

Summary of the 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) released a [Medicare annual payment rule](#) for calendar year (CY) 2020 that impacts payments for physicians and other health care practitioners. The rule combines proposed policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). Below is a summary of key proposals, separated by proposed PFS and QPP policies. Over the next few weeks, ACEP will be working on a comprehensive response. Comments are due to CMS on September 27, 2019.

Physician Fee Schedule (PFS)

The Medicare Physician Fee Schedule (PFS) section of the rule includes numerous significant proposals. These proposals will cause the PFS conversion factor, which converts the relative value units (RVUs) for each CPT code to dollars, to slightly increase from \$36.05 in 2019 to \$36.09 in 2020.

One of the most significant proposals for emergency medicine relates to payment for emergency department (ED) evaluation and management (E/M) services -- the most commonly billed services for emergency physicians. In recognition of the critical value of these services, CMS is proposing to slightly increase these payments (codes 99281-99285) in line with the American Medical Association (AMA) RVS Update Committee (RUC) recommendation.

A summary of the major proposals is below:

1. Revaluation of the ED Evaluation and Management (E/M) Codes

- CMS identified the codes describing the five levels of ED E/M services to be potentially misvalued. The codes were reconsidered during the April 2018 RUC meeting based on survey data collected by ACEP from practicing emergency physicians.
 - Based on the compelling evidence presented, the RUC approved increases in work values of between 1.5 percent and 6.5 percent for levels 1 through 4, while keeping level 5 the same.
 - Level 5 did not increase because the survey intra-service time dropped by 25 percent from 40 minutes to 30 minutes in the survey median. This would normally result in a commensurate decrease in the work RVU; however, ACEP presented a convincing argument to the RUC that the intensity of a level 5 service had significantly increased over the twelve years since the codes were last considered by the RUC. The result was that the current value was maintained despite the decrease in time spent.

- **CMS is proposing to accept the increased values in the 2020 PFS. The fiscal impact of these RVU changes combined with the slight increase in the conversion factor should yield increases in ED E/M Medicare payments of approximately \$130 million dollars annually, before any additional budget neutrality adjustments are made.** CMS estimates the 2020 impact on total allowed charges for the specialty of emergency medicine to be + 1 percent, because of budget neutrality adjustments.

2. Office and Outpatient E/M Services

- CMS is proposing to increase payment for the office and outpatient E/M codes (99201-99215) in 2021, based on a RUC revaluation in 2019. In a reversal from last year's rule, which created a flat rate for E/M services levels 2 through 4, CMS is proposing to retain five levels of E/M services for established patient visits and reduce new patient visit codes to four levels. The E/M code level would be chosen based on visit duration or medical decision-making and would only require performance of history and exam as medically appropriate.
- Those changes, if finalized, would not go into effect until 2021. CMS also offers several different proposals for their implementation, all of which would impact the eventual payments to ED E/M codes because of required budget neutrality adjustments.
 - Because of the high-volume utilization of these codes by most medical specialties, the resulting budget neutrality adjustments would be substantial. Any specialty that does not regularly use the office codes will see decreases in total allowed charges in 2021.
 - The proposal eliminated the lowest level of new patient encounter (99201), thereby increasing the average payment level for new office visits.
 - Yet because there has been a longstanding acceptance that there should be rank order between the office and ED E/M codes, there is a chance for further positive adjustments to the ED E/M codes to maintain that balance going forward.

3. Medical Record Documentation Requirements

- In last year's PFS rule, CMS finalized a policy that would allow physicians, residents, or nurses to document the presence of a teaching physician during E/M services performed by residents. In this year's rule, CMS is proposing a broad modification to the documentation policy to now allow the physician, the physician assistant, or the advanced practice registered nurse who delivers and bills for their professional services, to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team.

4. Telehealth Services

- CMS is proposing the addition of three codes to the list of telehealth services: HCPCS codes GYYY1, GYYY2, and GYYY3, which describe a bundled episode of care for treatment of opioid use disorder.
- CMS did not propose any telehealth codes related to emergency medicine. ACEP strongly supports the delivery of telehealth services by board-certified emergency physicians and has repeatedly asked CMS to add ED services to the list of approved telehealth services.
- CMS is proposing to create six new non-face-to-face codes to describe and reimburse for “patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.”

5. Opioid Use Disorder Coverage

- The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act) added a new Medicare benefit beginning in 2020 for opioid use disorder (OUD) treatment services delivered by an opioid treatment program (OTP). In this rule, CMS establishes requirements to govern Medicare coverage of and payment for OUD treatment services furnished in OTPs. CMS also proposes Medicare enrollment requirements and a program integrity approach for OTPs.
- Under CMS’ proposals, providers in OTPs would be able to dispense methadone, as well as buprenorphine and naltrexone, and provide counseling, therapy, and toxicology testing. Reimbursement would be at a weekly bundled rate determined annually (though CMS solicits comments on daily or monthly bundled payments instead) and based on the costs of the drugs administered plus the services provided. Therapy and counseling would be allowed either in-person or via audio-video equipment. CMS is proposing 19 new codes to describe these services, with payment ranging from \$50.23 for a partial week of non-drug treatment to \$5,097 for treatment via buprenorphine implant. The copayment for these services would be \$0 for a limited trial period.

6. Bundled Payment for Substance Abuse Disorder

- CMS is proposing to establish bundled payments for the overall treatment of OUD (including outside OTPs), including management, care coordination, psychotherapy, and counseling activities. To implement this new bundled payment, CMS is proposing to create two new codes to describe monthly bundles of services as well as an add-on code to account for additional resource costs required to perform these services.
- Of particular note, CMS recognizes that there is not specific coding that describes diagnosis of OUD or the initiation of, or referral for, medication-

assisted treatment (MAT) in the emergency department (ED) setting. **CMS is seeking comment on the use of MAT in the ED in order to better understand typical practice patterns to help inform whether the agency should consider making separate payment for such services in the ED in future rulemaking.**

7. Bundled Payment Comment Solicitation

- CMS is seeking comment on opportunities to expand the concept of bundling to improve payment for services under the PFS and more broadly align PFS payment with the broader CMS goal of improving accountability and increasing efficiency in paying for the health care of Medicare beneficiaries.

8. Appropriate Use Criteria (AUC) Program

- CMS is proposing no changes regarding implementation of the requirement that clinicians consult appropriate use criteria (AUC) through a qualified clinical decision support mechanism (CDSM) starting January 1, 2020 when ordering advanced imaging services (i.e., SPECT/PET MPI, CT, and MR).
- In last year's rule, due to significant advocacy by ACEP, CMS clarified that exceptions granted for an individual with an emergency medical condition include instances where an emergency medical condition is suspected, but not yet confirmed. This may include, for example, instances of severe pain or severe allergic reactions. In these instances, the exception is applicable even if it is determined later that the patient did not, in fact, have an emergency medical condition. In other words, if physicians think their patients are having a medical emergency (even if they wind up not having one), they are excluded from the AUC requirements.

CMS has now posted [instructions](#) about how to claim this exemption. The guidance instructs clinicians to use modifier "MA" on the same line as the CPT code for the advanced diagnostic imaging service in cases where the service is "being rendered to a patient with a suspected or confirmed emergency medical condition."

9. Physician Supervision for Physician Assistant (PA) Services

- CMS is proposing to modify current regulations around the physician supervision of PA services. CMS clarifies that the physician supervision requirement under Medicare is met as long as PAs deliver their services in accordance with state law and state scope of practice rules, with medical direction and appropriate supervision as provided by that state law. In the absence of state law, the physician supervision would be evidenced by including documentation in the medical record describing the PA's approach to working with physicians in delivering their services.

10. Care Management Services

- CMS is proposing to increase payment for Transitional Care Management (TCM) and implement a set of Medicare-developed HCPCS G codes for certain Chronic Care Management (CCM) services. Additionally, CMS is proposing to create new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single serious and high-risk condition.

11. Ambulance Physician Certification Statement Requirement

- CMS is proposing to clarify that there is no prescribed form for physician certification statements for ambulance transports. If the elements required by regulation are clearly conveyed, ambulance suppliers and providers would be allowed to choose the format by which the information is displayed, and they may find that other forms that may be required by other legal requirements to perform the transport may also satisfy the function of the PCS.
- CMS is also proposing to grant ambulance suppliers and providers greater flexibility around who may sign a non-physician certification statement in certain circumstances. The proposal would also add licensed practical nurses (LPNs), social workers, and case managers as staff members who may sign the non-physician certification statement if the provider/supplier is unable to obtain the attending physician's signature within 48 hours of the transport.

12. Medicare Ground Ambulance Services Data Collection System

- CMS is required by law to develop a data collection system to collect cost, revenue, utilization, and other information determined appropriate with respect to ground ambulance providers suppliers.
- CMS is proposing the data collection format and elements, a sampling methodology that CMS 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 is also proposing to reduce by 10 percent the payments that would otherwise be made to a ground ambulance organization that is identified for reporting but fails to sufficiently submit data, as well as a process under which a ground ambulance organization can request a hardship exemption that, if granted by CMS, would allow it to avoid the payment reduction.

13. Medicare Shared Savings Program

- CMS is soliciting comment on how to potentially align the Medicare Shared Savings Program quality performance scoring methodology more closely with the Merit-based Incentive Payment System (MIPS) quality performance scoring methodology. Additionally, CMS is proposing modifications to the program's current set of quality measures.

14. Bundled Payment Comment Solicitation

- CMS is seeking comment on opportunities to expand the concept of bundling to improve payment for services under the PFS and more broadly align PFS payment with the broader CMS goal of improving accountability and increasing efficiency in paying for the health care of Medicare beneficiaries.

15. Application of the Physician Self-Referral Law

- CMS is soliciting additional comments on potential changes to its advisory opinion process to address stakeholder comments received from last year's Request for Information (RFI) on how to address unnecessary burden created by the Stark physician self-referral rules. As background, the RFI had focused on how it may impede care coordination, and several stakeholders urged CMS to update the regulations governing its advisory opinion process on physician referrals to reduce provider burden and uncertainty around complying with the self-referral law.

The Quality Payment Program

CMS introduces policies that impact the fourth performance year (2020) of the Quality Payment Program (QPP). The QPP includes two tracks: [the Merit-based Incentive Payment System \(MIPS\)](#) and Advanced Alternative Payment Models (APMs).

MIPS Policies

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2020 will impact Medicare payments in 2022).

The first five years of MIPS include some flexibilities that allow for a transition into the Program. In this year's rule, CMS lays out a new MIPS Values Pathway (MVP) framework, that, once implemented, will hopefully provide a more cohesive and meaningful participation experience for clinicians. Further, CMS proposes numerous other changes to MIPS, including to the four performance categories and their associated weights, the overall performance threshold, and reporting requirements for qualified clinical data

registries (QCDR)—which directly affect ACEP’s QCDR the [Clinical Emergency Data Registry \(CEDR\)](#).

1. MIPS Value Pathways (MVP) Framework

- CMS has heard feedback, including from ACEP, that MIPS reporting should be streamlined and more meaningful to clinicians. CMS is therefore proposing to create the MIPS Value Pathways (MVPs) beginning with the 2021 performance year. Ultimately, CMS wants all clinicians to participate through an MVP or APM.
- An MVP would connect measures and activities across three categories in MIPS: quality, cost, and improvement activities. Initially, a uniform set of Promoting Interoperability measures would be included in all MVPs. These pathways would be organized around specialty or health condition, and the quality measures and activities for clinicians would be related to the organization.
- CMS outlines four guiding principles for the MVPs:
 - Consist of a limited set of measures that are important to clinicians, reducing burden related to measure selection, scoring, and leading to sufficient comparative data;
 - Include measures that result in comparative performance data that is of value to patients in evaluating clinicians and making care decisions;
 - Include measures that encourage performance improvements in priority areas; and
 - Reduce barriers to APM participation by using measures that are part of APMs and linking cost and quality measurement.
- CMS is requesting stakeholder feedback related to the MVPs, including on MVP construction, measure selection, organization, MVP assignment, and the transition to MVPs.

2. Performance Category Weighting in Final Score:

- As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. Under current law, CMS has the flexibility to keep the Cost category percentage less than 30 percent until 2022, when this category is required to have a 30 percent weight. In the rule, CMS proposes to increase the Cost category incrementally over time, reaching the required 30 percent by 2022. CMS proposes to make corresponding decreases to the Quality category weight each year.

- General Performance Category Weights Proposed for 2020:
 - **Quality: 40% (down from 45% in 2019)**
 - **Cost: 20% (up from 15% in 2019)**
 - Promoting Interoperability (EHR): 25% (same as 2019)
 - Improvement Activities: 15% (same as 2019)
- General Performance Category Weights Proposed for 2021:
 - **Quality: 35%**
 - **Cost: 25%**
 - Promoting Interoperability (EHR): 25%
 - Improvement Activities: 15%
- General Performance Category Weights Proposed for 2022:
 - **Quality: 30%**
 - **Cost: 30%**
 - Promoting Interoperability (EHR): 25%
 - Improvement Activities: 15%

3. Performance Threshold

- The performance threshold is the point total a clinician must surpass to be eligible for an upward payment adjustment (bonus). CMS is proposing to increase the performance threshold from 30 points in 2019 to **45 points** in 2020 and **60 points** in 2021.
- There is also an additional performance threshold that is applied to reward providers for exceptional performance. Providers who surpass this threshold can receive an additional bonus on top of their upward payment adjustment. CMS is proposing to increase this threshold from 75 points in 2019 to **80 points** in 2020.
- As required by statute, the maximum negative payment adjustment in 2022 (based on performance in 2020) is -9%, and the positive payment adjustment can be up to 9% (before any exceptional performance bonus). Since MIPS is a budget neutral program, the size of the positive payment adjustments is ultimately controlled by the amount of money available through the pool of negative payment adjustments. In other words, the 9% positive payment adjustment can be scaled up or down (capped at a factor of + 3%). Likewise, the exceptional performance bonus is capped at \$500 million across all eligible Medicare providers, so the more providers who qualify for the bonus, the smaller it is. In the first two years of the program, most clinicians qualified for a positive payment adjustment, so the size of the adjustment was relatively small. For example, if a clinician received a perfect score of 100 in 2018, the clinician will only receive a positive adjustment of 1.68 percent in 2020 (much less than the 5 percent permissible under law). In the rule, CMS provides an example of

what the positive adjustments could be in 2022 (based on performance in 2020). CMS estimates that the 9 percent payment update would be scaled down to 1.8 percent and that the maximum bonus for exceptional performance would be 4.0 percent. Therefore, the total maximum payment adjustment a provider could receive in 2022 if they received a perfect MIPS score in 2020 would be 5.8 percent (1.8 percent + 4.0 percent).

4. Quality Performance Category

- CMS is proposing to increase the data completeness requirements in 2020. Currently, clinicians are required to report on 60 percent of their patients across the 12-month reporting period. CMS is proposing to increase that percentage to **70 percent** in 2020.
- Currently, a quality measure may be considered for removal if the measure is no longer meaningful, such as measures that are topped-out. CMS is proposing to also remove measures that do not meet case minimum and reporting volumes required for benchmarking for two consecutive years.
- Bonus points for high priority measures will be applied in 2020, just like in 2019. Providers will also still be eligible for additional bonus points based on improvement.

5. Cost Category

- CMS is proposing to revise the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and will add 10 episode-based cost measures on top of the 8 episode-based cost measures CMS added to the program in 2019.

The case minimum will be 10 for procedural episodes and 20 for acute inpatient medical condition episodes. In our previous comments, ACEP had expressed serious concerns with the total per capita cost and MSPB measures and had encouraged CMS to develop new episode-based measures.

6. Improvement Activities

- CMS is proposing some modifications, which include:
 - Slightly modifying the definition of rural area and the patient-centered medical home criteria;
 - Adding 2 new Improvement Activities;
 - Modifying 7 existing Improvement Activities; and,
 - Removing 15 existing Improvement Activities.
- CMS is proposing to allow groups to attest to an improvement activity when at least 50 percent of clinicians in the group participate in or perform the activity.

Currently, a group can attest to an improvement activity if at least one clinician in the group participates in or performs the activity.

- CMS is also establishing specific factors that the agency will consider for the removal of improvement activities.

7. Promoting Interoperability

- **In a major victory for ACEP, CMS is proposing to change the definition of “hospital-based” for groups. ACEP has been extremely concerned with how CMS defines “hospital-based” to approve hardship exemptions for Promoting Interoperability category. Currently, clinicians who are deemed “hospital-based” as individuals are exempt from the Promoting Interoperability category. However, if individual clinicians decide to report as a group, they lose the exemption status if one of them does not meet the definition of “hospital-based.”**

We have repeatedly argued that this “all or nothing rule” is unfair and penalizes hospital-based clinicians who work in multi-specialty groups. In this year’s rule, CMS is proposing to modify this policy by exempting groups from the Promoting Interoperability category of MIPS if 75 percent of the individuals in the group meet the definition of hospital-based.

- Last year, CMS proposed and finalized major changes to this category. CMS eliminated the base, performance and bonus scores, and created a new scoring methodology. This year’s rule keeps this new structure in place.
- CMS is proposing to remove the “Verify Opioid Treatment Agreement” measure and keep the “Query of PDMP” measure as optional.
- CMS includes six requests for information that address the inclusion of opioid measures, ways to improve efficiency, patient exchange information, patient-generated data in EHRs, and engaging in activities that promote safety.

8. Qualified Clinical Data Registries (QCDR)

- QCDRs are third-party intermediaries that help clinicians report under MIPS. As stated above, ACEP has its own QCDR called the Clinical Emergency Data Registry (CEDR). CMS has separate policies governing QCDRs and the approval of QCDR measures.
- For 2020, CMS is proposing the following new QCDR requirements:
 - Grant QCDR measures that are potentially duplicative with another measure one year of conditional approval. The measures will be removed if they cannot be harmonized within that period.

- Establish formal guidelines for measures to help QCDRs understand when a QCDR measure would likely be rejected during the annual self-nomination process.
- For 2021, CMS is proposing the following new QCDR requirements:
 - Have the capability to submit data on the Quality, Improvement Activities, AND the Promoting Interoperability categories of MIPS. Currently, CEDR only helps emergency physicians meet the Quality and Improvement category requirements. However, CEDR may be exempt from this requirement since the majority of emergency physicians are exempt from the Promoting Interoperability category of MIPS.
 - Engage in additional activities that foster improvement in the quality of care.
 - Include in mandated quarterly reports information on how participants compare to other clinicians who report through the QCDR.
 - Identify a linkage between QCDR measures and a cost measure, Improvement Activity, or CMS developed MVP.
 - Remove QCDR measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive years.
 - Grant CMS the ability to approve QCDR measures for two years.
 - Completely develop and test measures so that they are ready for implementation at the time of self-nomination.
- Last year, CMS proposed, but did not finalize, a proposal that would have required all QCDR measures to be available to all QCDRs at no cost. In this rule, CMS is proposing a policy in which the agency would consider the extent to which a QCDR measure is available to clinicians reporting through QCDRs other than the QCDR measure owner. If CMS determines that a QCDR measure is not available to these clinicians, CMS may not approve the measure.

9. Physician Compare

- CMS makes a few proposals related to Physician Compare. CMS is proposing to make aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores, available on Physician Compare beginning with 2018 data.
- CMS is also proposing to post on Physician Compare an indicator on that displays if a clinician is scored using facility-based measurement. Most emergency physicians are eligible to be scored under the facility-based scoring option established in last year's rule.

Alternative Payment Model (APM) Policies

1. Other Payer Medical Homes

- Currently, clinicians can receive credit for participating in APMs initiated by other payers beyond Medicare. CMS is proposing to create a new “aligned Other Payer Multi-Payer Medical Home Model” definition, which would expand the ability for clinicians participating in other-payer medical home APMs to potentially qualify for the five percent bonus available under MACRA.

2. Other Technical Changes

- CMS is proposing technical changes to the definition of risk and the APM scoring standard. Further, CMS establishes a few more conditions for when a clinician would or would not qualify for the five percent bonus.