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Medicare Physician Fee Schedule CY 2020

OVERVIEW

On July 29th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update the Physician Fee Schedule (PFS) and implement other Medicare policy, payment, and quality changes for CY 2020. Proposed changes below impact numerous areas of Medicare reimbursement and reporting, including telehealth, opioid treatment services, technology standards and quality measures.

The PFS sets physician payment rates by establishing relative value units (RVUs) and converting them into rates through a conversion factor. The rule proposes a 2020 PFS conversion factor of $36.09, which is an increase of $0.05 from the 2019 PFS conversion factor. Variation in RVU adjustments by specialty for 2020 range from -4% to +3%, with Ophthalmology receiving the greatest reduction, and Clinical Psychology and Clinical Social Worker specialties receiving the largest increases.

CMS will accept comments on the rule until September 27th. The proposed rule is available here.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

CMS is proposing to increase the MIPS performance threshold to 45 points (maximum is 100), increase the threshold for exceptional performance to 80 points, reduce the Quality performance category weight to 40%, and increase the Cost performance category weight to 20% in 2020. Between 2022 to 2024 MIPS Payment Years, the Quality performance category weight would further decrease to 30%, and the Cost performance category would increase to 30%. Improvement Activities and Promoting Interoperability performance categories will not be adjusted. Failing to meet the performance threshold will result in a 9% negative payment adjustment by 2022.

CMS is seeking to simply MIPS for physicians, use it to empower patients, better align MIPS with the Shared Savings Program, and create a stronger path from MIPS to Advanced Alternative Payment Models (Advanced APMs). As part of its efforts to meet these objectives, in 2021 CMS will introduce the MIPS Value Pathways (MVPs) program, a new framework that will allow clinicians to report on a set of 106 specialty-specific, outcome-based measures beginning in the 2021 performance year. The MVP program would allow physicians to report on a smaller number of measures that are more closely aligned with their core scope of practice, and also require greater measure standardization within specialties. The measures would emphasize capabilities that prepare clinicians to successfully transition to Advanced APM models, including quality and cost performance tracking, performance improvement processes, and interoperability and data sharing.

CMS is also seeking input through a request for information on the following MIPS program components: (1) Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category, (2) NQF and CDC Opioid Quality Measures, (3) a Metric to Improve Efficiency of Providers within EHRs, (4) the Provider to Patient Exchange Objective, (5) Integration of Patient Generated Health Data into EHRs Using CEHRT, and (6) Engaging in Activities that Promote the Safety of the EHR.

MEDICARE SHARED SAVINGS PROGRAM

CMS is soliciting comments on how to align the Shared Savings Program quality reporting requirements and scoring methodology more closely with the MIPS quality reporting requirements and scoring methodology, including the new MVP program model.

CMS is proposing a number of changes to the claims-based measures under the Medicare Shared Savings Program. In the 2020 performance year, the Shared Savings quality measure set will align with the MIPS Web Interface measure set. Under the proposed rule, accountable care organizations (ACOs) would no longer be required to report on ACO-14: Preventative Care and Screening Influenza Immunization. Instead, ACOs would be required to report on ACO-47: Adult Immunization Status.

ADVANCED APMS

CMS estimates that 175,000-225,000 clinicians will become Qualifying APM participants eligible for the 5% advanced APM payment bonus in 2022, receiving $500-$600 million in incentive payments in addition to any shared savings received. The Pathways to Success ACO model and the Direct Contracting model are expected to drive much of the growth in Advanced APMs in future years.

Other Payer Advanced APMs

To further support the ability of providers to achieve Advanced APM status by including value-based payment arrangements from non-Medicare payers, CMS is proposing that other payer Medical Homes arrangements count towards Other Payer Advanced APMs if they meet the conditions of an Aligned Other Payer Medical Home. CMS is also proposing to calculate average marginal risk in Other Payer risk contracts based on a formula considering the marginal risk at each defined deviation from the benchmark.

MEDICAID PROMOTING INTEROPERABILITY PROGRAM

CMS is proposing that Medicaid eligible professionals (EPs) participating in the Medicaid Promoting Interoperability program who have demonstrated meaningful use in a prior year would report any six relevant electronic clinical quality measures (eCQMs) that are relevant to their scope of practice during any continuous 274-day period in 2020 and on at least one outcome measure. CMS is also proposing to require that states provide sufficient time for EPs to attest from program year 2020 beyond January 1st, 2021 in order for EPs to select electronic health record (EHR) and eCQM reporting periods that take place through December 31st, 2020. This would ultimately allow states to accept attestations for program year 2020 as early as October 1st, 2020. CMS is also proposing to allow Medicaid EPs to conduct a security risk analysis at any time during 2021, even if the analysis occurs after EPs attest to the state meaningful use of Certified EHR Technology (CEHRT).

OPEN PAYMENTS

CMS is proposing to revise the Open Payments regulations governing certain financial relationships between providers and the pharmaceutical and device industries. The changes would apply to data collected in 2021 and reported in 2022.

The proposed rule expands the definition of a covered recipient to align with the SUPPORT Act, expands the nature of payment categories, and standardizes data on reported covered drugs, devices, biologicals, or medical supplies. The proposed rule includes nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwifes in the definition of a covered recipient. CMS is also proposing to make a correction to the national drug codes

(NDCs) reporting requirements for drugs and biologicals to specify that they include both research and non-research payments.

OPIOID USE DISORDER TREATMENT SERVICES AND PAYMENTS

MEDICARE CONVERAGE FOR OUD TREATMENT FURNISHED BY OTPs

CMS is establishing definitions of opioid use disorder (OUD) treatment services and opioid treatment programs (OTPs), and proposing bundled payments for OUD treatment services. The rule would set copayment amounts for these services to zero. CMS is defining an episode of care for OUD treatment services as one contiguous 7-day period, and proposing that when an enrollee has received 51% of the services defined in a treatment plan over the course of that period, the OTP may bill for the full bundle. When an enrollee has received less than 51% of defined services, but at least one item, the OTP may bill for a partial weekly bundle.

Each bundle would be comprised of a drug component and a non-drug component. The drug component would be codified for opioid agonists and antagonists including Methadone (oral), Buprenorphine (oral), Buprenorphine (injection), Buprenorphine (implant), Naltrexone (injection), and a sixth category for new treatments that the Food and Drug Administration (FDA) may approve of in the future. The non-drug component would include substance use counseling, individual and group therapy, and toxicology testing. CMS is proposing a geographic locality adjustment to the bundled payment rate for these services.

BUNDLED PAYMENTS AND TELEHEALTH SERVICES FOR OUD

CMS is proposing to establish Part B bundled payments for overall management, care coordination, individual and group psychotherapy and counseling for office-based OUD treatment. CMS proposes to create three Healthcare Common Procedure Coding System (HCPCS) G-codes to describe these services. The proposed codes are:

- HCPCS code GYYY1: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- HCPCS code GYYY2: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- HCPCS code GYYY3: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure)

For HCPCS codes GYYY1 and GYYY2, CMS is assuming two individual psychotherapy sessions per month and four group psychotherapy sessions per month. The add-on HCPCS code GYYY3 can be billed when the total time spent by the billing professional and the clinical staff providing the OUD treatment services exceeds double the minimum amount of service time required to bill the base code for the month. CMS is proposing that the counseling, therapy, and care coordination described in the proposed OUD treatment codes could be provided by qualified professionals “incident to” the services of the billing physician or other practitioner, as consistent with state law. The codes are considered care management codes allowing general supervision of non-face-to-face services, and beneficiary consent to receive these services must be documented, since cost-sharing through the deductible and coinsurance remains.

CMS is proposing to allow any of the individual therapy, group therapy and counseling services included in HCPCS codes GYYY1, GYYY2, and GYYY3 to be provided via telehealth, as clinically appropriate, without geographic restrictions. Care management services may also be provided via telehealth. Billing and payment for medications under Medicare Part B or Part D would remain unchanged. If a patient's treatment involves medication-assisted treatment (MAT), the proposed bundle would not include payment for the medication itself. Additionally, payment for toxicology testing would not be included in the proposed OUD bundle, and would continue to be billed separately under the Clinical Lab Fee Schedule.

Some beneficiaries with OUD have comorbidities and may require medically-necessary psychotherapy services for other behavioral health conditions. CMS is proposing that, when furnished to treat OUD, CPT codes 90832, 90834, 90837, and 90853 may not be reported by the same practitioner for the same beneficiary in the same month as HCPCS codes GYYY1, GYYY2, and GYYY3.

CMS is proposing to expand the OUD treatment services that can be furnished by OTPs and seeking comment on any additional services that should be considered. Additionally, CMS is seeking comment broadly on opportunities to expand the concept of bundling to recognize efficiencies among physicians' services paid under the PFS and better align Medicare payment policies with CMS's broader goals.

CODING CHANGES

EVALUATION AND MANAGEMENT (E/M) SERVICES

The rule proposes to retain the current 5 levels of Evaluation and Management (E/M) visit coding for established patients, while reducing the levels of coding for E/M visits for new patients to 4. CMS is proposing to adopt revised E/M code definitions development by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel starting January 1st, 2021. The code changes would also revise the times and medical decision-making process for all of the codes, require performance of history and exam only as medically appropriate, and allow clinicians to choose the E/M visit level based on either medical decision-making or time. The rule also proposes to adopt the RVU Update Committee (RUC)-recommended values for the office/outpatient E/M visit codes for CY 2021, which increase payments for office/outpatient E/M visits and the new add-on CPT code for prolonged service time.

CHRONIC CARE MANAGEMENT (CCM)

For non-complex Chronic Care Management (CCM), CMS is proposing two new temporary HCPCS G-Codes with increments of either 20-minutes or 40-minutes of clinical staff time instead of the existing single CPT code. For complex CCM, CMS is proposing two new G-codes that would not require the service component of the care plan revision for establishment or substantial revision of the comprehensive care plan and the requirement for moderate to high complex medical decision-making.

CMS is also proposing changes to increase the use Transitional Care Management, including allowing TCM codes to be billed with a number of HCPCS codes that were previously precluded, in addition to separate coding and payment for Principal Care Management, which describe care management services for one serious chronic condition.

OTHER PROVISIONS

PA SUPERVISION AND MEDICAL RECORD DOCUMENTATION

CMS is proposing to revise current regulations requiring that PAs deliver services under general supervision by physicians or other qualified practitioners. The new regulation would state that the statutory physician supervision requirement for PA services would be 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, with medical direction and appropriate supervision as provided by state law in which the services are performed. In the absence of any governing state law, evidence of physician supervision of physician assistants (PAs) could be satisfied by documentation in the medical record of the PAs approach to working with the physician, allowing PAs to practice more broadly.

This would allow collaborative approaches to physician supervision, and substantially align Medicare supervision of PAs with nurse practitioners (NPs). Additionally, Physicians, PAs and NPs would be permitted to review and verify documentation in a patient's medical record instead of re-documenting information made by other members of the medical care team for all Medicare-covered services paid under the PFS.

THERAPY SERVICES

CMS is proposing a policy to implement the modifiers to identify therapy services that are provided by physical therapy (PT) and occupational therapy (OT) assistants and the 10% *de minimis* standard established in the CY 2019 PFS final rule. Beginning January 1st, 2020, these modifiers will be required to be reported on claims.

AMBULANCE SERVICES

CMS is proposing to clarify that there is no CMS-prescribed form for physician certification statements (PCSs) for ambulance transplants, and that ambulance providers and suppliers are free to choose the format by which information is displayed, allowing greater flexibility for obtaining a non-physician certification statement. CMS is proposing to add licensed practical nurses (LPNs), social workers, and case managers to the list of staff that can sign a certification statement if an ambulance provider and supplier are unable to obtain an attending physician's signature within 48 hours of transport.

CMS is also proposing data collection format and elements, a sampling methodology, and reporting timeframes to collect cost, revenue, utilization, and other information from ambulance providers and suppliers as required by the Bipartisan Budget Act (BBA) of 2018. Ambulance organizations identified for reporting that fail to submit data would have payments reduced by 10%.

CMS is soliciting comments on the air ambulance industry and how they can work within its statutory authority to ensure that appropriate payments are made to air ambulance organizations serving the Medicare population.