American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

FACT SHEET

ACEP Responses to Major Medicare Payment Rule for Calendar Year (CY) 2020

Each year, the Centers for Medicare & Medicaid Services (CMS) releases several proposed regulations for public comment that, once finalized, directly impact how emergency physicians are paid under Medicare. Just like last year, CMS combined the Physician Fee Schedule and the Quality Payment Program (MACRA) proposals into a single rule.

Key provisions of the rule and ACEP's responses to them are below—note that these are all only *proposed* by CMS. We expect final regulations setting CY 2020 payment policy to be released by CMS in early November.

To see ACEP's full response to this rule, please click here.

Medicare Physician Fee Schedule Proposals

- Revaluation of the Emergency Department (ED) Evaluation and Management (E/M) Codes— CMS is proposing to increase the value of the ED E/M codes, consistent with recommendations made by the American Medical Association (AMA) Relative Value Scale (RVS) Update Committee (RUC) at a meeting in April 2018. ACEP members that serve as emergency medicine representatives on the RUC had provided compelling evidence to the RUC that these codes were undervalued. To find out more about ACEP's role on the RUC, please click here.

  ACEP Response:

  - **We thank CMS for recognizing the RUC's recommended increase in the valuation of these codes.**
  - But as discussed in the "Payment for Office and Outpatient E/M Visits" section below, urge CMS to finalize an additional increase in these codes in CY 2020 to maintain the relative value between the new patient office and outpatient codes proposed for CY 2021 and the ED E/M codes.

- Payment for Office and Outpatient E/M Visits— 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. These codes represent approximately 20 percent of billed services under the PFS. The PFS includes a statutory budget neutrality requirement, which means that any increases in the value of one code results in corresponding decrease in the value of all other codes. Since emergency physicians do not bill for the office and outpatient E/M services, the impact on the emergency medicine specialty in terms of potential cuts to our codes is estimated to be extremely large. CMS cannot provide an exact estimate of the size of the reduction to emergency medicine Medicare payments, but includes an illustrative calculation of -7 percent.

  ACEP Response:

  - Support CMS' decision to accept the RUC's recommendations for the office and outpatient E/M codes. However, we are extremely cognizant of the significant budget neutrality adjustment that would be triggered if CMS finalized all of the proposals as proposed in CY 2021.
  - Believe that a reduction anywhere close to -7 percent could significantly jeopardize the emergency care safety net, especially in rural areas.
  - Further, such a large reduction to emergency medicine in CY 2021 does not make sense from a policy perspective. In CY 2020, CMS is proposing to increase the value of the most billed services for emergency physicians (the ED E/M codes) because the agency appropriately believes that these codes are currently undervalued. If CMS finalized the CY 2021 office and outpatient E/M proposals as proposed, all of the increases in emergency physician payments from CY 2020 would be completely

eliminated, and instead these physicians would see a significant decrease in Medicare payments.

- **Offer the following two solutions:**
    1) **Increase the value of the ED E/M codes, levels 1 through 3, to align with the corresponding levels for the office and outpatient E/M codes for new patients; AND,**
    2) **Delay the implementation of the add-on code for complexity.**

◆ Medical Record Documentation— CMS is proposing a broad modification to the current documentation requirements for Medicare services to 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.

ACEP Response:

- **Believe that this broad flexibility will significantly reduce burden for teaching physicians and urge CMS to finalize this proposal.**

◆ 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.

ACEP Response:

- State that although EDs are not included in the established definition of OTPs, we feel strongly about reducing barriers to treatment for patients with SUD, including OUD. One significant barrier to providing medication-assisted treatment (MAT) outside of OTPs is the "X waiver" requirement mandated by the Drug Addiction Treatment Act (DATA) of 2000.

◆ Bundled Payment for Substance Use 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. CMS is also 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.

ACEP Response:

- Recommend that CMS expand the use of bundled payments for the treatment of SUD to the ED setting.
- **Strongly support a future policy that would pay separately for MAT initiated in the ED and strongly encourage CMS to include such a proposal in next year's rule.**

◆ Appropriate Use Criteria (AUC) Program — CMS is not proposing any 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. 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.

ACEP Response:

- Express appreciation for the actions CMS has taken thus far related to the AUC Program.
- **Request that CMS postpone the AUC Program requirements until at least 2021. Since CMS did not propose this delay in the rule, CMS should issue an interim final rule announcing the delay.**

Quality Payment Program Proposals

- MIPS Value Pathways (MVP) Framework— Based on feedback from providers that participation in the Merit-based Incentive Payment System (MIPS) should be streamlined and more meaningful to clinicians, CMS is proposing to create the MIPS Value Pathways (MVPs) beginning with the 2021 performance year. An MVP would connect measures and activities across three categories in MIPS: quality, cost, and improvement activities. These pathways would be organized around a specialty, episode of care, or health condition. In the rule, CMS requests stakeholder feedback related to the MVPs, including on MVP construction, measure selection, organization, MVP assignment, and the transition to MVPs.

  ACEP Response:

  - Support the overall concept of MVPs, but express concerns about the short implementation timeline CMS is proposing. **We strongly recommend that CMS slow down their implementation timetable, allowing an additional year or two for CMS to continue to flesh out the details, receive additional public input, and propose and develop the first cohort of MVPs.**
  - Urge CMS not to simply replace current MIPS program with MVPs. We strongly believe that participation in MVPs should be voluntary, not mandatory. We do not support CMS assigning MVPs to clinicians.
  - Encourage CMS to work with specialty societies throughout the year and be prepared to provide a menu of MVP options before the start of the next performance year to give clinicians time to choose an MVP that best fits their practice.
  - Request that CMS provide incentives to clinicians to participate in MVPs and strongly encourage CMS to slowly phase in the reporting requirements.

- Definition of Hospital-based Clinicians— 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 the Promoting Interoperability category (that measures use of EHRs and health IT). Currently, clinicians who are deemed "hospital-based" as individuals are exempt from the Promoting Interoperability category of MIPS. 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.

  ACEP Response:

  - **Strongly support the proposal to change the definition of "hospital-based" for groups.**

- Performance Category Weighting in Final Score —CMS is proposing to increase the Cost category of MIPS incrementally over time, reaching the statutorily required 30 percent by 2022. CMS proposes to make corresponding decreases to the Quality category weight each year.

  ACEP Response:

  - Recommend that CMS maintain the Cost category percentage at 15 percent for one more year to provide CMS more time to develop more episode-based cost measures (which currently do not appropriately measure emergency care).

- Increasing Performance Threshold — CMS is proposing to increase the performance threshold needed for a MIPS bonus payment from 30 points in 2019, to 45 points in 2020, and to 60 points in 2021, and the threshold to get an exceptional performance bonus from 75 points in 2019, to 80 points in 2020, and to 85 points in 2021.

  ACEP Response:

  - Believe that the current proposal for the performance threshold represents a reasonable increase in the

performance threshold over the next two years.

- Urge CMS not to increase exceptional performance threshold to 85 points in 2021, since raising it above 80 points will adversely affect those specialties that do not have many reportable measures.

◆ 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. CMS is also proposing to eliminate 55 measures from the current inventory of MIPS quality measures.

ACEP Response:

- Do not support the proposed increase in the data completeness threshold to 70 percent, as the current threshold of 60 percent is already hard to reach for some emergency physicians.
- Recommend maintaining the existing MIPS quality measures to ensure consistency with program requirements and allow for more measures to form the basis of MVPs.

◆ Cost Category— CMS is proposing to keep, but revise, the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and add ten episode-based cost measures on top of the eight episode-based cost measures CMS added to the program in 2019.

ACEP Response:

- Express disappointment that CMS is continuing to maintain the MSPB and the Total Per Capita Cost measures, despite the proposed modifications. We have repeatedly asked CMS to remove these measures from the MIPS program.
- Applaud CMS for developing new episode-based measures. ACEP has been involved in CMS' ongoing work to develop new episode-based cost measures that are meaningful to emergency physicians, including on a cost measure related to sepsis.

◆ 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.

ACEP Response:

- Strongly oppose CMS' proposal to increase the minimum number of clinicians in a group who are required to perform an improvement activity to 50 percent and urge CMS to maintain the existing policy of only requiring one clinician in a group to participate in an improvement activity.

◆ Qualified Clinical Data Registries— CMS includes a number of proposals that would affect ACEP's QCDR, the Clinical Emergency Data Registry (CEDR).

ACEP Response:

- Respond to each individual QCDR proposal directly.
- Express general concern that some of the proposals may make it more difficult and burdensome for QCDRs to participate in MIPS successfully. In all, we fear that CMS is attempting to shift costs and burden of administering the MIPS program onto specialty societies that create measures and operate QCDRs.

◆ Alternative Payment Model (APMs)— CMS is proposing various technical modifications to current Advanced APM definitions and to the current requirements that clinicians must meet to qualify for the five percent payment bonus that MACRA makes available to those who participate in Advanced APMs.

ACEP Response:

- Strongly encourage CMS to develop more Advanced APMs that emergency physicians can directly participate in, starting with ACEP's APM, the Acute Unscheduled Care Model.