Summary of 2020 changes to the Medicare Physician Fee Schedule, Quality Payment Program, and other federal programs

Introduction 2

I. Payment and Coding Changes 2

2020 Conversion Factor 2

Practice Expense, Malpractice, and Geographic Pricing Cost Index Relative Value Units 2

Evaluation and Management (E/M) Office Visits 2

E/M Documentation Requirements 4

Physician Supervision for Physicians Assistant (PA) Services 5

Complex Chronic Care Management Services 6

Principle Care Management (PCM) Services 7

Opioid Use Disorder Telehealth Services 7

Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs) 8

Remote Patient Monitoring (RPM) 9

Coinsurance for Colorectal Cancer Screening Tests 9

Therapy Services 9

Open Payments 10

New Beneficiary Notification Requirements Related to Infusion Therapy Options 10

Deferring to State Scope of Practice Requirements 10

Advisory Opinions on the Application of the Physician Self-k o L 10

II. Quality Payment Program 11

MIPS Value Pathways (MVP) 11

Performance Category Weighting and Reweighting 13

MIPS APM Scoring Standard 13

Quality Category 14

Cost Category 16

Improvement Activities Category 18

Promoting Interoperability (PI) Category 18

Medicaid Promoting Interoperability Program (outside of QPP) 20

MIPS Payment Adjustments 20

Targeted Review and Data Validation and Auditing 21

Third Party Intermediaries 21

Physician Compare 22

Medicare Shared Savings Program (MSSP) Quality Changes 22

Advanced APMs Qualifying Payment Arrangements 23

Advanced APMs - Qualified Advanced APM Participant (QP) Status 24

prefatory language, and accompanying interpretive guidelines, which would govern what determines different levels of medical decision making (MDM) for office/outpatient E/M visits. Some changes parallel previously finalized policies for 2021, including the ability to choose time or MDM-based billing. However, several key aspects differ, including:

The number of code levels CMS proposes to retain 4 levels of E/M codes for new patient (99202 99205) and 5 levels of codes for established patients (99211 99215). CMS previously finalized paying a single flat fee for E/M levels 2-4 and retaining separate payment for Level 5 visits.

Times The current CMS proposal adjusts the time and work RVUs for office visit codes. For most codes, the time it takes to perform these services is 23-38 percent longer than what is currently reflected in the Medicare Physician Fee Schedule. Consistent with the time increase, these services are proposed with increased values of 13-34 percent.

- Importantly, there is no required minimuhImportantl

whether they are

Revision of the care plan (if applicable)

Interaction and coordination with outside resources and practitioners

Feedback is sought on the proposal, including language that would best guide clinicians as they decide what to include in their CCM comprehensive care plans.

Principle Care Management (PCM) Services

CCM codes currently require patients to have two or more chronic conditions so CMS proposes to create two new payable codes for Principle Care Management (PCM) services that would entail providing care management services to patients with a single serious, high-risk condition. HCPCS code GPPP1 has a proposed work RVU of 1.28 and could be reported for each calendar month at least 30 minutes of physician or other qualified health care provider time is spent on comprehensive care management for a single high-risk disease or complex chronic condition. HCPCS code GPPP2 has a proposed work RVU of 0.61 and could be reported for each calendar month at least 30 minutes of clinical staff time is spent on comprehensive management for a single high-risk disease or complex chronic condition.

> *HCPCS code GPPP1*: CCM services for a single high-risk disease, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: 1) one complex chronic condition lasting at least 3 months, which is the focus of the care plan; 2) the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization; 3) the condition requires development or revision of disease-specific care plan; and 4) the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities.
>
> HCPCS code GPPP2: CCM for a single high-risk disease services, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: 1) one complex chronic condition lasting at least 3 months, which is the focus of the care plan; 2) the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization; 3) the condition requires development or revision of disease-specific care plan; and 4) the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities.

Opioid Use Disorder Telehealth Services

CMS proposes to add the new payment codes for opioid treatment services to the Category 1 list of telehealth services, which entails services similar to professional consultations, office visits, and office psychiatry services on the list of currently covered telehealth services. The addition of the codes aims to expand the reach of opioid use disorder treatment, particularly in rural areas experiencing high rates of opioid use or overdose. The new codes are as follows:

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.

Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

The Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) directed CMS to establish a new Part B benefit category for opioid use disorder (OUD) treatment services delivered by opioid treatment programs (OTP, also known as methadone clinics). Under this proposal, CMS would establish a bundled payment for OTPs for the delivery of medication assisted treatment (MAT) for OUD. The bundle would include FDA-approved medications for OUD (methadone, buprenorphine, naltrexone), dispensing and administration of such medication, substance use counseling, individual and group therapy, and toxicology testing, and other items and services that the Secretary determines are appropriate, which the Agency also seeks suggestions on (but specifically notes no meals or transportation). The Agency requests information on other OUD treatment medications in the development pipeline and how they could be incorporated into the benefit in the future. Certain services, specifically substance use counseling and therapy would be delivered via telecommunication. Under past regulations, telemedicine may not expand scope of practice or permit practice in a jurisdiction where the clinician is not licensed to practice. CMS would define a single episode of care as one week.

Under statute, OTPs must be: 1) accredited by a SAMHSA-approved accrediting body; 2) certified by SAMHSA; and 3) enrolled in Medicare. The rule establishes special requirements OTPs must meet in addition to standard Medicare enrollment requirements, including but not limited to: 1) maintaining and submitting a list of all eligible professionals legally authorized to prescribe, order, or dispense controlled substances on behalf of the OTP; 2) satisfying risk screening requirements (including site visits and background checks), and 3) not employing or contracting with any individual who within the preceding 10 years have been convicted of a related federal or state felony, been revoked from Medicare, are on the Medicare preclusions list, or have a current or prior adverse action imposed by a state oversight board. CMS intends to maintain program integrity and patient safety through monitoring billing patterns and quality of care, performing audits, and revoking/terminating Medicare enrollment and provider agreements for abusive or dangerous prescribing patterns or non-compliance with Medicare requirements. Enrollment revocations or terminations may be appealed.

Open Payments

CMS proposes to codify statutory changes to expand the definition of eligible clinician to include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives in addition to the previously covered
CMo
categories by consolidating separate categories for serving as faculty and a speaker for both accredited/certified and unaccredited/non-certified continuing education programs, and to add three new categories: debt forgiveness, long-term medical supply or device loans (longer than 90 days), and acquisitions. Finally, CMS proposes to require applicable manufacturers and group purchasing organizations to report the device identifier (fixed portion of the unique device identifier).

New Beneficiary Notification Requirements Related to Infusion Therapy Options

The 21st Century Cures Act created a Part B benefit to cover home infusion therapy-associated professional services for certain drugs and biologicals administered intravenously or subcutaneously through a pump that is an item of durable medical equipment in the
u A
the patient, which could include verbal discussion with EHR annotation or in writing with written patient attestation. CMS seeks input on the appropriate form, manner, and frequency for physicians to satisfy the requirement of notifying beneficiaries with their infusion therapy options under Part B.

Deferring to State Scope of Practice Requirements

CMS proposes to allow an anesthetist or a physician to examine and evaluate the patient before surgery for anesthetist and planned procedure risk, which would allow for pre- and post-procedure anesthesia evaluations to be performed by the same clinician. CMS also proposes to allow hospice staff to accept drug orders from physicians, NPs, or PAs, provided the PA is acting within his/her state scope of practice requirements and hospice rules, is the p
physician, and is not employed by or has a contractual agreement with the hospice.

Advisory Opinions on the Application of the Physician Self-Referral Law

CMS proposes several changes to the Stark Law advisory opinion process, including the logistics of requesting and receiving an advisory opinion, as well as updating their scope, applicability, and permissible subject matter. Under current law, the Secretary is required, upon request and when requirements are met, to issue written advisory opinions regarding whether an arrangement involving a designated health service referral is prohibited under Stark Law. These advisory opinions are binding to the party or parties requesting the opinion and OIG is prohibited from opining on questions of interpretation, hypothetical situations, or those involving the activities of third parties. The proposed changes to the Stark Law advisory opinion process is outlined below:

The MVP was largely based off of a similar proposal by the American Medical Association but differs notably in that the AMA proposed an optional pathway

How data should be displayed on Physician Compare.

Performance Category Weighting and Reweighting

- Next Generation Accountable Care Organization (ACO) Model
- Oncology Care Model
- Medicare Shared Savings Program
- Medicare ACO Track 1+ Model
- Maryland Total Cost of Care Model
- Vermont All-Payer ACO Model
- Comprehensive Primary Care Plus
- BPCI Advanced

CMS proposes granting

capturing several medication-specific data elements. CMS seeks further comment.

The Agency requests feedback on several changes to the CAHPS for MIPS survey, including a new question on overall patient experience and satisfaction, open-ended narrative questions, collecting data at the clinician level, and collecting data via the web and email, in addition to phone and paper surveys.

CMS proposes to modify the measure development and removal process in the following ways:

CMS is considering aligning the MIPS quality measure update cycle with the electronic clinical quality measure (eCQM) annual update cycle and seeks comment on this proposal.

CMS proposes to remove measures in cases where the measure steward/owner refuses

for measures that meet data completeness requirements but do not have a benchmark or fail to meet case minimum requirements, and 6-point cap on bonus points.

Cost Category

Final measures specifications and attribution methodologies for the MIPS cost measures will be made available at the MIPS resource library following publication of the final rule. Proposed measures and methodologies are summarized below.

Episode-based measures

CMS proposes to add the following episode-based cost measures:

Acute kidney injury requiring new inpatient dialysis (procedural)

Elective primary hip arthroplasty (procedural)

Femoral or inguinal hernia repair (procedural)

Hemodialysis access creation (procedural)

Inpatient chronic obstructive pulmonary disease (COPD) exacerbation (acute inpatient medical condition)

Lower gastrointestinal hemorrhage (acute inpatient medical condition)*

apply. CMS additionally seeks comment on

C
would be excluded.

A case minimum of 35 beneficiaries would continue to apply.

Improvement Activities Category

CMS proposes to remove the specific accrediting organizations previously listed for patient-centered medical homes and comparable specialty practice designations so as not to restrict to only these groups. The previously listed organizations include the Accreditation Association for Ambulatory Health care, the National Committee for Quality Assurance (NCQA), the Joint

How to promote bi-directional exchange of health information with community partners;

How CMS can facilitate and support private sector efforts to develop a workable and scalable patient matching strategy so that the lack of a specific uniform patient identifier (UPI) does not impede the free flow of information;

H

remain pay-for-performance in 2020. The complete list of proposed 2020 MSSP quality measures can be found in Table 32 starting on page 227.

CMS solicits comment on how to align MSSP quality reporting requirements and scoring methodologies more closely with MIPS, including how to use MIPS quality scores to adjust shared savings and losses. Specifically, the Agency will explore replacing the MSSP quality score with the MIPS quality performance score (which was slightly higher than the MSSP quality score based on 2017 performance data). This would entail: 1) scoring measures as it does for non-

For non-MHM models, the Agency proposes to make several changes to the definition of risk that could impact which models qualify as Advanced APMs. CMS is concerned that payers may inflate benchmarks so that the risk of actual expenditures reasonably exceeding it is artificially

but would also mean clinicians would still be expected to participate in MIPS or face a penalty for any non-APM TINs. In addition, Advanced APM Entities would not count towards a

j h

performance period; or 2) prior to bearing responsibility for financial risk under the terms of the APM.