

## **2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Final Rule Summary**

On November 1, 2019, the Centers for Medicare and Medicaid Services (CMS) released the [CY 2020 Revisions to Payment Policies under Physician Fee Schedule and Other Changes to Part B Payment Policies](#) final rule. CMS has published also published a [fact sheet on the PFS final rule for 2020](#). AMA is continuing to review the rule and will work with our colleagues in the federation to further analyze these policies in the coming weeks. Below is a summary of some of the policies CMS finalized in the rule.

### **Medicare Physician Fee Schedule**

#### **CY 2020 Conversion Factor**

The 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 Principal Care Management services.

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

##### *Practice Expense RVU Updates*

Updates to the direct practice expense inputs were finalized for individual codes based on recommendations from the RUC. CMS will continue to transition to updated pricing for medical supplies and equipment. Several updates were finalized 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 will 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.

##### *GPCI Updates*

For CY 2020, CMS conducted its statutorily required 3-year review of the GPCIs. CMS finalized the CY 2020 GPCI update and methodological refinements as proposed, and some localities will experience significant decreases in the GPCIs based on this update. The methodology did not include the 1.0 work GPCI floor, as the Balance Budget Act of 2018 (BBA) only extended the floor through December 31, 2019.

#### **Evaluation and Management (E/M) Office Visits**

CMS finalized its policy to utilize the CPT framework and RUC recommendations for E/M office visits. The changes will be implemented on January 1, 2021 to allow time for extensive education for use of the new guidelines and revised codes. AMA is engaged in significant efforts to prepare physicians, coders, insurers and electronic health record vendors for the new documentation standards.

#### **Key Elements of Office Visit Final Rule:**

- Effective January 1, 2021, CMS will adopt the CPT guidelines to report office visits based on either medical decision making or physician time.
- CMS adopted the RUC work recommendations for the office visit codes. The work value increases represent \$3 billion in redistributed spending, resulting in a 3% reduction in the conversion factor.
- CMS adopted the RUC physician time recommendations. Coupled with the work value increases and some modifications in direct practice costs, these changes lead to an additional \$2 billion in redistributed spending, resulting in an additional 2% across-the-board reduction.

- CMS departed from the CPT and RUC recommendations in two ways that further intensify the specialty redistribution impact. In fact, these two policies will result in lower payment for office visits for surgeons than their colleagues:
  - CMS will implement an add-on payment for office visits for primary care and patients with serious or complex conditions. This proposal redistributes an additional \$2.6 billion, resulting in an additional 3% reduction to the Medicare conversion factor. There are serious flaws with an implementation of such a code. CMS states that although they have no specialty restrictions on reporting new code GPC1X, they assume that the following specialties will report this add-on code with 100% of their office visits, essentially making this a bonus payment for: family medicine, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease. It is estimated that the add-on payment for GPC1X will be approximately \$18 per visit.
  - Although the surgical specialties participated in the RUC survey and their data and vignettes were incorporated into the RUC recommendations, CMS will not to apply the office visit increases to the global surgery packages. The Agency offers to continue to review data to address the Agency's concern that the follow up visits are not typically performed.

The attached Table 120 illustrates the specialty payment impacts. Redistributions will be significant, with family medicine increasing by 12% and many specialties that do not perform office visits decreasing by 7% or more. The January 2021 office visit guidelines and descriptions; an AMA Ed Hub tutorial; detailed RUC recommendations, data, and a vote report are all posted on the AMA website and may be obtained via [www.ama-assn.org/cpt-office-visits](http://www.ama-assn.org/cpt-office-visits).

### **Immunization Administration**

CMS acknowledges that proposed reductions to immunization administration payment is problematic and states that payment will remain at the 2019 payment level. The payment files, however, indicate that CMS only applied this policy decision to certain immunization services. A technical correction was requested.

### **Scope of Practice**

#### *Physician Supervision Requirements for Physician Assistants (PAs)*

CMS finalized its revisions to regulations on physician supervision for physician assistant services. The current policy requires general physician supervision for PA services, however, CMS' revisions 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 documenting at the practice level the PA's scope of practice and the working relationship the PA has with the supervising physician/s when furnishing professional services.

#### *Ambulatory Surgical Centers (ASCs)*

CMS finalizes its proposal to allow either a physician or an anesthetist to examine the patient immediately before surgery for anesthesia risk to reduce regulatory burden. CMS clarifies that there are two components to any pre-procedure evaluation, which require that immediately before surgery, a physician must examine the patient to evaluate the risk of the procedure to be performed, and a physician or anesthetist must examine the patient to evaluate the risk of anesthesia.

### *Hospice*

CMS finalizes its proposal to 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.

### **Medical Record Documentation**

CMS finalizes its proposal 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 finalized its proposal to increase payment for the two Transitional Care Management (TCM) codes as recommended by the RUC.

#### *Chronic Care Management (CCM)*

CMS finalized its proposal to implement one new add-on code for non-complex CCM which will allow providers to bill incrementally to reflect additional clinical staff time resources that are required in certain cases. However, CMS did not finalize its proposals to create G-codes for the complex CCM codes, due to the ongoing work of the CPT Editorial Panel in this area.

#### *Principal Care Management (PCM)*

CMS finalized the creation of two new codes for PCM services, which will 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.

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

CMS finalized 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 finalized a methodology 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.

### **Medicare Telehealth**

CMS finalized its proposal to add three new telehealth codes, which describe a bundled monthly episode of care for treatment of opioid use disorders (CMS finalized the codes as G2086, G2087 and G2088). This treatment includes care coordination, individual therapy, and group therapy and counseling.

### **Physician Enrollment**

CMS finalized new authority to deny or revoke a physician's enrollment if he or she has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. CMS excluded required participation in rehabilitation or mental/behavioral health programs and required abstinence from drugs or alcohol and random drug testing from the type of sanctions or disciplinary actions that could trigger a denial or revocation.

### **Open Payments**

CMS expands 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 also modifies payment categories to include debt forgiveness, long-term medical supply or device loan and acquisitions. CMS finalized a requirement that applicable manufacturers and group purchasing organizations provide the device identifiers to identify reported devices.

### **Medicare Shared Savings Program (MSSP)**

CMS finalized a set of 23 measures on which ACO's quality performance will be assessed for the performance year 2020 and subsequent performance years. In the proposed rule, CMS sought 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. In this final rule, CMS stated that the majority of the comments it received were opposed to aligning the Shared Savings Program quality score with the MIPS quality performance category score. CMS stated that as it plans for future updates and changes to the Shared Savings Program quality scoring methodology, it will consider the feedback it received in the development of its proposals.

### **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 sought comments in the proposed 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. In this final rule, CMS does not finalize its proposal that physicians notify beneficiaries and states that it intends to undertake a comprehensive review of all if its outreach material to see if Medicare policies on payment and coverage can be made clearer.

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

CMS finalizes its proposal to add reasons that CMS will not accept a Stark advisory opinion request or issue an advisory opinion. CMS also finalizes its proposal 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 finalizes a 60-day timeframe for issuing advisory opinions. CMS finalizes 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)**

The MVP approach responds to some of the recommendations made to CMS by the AMA after significant consultation with specialty and state medical societies about opportunities to improve MIPS and move away from the current check-the-box reporting requirements. Physicians in MVPs would focus their MIPS participation on a set of measures tailored to an episode of care or condition starting in the 2021 performance period. The MVP framework would also provide enhanced data and feedback to physicians.

While CMS did not finalize specifics about the MVP, it emphasized that it is developing the MVP to reduce physician burden associated with the MIPS program and will work with specialty societies to further develop this approach so that it's relevant to the specific episodes of care they provide and their patient population. One of the most concerning aspects of the MVP framework in the proposed rule was an indication it would be mandatory, which CMS has appeared to back away from, and will make a determination in the future. CMS expects MVPs will be available starting in 2021 and more details will be included in future rulemaking. The AMA will continue to work with CMS on MVP to ensure it is voluntary, less burdensome than the current program, and incentivizes physicians to opt into this new framework.

### **Performance Threshold and Complex Patient Bonus**

CMS increased the performance threshold from 30 points to 45 points in 2020 and 60 points in 2021. CMS had proposed to increase the exceptional performance threshold from 70 to 80 points in 2020, but instead finalized increasing the exceptional performance threshold to 85 points in 2020 and 2021.

CMS maintained the complex patient bonus, which increases physicians' and groups' final scores up to 5 points based on their patients' medical complexity and social risk. CMS calculates medical complexity using HCC scores and social risk based on dual eligibility for Medicare and Medicaid.

### **Performance Category Weights**

CMS did not finalize its proposal to reduce the Quality performance category weight to 40 percent of the final MIPS score in 2020, or to increase the Cost performance category weights by to 20 percent in 2020. The Quality performance category will remain weighted at 45 percent for 2020 and the Cost performance category will remain weighted at 15 percent for 2020. CMS agreed with the AMA's recommendations not to increase the weight of the cost category due to a lack of sufficient feedback for physicians to understand how they are evaluated on costs.

### **Quality Performance Category**

- CMS did not finalize its proposal to decrease the quality performance category weight to 40 percent in 2020 performance year. The quality performance category weight will remain at 45 percent for the 2020 performance year.
- CMS finalizes new specialty sets including Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition and Endocrinology.
- CMS finalizes increasing the data completeness threshold to 70 percent.
- CMS finalizes removing measures that do not meet the case minimum or volumes required for benchmarking for two consecutive years.
- CMS proposed to eliminate 21 percent of the existing quality measures. While CMS finalizes removing some of the measures it had proposed to eliminate, it also did not finalize the removal of certain measures, particularly those that are available to non-patient facing clinicians.

- CMS finalizes applying the flat percentages methodology as an alternative to their standard method to calculating benchmarks when CMS determines the standard method has the potential to result in inappropriate treatment. For the 2022 payment year the flat percentage methodology applies to the following two measures: MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and MIPS #236 (NQF #0018): Controlling High Blood Pressure.
- After consideration of comments, CMS did not finalize its proposal to apply the population health All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions measure for the 2021 Performance Year/ 2023 Payment Year. However, CMS seeks to propose it through future rulemaking once CMS can consider feedback from the MAP on this measure.
- CMS continues to apply favorable scoring policies to small practices.

### **Qualified Clinical Data Registry (QCDR) Requirements**

CMS finalizes proposals 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 will be required to submit data for quality, improvement activities and promoting interoperability performance categories. Also beginning in 2021, all QCDRs and Qualified Registries will 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 will have to license their measures to other QCDRs and have measure testing completed at the time they submit their application to CMS.

### **Request for Information on Opioid Overuse Measure**

In the proposed rule CMS sought feedback on potential opioid overuse measures that focused on dose duration and days prescribed. While CMS did not finalize or propose new measures, CMS plans to take comments into account as it considers further development of the potential opioid overuse measure.

### **Cost Performance Category**

- CMS did not finalize its proposal to increase the cost category weight to 20 percent in performance year 2020. Instead, it will continue to weigh the cost performance category at 15 percent in 2020. CMS agreed with AMA concerns about the lack of detailed and actionable performance feedback provided about the cost measures to date.
- CMS added 10 new episode-based measures, bringing the total number of episode-based cost measures in MIPS to 18 in 2020.
- CMS revised the Medicare Spending Per Beneficiary and Total Per Capita Cost (TPCC) measures. Among other things, the revised TPCC eliminates the problem of attributing costs that occurred before the physician ever saw the patient and excludes clinicians in specialties unlikely to be responsible for providing primary care to a patient.

### **Improvement Activities Performance Category**

CMS finalized increasing the participation threshold from a single clinician to 50 percent of the clinicians in the practice. The finalized policy differs from the proposal in that it permits the clinicians to perform the activity during any continuous 90-day period during the performance year (i.e., everyone does not need to perform the activity at the same time).

### **Promoting Interoperability Performance Category**

CMS finalized the removal of 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.

The final PI measures for the 2020 program year are as follows:

Objective	Measure
e-Prescribing	<b>e-Prescribing</b>
	<i>Bonus (not required):</i> Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	<b>Support Electronic Referral Loops by Sending Health Information</b>
	<b>Support Electronic Referral Loops by Receiving and Incorporating Health Information</b>
Provider to Patient Exchange	<b>Provide Patients Electronic Access to Their Health Information</b>
Public Health and Clinical Data Exchange	<p><b><u>Report to two different public health agencies or clinical data registries for any of the following:</u></b></p> <ol style="list-style-type: none"> <li>1. Immunization Registry Reporting</li> <li>2. Electronic Case Reporting</li> <li>3. Public Health Registry Reporting</li> <li>4. Clinical Data Registry Reporting</li> <li>5. Syndromic Surveillance Reporting</li> </ol>

CMS adjusted its reweighting policy for hospital-based clinicians who choose to report as a group or virtual group. Such clinicians are eligible for reweighting when more than 75% of the NPIs in the group or virtual group meet the definition of a hospital-based individual MIPS eligible clinician.

**MIPS Participation Projections**

Table 122 of the 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. In total, CMS estimates approximately 880,000 clinicians will be MIPS eligible in 2020.

MIPS penalties and incentive payments increase to a maximum of 9 percent in 2022, which is tied to the 2020 performance year. CMS estimates 92.5 percent of eligible clinicians who submit data will be eligible for a neutral payment adjustment or incentive payment and 45 percent will be eligible for an additional bonus for exceptional performance.

**Alternative Payment Models (APMs)**

CMS finalized 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 final rule includes an estimate that between 210,000 and 270,000 clinicians will become Qualifying APM Participants in 2020 and receive an APM incentive payment in 2022.