McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

Sound Health Policy Objectives Achieved

CY 2020 Final Rules: PFS, OPPS, ASC

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Who We Are

McDermott+Consulting serves health industry clients with one-stop lobbying services, data analytics and modeling, and policy advice.

McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

Sound Health Policy Objectives Achieved

- ✓ Work with clients to understand, evaluate and respond to the Quality Payment Program
- ✓ Assess coding, coverage and reimbursement landscapes for public and private payers at the national and state level
- ✓ Develop coding, coverage and reimbursement strategies for clients before and after launch of new products
- ✓ Analyze and model Medicare payment systems (*e.g.,* Medicare Physician Fee Schedule)
- ✓ Create models to demonstrate product and service value (*e.g.*, budget impact models)
- ✓ Develop materials for payer communications
- ✓ Establish and represent issue coalitions

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Agenda

- Key takeaways from the Medicare Physician Fee Schedule (PFS) 2020 Final Rule, including highlights from the Quality Payment Program
- Key takeaways from the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems 2020 Final Rule

Key Themes of the 2020 Rule Cycle

- The recently released final rules reflect the Administration's key goals and priorities:
  - Continued focus on clinician burden reduction and streamlining of quality and other programs
  - Increased efforts around price transparency
  - Implementation of policies intended to drive care to the lowest cost clinician/site of service
  - Expansion of bundling beyond traditional innovation models and integration into the traditional fee schedule or payment system

2020 PFS Final Rule Overview

Quality Payment Program CMS transitions to MIPS Value Pathways in 2021	**2020 Physician Conversion Factor (CF)** 2020 CF remains relatively flat at $36.0896, a slight increase from the 2019 CF of $36.0391
Evaluation & Management (E/M) Services CMS increases payment for E/M services in CY 2021	**Opioid Treatment Services** Establishment of bundled payments, telehealth services and coverage for methadone
Care Coordination and Management Coding changes, revised billing requirements and payment increases for transitional care management, chronic care management and principal care management services	**Non-Physician Healthcare Professionals** Allowed scope of practice for non-physician healthcare providers expanded as CMS relaxes supervision requirements

Quality Payment Program

Quality Payment Program Overview

Eligible Clinicians Will Choose a Pathway

Medicare Access and CHIP Reauthorization Act (MACRA) revised the payment system for physicians and other healthcare professionals by stabilizing annual updates and establishing incentives for value-based care through quality reporting or participation in payment models that require clinicians to take on risk.

Payment Adjustment Timeline

Payment Year	2015-2018	2019	2020	2021	2022	2023	2024	2025	2026
Physician Conversion Factor									
Annual Update	0.5%	0.25%	0%	0%	0%	0%	0%	0%	QPs = 0.75% All other physicians: 0.25%
MIPS									
*Payment Adjustment**		+/-4%	+/-5%	+/-7%	+/-9% (2022 & beyond)				
Exceptional Performance Adjustment		Applies to Top 25% of Performers (2019-2024)						N/A	N/A
APMs									
Incentive Payment		5% Incentive Payment (2019-2024)						N/A	N/A

- ✓ 2019 CF update was reduced to 0.25% from the 0.50% authorized by MACRA as a result of a provision in the BBA of 2018.
- ✓ Beginning in 2020 a period of 0% updates begins.
- ✓ *Note that the MACRA statute included additional bonus potential due to application of a scaling factor, not reflected here.

2020 Final Physician Conversion Factor

Conversion Factor (CF) Remains Flat

Physician CF

CY 2019 CF		**36.0391**
CY 2020 RVU Budget Neutrality Adjustment	0.14% (1.0014)	
CY 2020 CF		**36.0896**

Anesthesia CF

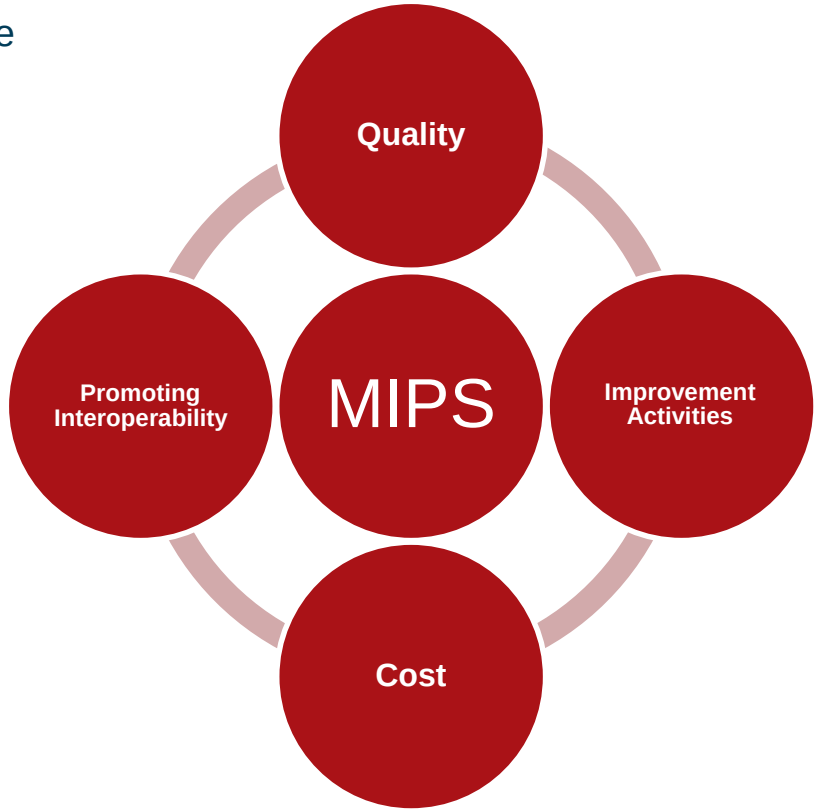
CY 2019 CF		**22.2730**
CY 2020 RVU Budget Neutrality Adjustment	0.14% (1.0014)	
CY 2020 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-0.46% (0.9954)	
CY 2020 CF		**22.2016**

The annual positive update authorized by MACRA expired in 2019.

Source: Tables 117 and 118, CY 2020 PFS Final Rule

Key Finalized Changes for MIPS in 2020

- √ **Bar to avoid negative adjustment raised**
  - Increasing the performance threshold (minimum number of points to avoid a negative adjustment) from 30 points in 2019 to 45 points in 2020 and 60 points in 2021
- √ **Maintained the weight of Quality Performance Category and Cost Performance Category**
  - Quality Performance category weight will remain at 45% and the Cost Performance category will remain at 15% for performance year 2020
- √ **Numerous measure changes**
  - Removing a number of low-bar, standard care and process measures
  - Adding new specially sets (Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician and Endocrinology)
  - Adding 10 new episode-based cost measures



MIPS Performance Threshold Increased

CMS increased the MIPS performance threshold from 30/100 points to 45/100 points for 2020 and 60/100 for 2021

- The "performance threshold" represents the score that is needed to receive a neutral to positive payment adjustment for the year.
- A score below the performance threshold will result in a negative payment adjustment; a score above the payment threshold will result in a positive payment adjustment (a score at the payment threshold will result in a neutral payment adjustment).
- MACRA also authorized an additional $500 million each year from 2019 to 2024 to award "exceptional performance" bonuses to MIPS providers with the highest composite performance scores.

Performance Year	Performance Threshold	Exceptional Performance Threshold
2021	60	85
2020	45	85
2019	30	75
2018	15	70
2017	3	70

Performance Category Weights Maintained

2019 Versus 2018 Performance Category Weights		
Performance Category	**2020 Weights**	**2019 Weights**
Quality	45%	45%
Cost	15%	15%
Promoting Interoperability	25%	25%
Improvement Activities	15%	15%

- ✓ Beginning with the sixth year of the program (2022 performance period) the Quality and Cost performance categories must be equally weighted at 30% each.
- ✓ In the final rule, CMS acknowledged commenters' concerns about increasing the weight of the Cost performance category due to limited feedback on both new and existing cost measures, and therefore they did not increase the weight of the Cost performance category in 2020.

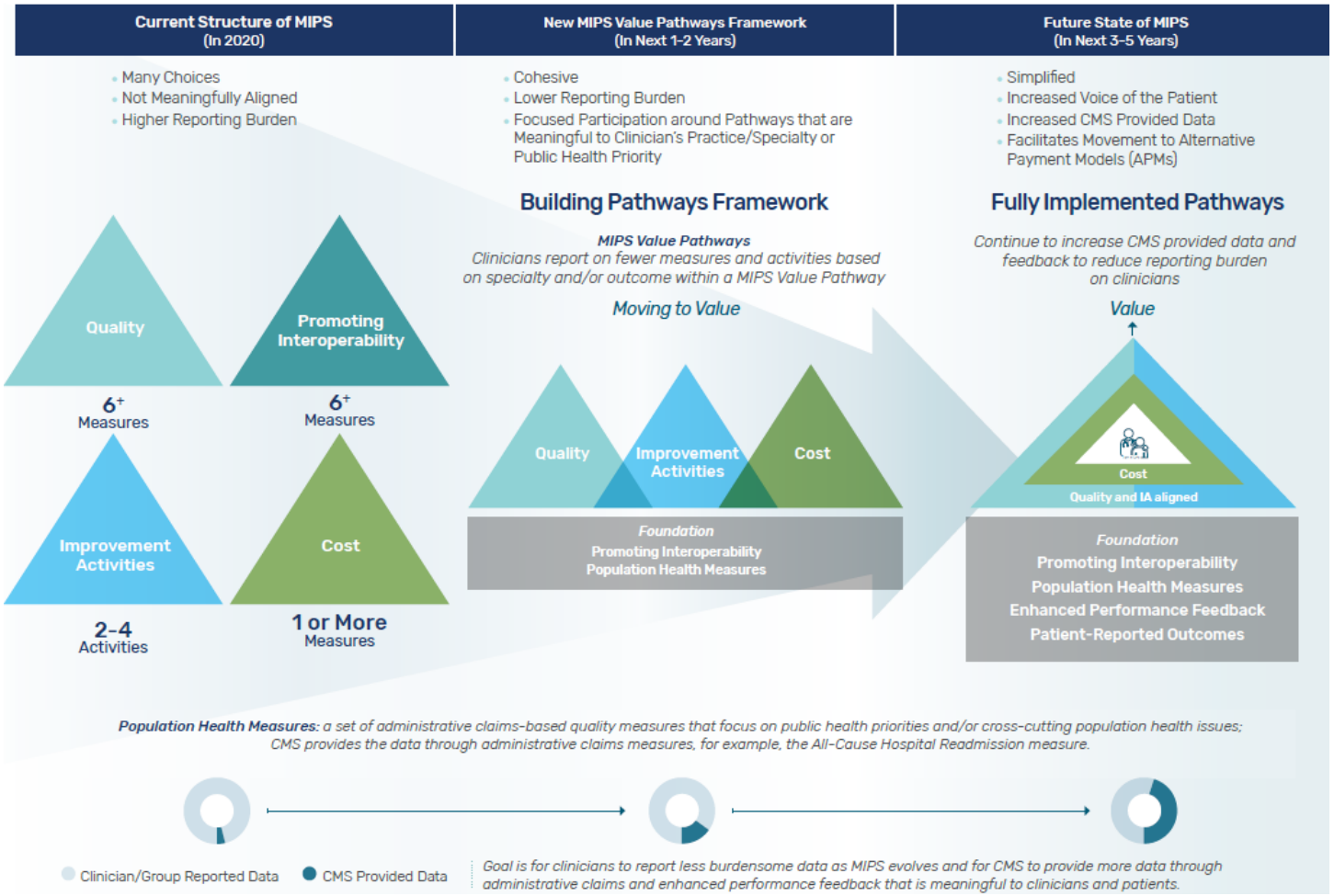
CMS Charts New Vision to Transform MIPS

- MIPS Value Pathways (MVP)
  - CMS will begin transitioning MIPS to MVPs in CY 2021
    - CMS indicated that it will engage with stakeholders in 2020 to gather more feedback
    - In the final rule CMS states that MVP measures and activities will be established through rulemaking
    - This is a modification from the proposed rule, where CMS had stated measures and activities would be "as specified by CMS"
  - CMS concern with current design of MIPS
    - MIPS had evolved into a highly complex program
    - Not producing robust and comparable clinician performance information
  - CMS proposed solution
    - Clinicians measured on a unified set of measures and activities around a clinical condition or specialty
    - These measures would then be layered on top of a base of population health measures, which would be included in virtually all of the MVPs

MIPS Value Pathways (MVPs)

- MVPs are a conceptual participation framework applying to proposals beginning with the 2021 performance year streamlining reporting requirements and reducing clinician burden.
- Clinicians or groups in one MVP are associated with a specialty or with a condition, reporting the same measures as other clinicians within a MVP.
  - Connects measures and activities from the Quality, Cost and Improvement Activities Performance Categories while requiring completion of the Promoting Interoperability Performance Category
  - Clinicians would report on a smaller set of measures that are specialty specific, outcomes based and more closely aligned to Advanced APMs

MIPS Value Pathways (MVPs)



Source: CMS QPP Resource Library, "MIPS Value Pathways Diagrams," 2019.

Advanced APM

- CMS finalized modest changes in the Advanced APM track
  - Refinements to the APM scoring standard in an effort to improve flexibility for participants
  - Addition of Aligned Other Payer Medical Home Models
  - Modified definitions of marginal risk and expected expenditures for Other Payer Advanced APMs
- Additional changes to Advanced APMs are expected outside of this rulemaking
  - The release of new payment models is expected, including the Direct Contracting Application

Physician Fee Schedule Final Rule Highlights

Evaluation & Management (E/M) Office Visits

- Reversed numerous policies for E/M services finalized in CY 2019 PFS
  - Retained 5 levels of coding for established patients but reducing the number of levels to 4 for office-/outpatient E/M visits for new patients
  - Adopted a new add-on CPT code for prolonged service time (99XXX)
  - Adopted a revised add-on HCPCS code for complex visits (GPC1X)
- E/M visit levels are to be chosen based on either medical decision-making or time
  - Each level has distinct payment rate; blended payment rates no longer apply to visits with levels 2-4

Evaluation & Management (E/M) Office Visits

HCPCS	CY 2020 Work RVU	CY 2021 Work RVU
New Patient Office Visit		
99201	0.48	N/A
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
Established Patient Office Visit		
99211	0.18	0.18
99212	0.48	0.7
99213	0.97	1.3
99214	1.5	1.92
99215	2.11	2.8

Source: Table 35, CY 2020 PFS Final Rule

Prolonged & Complex Visit Add-Ons

HCPCS	CY 2020 Work RVU	CY 2021 Work RVU	Billed with E/M Levels				
			1	2	3	4	5
Prolonged Services (Extended Visits)							
99XXX	NA	0.61					✓
Complex Visits							
GPC1X	NA	0.33	✓	✓	✓	✓	✓

Global Surgery & Specialty-Specific Office Visits

- E/M changes were not incorporated into
  - Global surgeries
  - Specialty-specific visits
- This further alters the relative distribution of payments under the Physician Fee Schedule

Specialty	Projected Impact
Endocrinology	+ 16%
Family Practice	+ 12%
Gastroenterology	-4%
Hematology/ Oncology	+ 12%
Ophthalmology	- 10%
Orthopedic Surgery	-2%
Radiology	-8%
Rheumatology	+ 15%
All Specialties	**+/- 0%**

Source: Excerpt from Table 120, CY 2020 PFS Final Rule

Impact of E/M Changes

- The impact of higher work RVUs on payment will not be known until the CY 2021 rulemaking schedule
- Changes under the Medicare PFS are required to be budget neutral
  - To offset increased spending from the finalized E/M changes, CMS will need to make across-the-board reductions, which will likely be implemented through a reduction in the conversion factor
  - Reductions to the conversion factor will work to reduce payment for all services reimbursed under the PFS compared to rates without the budget neutrality adjustment
- CMS acknowledged the "redistributive impact" of the finalized E/M changes as well as commenter concerns, but indicated that it is premature to discuss strategies for mitigating the impact of these changes
- CMS intends to address them in future rulemaking

Care Coordination & Management

- Transitional Care Management (TCM) (99495, 99496)
  - Increased payment for these existing codes
  - Revised billing requirements, allowing concurrent billing of 14 codes currently restricted from being billed with TCM
- Chronic Care Management (CCM) (G2058)
  - Established a new code to report 20 minutes of additional clinical staff time beyond what is described by current service 99490
- Principal Care Management (PCM) Services (G2064, G2065)
  - Established two new codes that will pay clinicians for providing care management services to patients with a single serious and high-risk condition

Non-Physician Healthcare Professionals

- Physician Assistants (PAs)
  - State law establishes the ceiling for which PAs can practice without direct supervision by a physician
- Certified Registered Nurse Anesthetists (CRNAs)
  - As part of the conditions for coverage (CfC) for ASCs, CRNAs can perform pre-anesthesia risk assessments
  - CRNA allowed scope of practice has been expanded, but a physician must still complete the pre-surgical risk assessment as part of the CfC

Flexibility & Regulatory Burden

- Revises documentation requirements to allow physicians, PAs and APRNs who furnish and bill for their professional services to review and verify information included in the medical record by physicians, residents, nurses, students or other members of the medical team in all settings
  - CMS modified this provision explicitly defining “students” to include PA, NP, CNS, CNM and CRNA students, along with medical students, as those permitted to document within a medical record for review
- Revises ambulatory surgical center and hospice regulations to reflect role of certain non-physician practitioners in those settings

Expansion of Opioid Use Treatment Services

- Bundled payments
  - CMS finalized the creation of three G-codes (G2086 – G2088) to describe bundled payments for the overall treatment of opioid use disorder (OUD), including management, care coordination, psychotherapy and counseling activities
- Telehealth services
  - CMS added these three codes to the list of approved Medicare telehealth services
- Coverage of Methadone for MAT
  - CMS implemented a new Medicare Part B benefit for OUD treatment services, including medications for medication-assisted treatment (MAT)
  - This includes payment for methadone

OPPS/ASC Final Rule Highlights

2020 OPPS Final Rule Overview

Conversion Factor	2020 CF is $80.784, an increase from the 2019 CF of $79.490
Prior Authorization	New prior authorization process and requirements effective July 1, 2020, for five categories of hospital outpatient department services
340B	ASP-22.5% continues as the payment rate for drugs purchased under the 340B program
Supervision Requirements	Supervision requirements for hospital outpatient therapeutic services reduced from direct supervision to general supervision for all hospitals
Inpatient Only List	Total hip arthroplasty and 11 other services eligible for payment when performed in the hospital outpatient setting

Changes effective January 1, 2020, unless otherwise noted

Prior Authorization for Certain OPD Services

- CMS established a process through which providers must submit a prior authorization request for a provisional affirmation of coverage before a covered outpatient service is furnished to the beneficiary and before the claim is submitted for processing
- Focused on procedures CMS identified as having the potential to be cosmetic procedures masquerading as therapeutic; applying to five categories of service:
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation
- Hospitals demonstrating high levels of compliance with Medicare coverage, coding and payment rules will be exempted
- **Prior authorization requirements are effective July 1, 2020**

OPPS 340B Payment Rates

- CMS maintained ASP-22.5% as the payment rate for drugs purchased under the 340B program in CY 2020
  - Amidst a legal battle in federal courts
- Agency expected to propose a specific remedy for 340B payment rates in the CY 2021 OPPS/ASC proposed rule

OPPS Changes to Supervision Requirements

- Final changes to the minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals
- "General supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the procedure
- Providers and physicians have the flexibility to require a higher level of supervision for particular services as they deem necessary

Services Removed from Inpatient Only List

HCPCS	Descriptor	National Payment Rate	Other
00670	Anesthesia for extensive spine and spinal cord procedures (for example, spinal instrumentation or vascular procedures)		Not separately payable. Costs bundled with primary procedure.
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy		Not separately payable. Costs bundled with primary procedure.
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)		Not separately payable. Costs bundled with primary procedure.
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy		Not separately payable. Costs bundled with primary procedure.
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty)		Not separately payable. Costs bundled with primary procedure.

Services Removed from Inpatient Only List

HCPCS	Descriptor	National Payment Rate	Other
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	$11,899.39	
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar; each additional interspace and segment		Not separately payable. Costs bundled with primary procedure.
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty) with or without autograft or allograft	$11,899.39	

Services Removed from Inpatient Only List

HCPCS	Descriptor	National Payment Rate	Other
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	$5,981.28	
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	$5,981.28	
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	$5,981.28	
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	$5,981.28	

2020 ASC Payment System Final Rule Overview

Conversion Factor	2020 CF is $47.747, an increase from the 2019 CF of $79.490
ASC Scalar	2020 ASC scalar is 0.8550, a decrease from the 2019 scalar of 0.8800; furthers the divide between OPPS and ASC rates
Covered Procedure List	Total knee arthroplasty and 19 other services now eligible for payment when performed in the ASC setting

Changes effective Jan. 1, 2020 unless otherwise noted.

Services Added to ASC Covered Procedures List

HCPCS	Descriptor	National Payment Rate	Notes
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)	$1,504.38	
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; 50 cc or less injectate	$1,504.38	
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands and/or feet; 25 cc or less injectate	$819.95	
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	$8,609.17	
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)	$8,484.72	
33016	Pericardiocentesis, including imaging guidance, when performed	$579.91	

Services Added to ASC Covered Procedures List

HCPCS	Descriptor	National Payment Rate	Notes
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	$1,100.20	
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	$315.83	
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	$315.83	
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	$315.83	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	$796.79	

Services Added to ASC Covered Procedures List

HCPCS	Descriptor	National Payment Rate	Notes
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	$2,392.91	
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	$2,392.91	

Services Added to ASC Covered Procedures List

HCPCS	Descriptor	National Payment Rate	Notes
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$3,021.41	
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)		Not separately payable. Costs bundled with primary procedure.
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,057.39	
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)		Not separately payable. Costs bundled with primary procedure.

Services Added to ASC Covered Procedures List

HCPCS	Descriptor	National Payment Rate	Notes
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming and imaging guidance when performed, posterior tibial nerve	$411.66	
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,188.83	
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)		Not separately payable. Costs bundled with primary procedure.

Links and Resources

- **PFS/QPP 2020 Final Rule**
  - PFS Final Rule available here
  - M+ summary
  - CMS PFS fact sheet
  - CMS QPP fact sheet
  - CMS QPP executive summary

- **OPPS/ASC 2020 Final Rule**
  - OPPS/ASC Final Rule available here
  - M+ summary
  - CMS fact sheet