropriate sites of service and use of telemedicine;
- A coding structure that varies by the medication administered; and
- Payment rates.

In addition to defining this new Part B benefit for OUD treatment services furnished in OTPs, CMS also proposes to establish bundled payments for the overall treatment of OUD, including management, care coordination, psychotherapy, and counseling activities. Unlike the Part B benefit, this bundled payment would not include payment for the medication itself and would apply to other physicians and health professionals not providing services in an OTP. To implement this bundled payment, CMS would create two HCPCS G-codes to describe monthly bundles of services for office-based OUD treatment and an add-on code to address additional resources for a patient that substantially exceeds the resources included in the base codes. CMS proposes to add the face-to-face portions of the services described by these three codes to the list of telehealth services eligible for Medicare payments for CY 2020. CMS would not create corresponding codes for rural health clinics and federally qualified health centers.

Advisory Opinions on Application of Physician Self-referral Law

In connection with the Request for Information on reforming the physician self-referral ("Stark") law that CMS issued on June 25, 2018, CMS proposes several changes to the advisory opinion process it uses to opine on whether a referral related to a designated health service is prohibited under Stark. The proposals cover several aspects of CMS's advisory opinions, including the connection between CMS's advisory opinions and those that the Office of the Inspector General issues regarding arrangements that could violate the Anti-Kickback Statute, CMS's discretion to respond to a request for an opinion if the agency is aware of related pending or past investigations, the time frame by which CMS must respond to requests, and who can rely on the opinions aside from the requestors.

Ground Ambulance Data Collection System

The Bipartisan Budget Act of 2018 required CMS to develop a data collection system with respect to ground ambulance providers and suppliers. As such, the agency proposes a specific data collection format and elements, a sampling methodology that it would use to identify ground ambulance organizations for reporting each year through 2024 and not less than every three years after 2024, and reporting timeframes. CMS also is proposing to reduce by 10% the payments that would otherwise be made to a ground ambulance organization that fails to sufficiently submit data, as well as a process under which a ground ambulance organization can request a hardship exemption.

Next Steps

Watch for a more detailed Regulatory Advisory in the coming weeks. Comments on the proposed rule are due to CMS on or before Sept. 27. If you have further questions on the payment provisions, please contact Shira Hollander, senior associate director of policy, at shollander@aha.org; for questions on quality provisions, please contact Akin Demehin, director of policy, at ademehin@aha.org.