Top 5 Takeaways: 2020 Medicare Physician Fee Schedule Proposed Rule

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) released the CY 2020 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies [CMS-1715-P], which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). The proposed regulations will be published in the Federal Register on August 14, 2019. Comments are due September 27, 2019.

The proposed rule is expected to increase Medicare payments under the PFS by $300 million in 2020. Most significantly, the proposed rule contains an about-face on a previously finalized change to Evaluation and Management (E/M) services. The rule also lays out a vision for a more streamlined Merit-based Incentive Payment System (MIPS) through the proposed establishment of the MIPS Value Pathways (MVP). CMS has characterized the rule as "reflecting a broader Administration-wide strategy to create a health system that results in better accessibility, quality, affordability, empowerment and innovation."

+ The proposed regulations are available here.
+ The proposed rule fact sheet is available here.
+ The QPP factsheet is available here.

A summary of the top five takeaways from the proposed rule follows.

2020 Medicare Physician Fee Schedule Proposed Changes

Medicare physician payment is based on the application of the dollar conversion factor to work, practice expense (PE) and malpractice relative value units (RVUs), which are then geographically adjusted. PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service.

1. **CMS Pivots on E/M: Proposes to Adopt CPT Coding Changes and RUC Recommended Values for CY 2021**

   √ Increases Payment Rates for Most Office/Outpatient E/M Services, Benefits Do Not Extend to Global Surgeries

   Evaluation and management E/M services make up approximately 40% of allowed charges under the PFS (office/outpatient services comprise approximately 20% of allowed charges). Last year, CMS proposed and finalized significant changes to the documentation and payment for these services, to take effect January 1, 2021. CMS is now proposing to change course.

   In the CY 2020 Proposed Rule, CMS proposes to adopt E/M coding recommendations from the CPT Editorial Panel for CY 2021.

- **New patient codes:** Reduce the number of levels to from five to four for office/outpatient E/M visits for new patients
- **Established patient codes:** Retain five levels of coding for established patients
- **New add-on code:** Adopt a single add-on CPT code (99XXX) to describe prolonged office/outpatient E/M services
- **Revised code definitions:** Revise the definitions for each code

Finally, CMS proposes to accept a number of payment recommendations made by the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) for the office/outpatient E/M visit codes for CY 2021 and the new add-on CPT code for prolonged service time. The AMA RUC-recommended values yield higher work RVUs (and payment) for most office/outpatient E/M services.

Notably, CMS rejected the AMA RUC recommendation to increase the RVUs of surgical services with 10- and 90-day global periods to reflect the changes made to RVUs for office/outpatient E/M visits. CMS remains concerned about the accuracy of follow-up E/M visits assigned to global surgical services and is still considering ways to address these services.

HCPCS Code	2019 Work RVU	CY 2021 Work RVU	RUC (Recommended Work RVU)
New Patient Office Visit			
99201	0.48	0.48	N/A
99202	0.93	1.76	0.93
99203	1.42	1.76	1.60
99204	2.43	1.76	2.60
99205	3.17	3.17	3.50
Established Patient Office Visit			
99211	0.18	0.18	0.18
99212	0.48	1.18	0.70
99213	0.97	1.18	1.30
99214	1.50	1.18	1.92
99215	2.11	2.11	2.80
Prolonged Services Add-On (Extended Visits)			
99XXX	NA	1.17	0.61

Note: Extracted from table 27B, CY 2020 PFS Proposed Rule (page 510, display copy)

In assessing the financial impact of the E/M changes, there are two factors to consider. The first factor is that it is likely that CMS will need to implement across-the-board reductions, given the magnitude of the changes in spending resulting from proposed E/M changes and the budget-neutral nature of the Medicare PFS. These across-the-board reductions would likely be implemented through a reduction in the physician conversion factor.

Second, specialties or even individual practices will be impacted based on the mix of E/M services they bill. Specialties and practices that bill higher level established patient visits will see the greatest increases, as those codes were revalued higher relative to the rest of the office/outpatient E/M code set. The specialties and practices that do not generally bill office/outpatient E/M visits may experience greater decreases. While CMS published a specialty-specific impact table for CY 2021 in the proposed rule (Table 111), the agency indicated that

there may be significant uncertainty in its estimated impacts due to the many factors involved and the significant number of unknowns regarding other changes that will occur in CY 2021.

Elsewhere in the rule, CMS also proposes increased payment for transitional care management services, a set of Medicare-developed HCPCS G-codes for certain chronic care management services, and a new coding for principal care management services that would pay clinicians for providing care management for patients with a single serious and high-risk condition.

2. 2020 Physician Conversion Factor Remains Flat

√ 2020 Proposed Physician Conversion Factor Is $36.0896

The 2020 proposed physician conversion factor is $36.0896. This represents an increase of just 5 cents from the 2019 conversion factor of $36.0391. The proposed anesthesia conversion factor is $22.2774, in comparison to the 2019 conversion factor of $22.2730. While there was no statutorily required update of the conversion factor (the annual update to the physician conversion factor authorized by the Medicare Access and CHIP Reauthorization Act (MACRA) expired in 2019), CMS did apply a relative value unit (RVU) budget neutrality adjustment (0.14%). CMS also applied a practice expense and malpractice adjustment (-0.12%) to the anesthesia conversion factor.

In addition, CMS is implementing a series of standard technical proposals involving practice expense, including the implementation of the second year of the market-based supply and equipment pricing update, and standard rate setting refinements to update premium data involving malpractice expense and geographic practice cost indices (GPCIs).

3. CMS Lays Out Vision for Transformed and Streamlined MIPS

√ CMS Proposes Establishment of MVP Framework for 2021

Under authority from MACRA, CMS established the QPP in 2017. The QPP has incentives for value-based care through quality reporting or participation in payment models that require the taking on of risk by clinicians. CY 2020 will be the fourth performance year of the QPP. In response to feedback from participating clinicians, a recommendation from the Medicare Payment Advisory Commission and CMS's own analysis of the data from the initial launch of MIPS, CMS proposes to transform the program with the establishment of the MVP. CMS proposes that by 2021 to move away from reporting on activities and measures from the four performance categories (Quality, Cost, Improvement Activities and Promoting Interoperability) under MIPS and transition to the MVP framework with a unified set of measures and activities centered around a specific condition or specialty along with a set of population health measures.

CMS believes that in an attempt to provide flexibility to clinicians in the first few years of the program, MIPS is now an enormously complex program that does not provide robust clinician performance information. Moreover, inherent in the concept of the MVP framework is a reduction in the number of MIPS quality measures, which is consistent with the agency's Meaningful Measures initiative. Launched in 2017, the Meaningful Measures initiative has reduced the number of measures in a variety of quality programs across the Medicare and Medicaid programs. CMS is soliciting comments on this proposal.

CMS is also proposing some more modest changes for participants in the Advanced Payment Model track of the QPP.

4. **CMS Looks to Expand the Scope of Non-Physician Healthcare Providers**

√ CMS Proposes to Align Physician Supervision for PA Services with State Law and Scope of Practice Rules

In response to the evolving and expanding role of the non-physician provider in various healthcare environments, CMS proposes to expand the scope of physician assistants (PAs) in the Medicare environment. CMS proposes that the statutory physician supervision requirement for PA services would be met when a PA furnishes 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 documentation in the medical record of the PA's approach to working with physicians in furnishing his or her services.

CMS also proposes to defer to state scope of practice requirements on certain services provided by non-physician providers in the ambulatory surgical center (related to anesthetic care) and the hospice environment (related to acceptance of drug orders).

5. **CMS Proposes Expansion of Opioid Use Treatment Services**

√ CMS Addresses Opioid Use in Multiple Proposals, Including Bundled Payments, Additions to Telehealth Services List and Coverage for MAT

Throughout the US government and in local communities across the country, strategies have been implemented to address the opioid epidemic. In 2017 the US Department of Health and Human Services launched a five-point strategy to combat the opioid crisis that included better access to treatment. Along those lines, there are several proposals in this rule to expand access to opioid treatment services.

+ **Bundled payments:** CMS proposes to create three HCPCS G-codes (GYYY1 – GYYY3) to describe bundled payments for the overall treatment of opioid use disorder (OUD), including management, care coordination, psychotherapy and counseling activities.
+ **Telehealth services:** CMS proposes to add these three codes (GYYYY1 – GYYY3) to the list of approved Medicare telehealth services.
+ **Coverage of Methadone for MAT:** Through authority granted under Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act), CMS proposes to implement a new Medicare Part B benefit for opioid use disorder treatment services, including medications for medication-assisted treatment (MAT). This would include payment for methadone.

The Medicare PFS Final Rule is expected be released on or around November 1, 2019, with most changes effective January 1, 2020. The E/M changes are effective January 1, 2021.

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