

## Summary of the 2020 Medicare Physician Fee Schedule and Quality Payment Program Final Rule

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) released a [Medicare annual payment rule](#) that impacts payments for physicians and other health care practitioners in calendar year 2020. The rule combines 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). CMS had issued a proposed rule in July, which ACEP responded to with a robust set of comments. Highlights of ACEP’s response are found [here](#).

Found below is a summary of key policies that are now finalized and that will become effective January 1, 2020.

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### Physician Fee Schedule (PFS)

The Medicare Physician Fee Schedule (PFS) section of the rule includes numerous significant policies, but the most consequential to emergency medicine relates to payment for emergency department (ED) evaluation and management (E/M) services -- the most commonly billed services for emergency physicians (codes 99281-99285).

In recognition of the critical value of these services, CMS finalized an increase in these payments for 2020. Yet CMS also finalized a separate proposal for 2021 that will result in an overall decrease in emergency medicine reimbursement.

1. The PFS conversion factor, which converts the relative value units (RVUs) for each CPT code to dollars, will slightly increase from \$36.05 in 2019, to \$36.09 in 2020.

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

- CMS had in 2017 identified the five ED E/M codes 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.
  - For Level 5, the survey's median intra-service time dropped by 25 percent from 40 to 30 minutes. This would normally result in a commensurate decrease in the work value; 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. The result was that the current value was maintained.
- CMS is accepting the increased values for 2020. The fiscal impact of these RVU changes combined with the slight increase in the PFS conversion factor should yield total increases in ED E/M Medicare payments of approximately \$130 million dollars annually. CMS estimates the 2020 impact on total allowed charges for the specialty of emergency medicine to be +1 percent.

3. Office and Outpatient E/M Services

- CMS is finalizing an increase in 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 these E/M services levels 2 through 4, CMS will 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.

- Because of the high-volume utilization of these codes by most medical specialties, the resulting adjustments that are required by law to maintain budget neutrality will likely be substantial. Any specialty that does not regularly use the office codes will see what could be substantial decreases in total allowed charges in 2021.
- CMS could not provide an exact estimate of the size of the reduction to emergency medicine Medicare payments, but included an illustrative calculation of a 7 percent cut.
- Since there has been a longstanding acceptance that there should be rank order between the office and ED E/M codes, ACEP had urged CMS to finalize an additional increase in these codes to maintain the relative value between the new patient office and outpatient codes that had been proposed for CY 2021 and the ED E/M codes.

CMS did not accept our recommendation; however, the agency states in the final rule that it is considering updating other E/M visits (including perhaps ED visits) to maintain relativity with the revalued office/outpatient E/M code set as part of PFS rulemaking for 2021.

#### 4. 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 modifies the documentation policy to now allow physicians, physician assistants, or advanced practice registered nurses who deliver and bill 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.

#### 5. Telehealth Services

- CMS is finalizing its proposal to add face-to-face requirements for three new codes to the list of telehealth services -- HCPCS codes G2086, G2087, G2088, which describe a bundled episode of care for treatment of opioid use disorders, with the codes delineating office-based treatment planning and therapy based on the time, length, and month of treatment.
- CMS did not propose or finalize 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.

#### 6. Opioid Use Disorder Coverage

- The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act) passed in 2018 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 the requirements governing enrollment, coverage, payment, and program integrity needed to implement this new Medicare benefit.
  - Physicians and other providers in OTPs will be able to dispense methadone, buprenorphine, and naltrexone, and provide counseling, therapy, and toxicology testing. Reimbursement will be at a weekly bundled rate determined annually and based on the costs of the drugs administered plus the services provided.

#### 7. Bundled Payment for Opioid Use Disorder

- CMS is establishing bundled payments for the overall treatment of OUD (whether within or outside an OTP), which includes management, care coordination, psychotherapy, and counseling activities. To implement this new bundled payment, CMS is creating 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. The codes are limited only to Medicare beneficiaries with OUD.

- Of particular note, CMS recognizes that there is no specific coding that describes the diagnosis of OUD in the ED setting, or the initiation of, or referral for, medication-assisted treatment (MAT) there. CMS sought comment on the use of MAT in the ED in the proposed rule (which ACEP supported) and confirms in the final rule that the agency is considering making separate payments available for such services in the ED in future rulemaking.

#### 8. Appropriate Use Criteria (AUC) Program for Advanced Imaging

- CMS did not propose or finalize any changes regarding implementation of the requirement that clinicians consult AUC through a qualified clinical decision support mechanism starting January 1, 2020 when ordering advanced imaging services (i.e., SPECT/PET MPI, CT, and MRI).
- In last year's rule, due to significant advocacy by ACEP in prior years, CMS clarified that the exemption granted in the AUC program for individuals with an emergency medical condition does extend to instances where an emergency medical condition is only suspected, but not yet confirmed.

This may include, for example, instances of severe pain, and is applicable even if it is determined later that the patient did not have an emergency medical condition. In other words, if physicians only think their patients are having a medical emergency, they are still exempted 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.”
- ACEP also has [a sample letter](#) you can use to let your hospital administrators know about this exemption and ask them to help make sure it is properly implemented in your ED.

#### 9. Physician Supervision for Physician Assistant (PA) Services

- CMS is modifying current regulations around the physician supervision of PA services. CMS clarifies that PAs must deliver their professional services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's services are delivered.
- For states with no explicit state law or scope of practice rules regarding physician supervision of PA services, CMS states that physician supervision will be evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician(s) when delivering services.

## 10. Care Management Services

- CMS is increasing payment for Transitional Care Management (TCM) and implementing a set of Medicare-developed HCPCS G codes for certain Chronic Care Management services. Additionally, CMS is creating new coding for Principal Care Management services, which will pay clinicians for providing care management for patients with a single serious and high-risk condition. While ACEP supports additional payments for care coordination, we note that most emergency physicians do not bill for these specific services. We have encouraged CMS to develop separate care coordination codes for the follow-up services provided to complex Medicare patients discharged from the ED.

## 11. Ambulance Physician Certification Statement Requirement

- CMS clarifies 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 will 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 physician certification statement.
- CMS is also granting ambulance suppliers and providers greater flexibility around who may sign a non-physician certification statement in certain circumstances. The policy 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 establishing the data collection format and elements, a sampling methodology it 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 reducing by 10 percent the payments that would otherwise be made to a ground ambulance organization that is identified for reporting but fails to submit data sufficiently. These organizations can request a hardship exemption that, if granted by CMS, will allow them to avoid the payment reduction.

## 13. Medicare Shared Savings Program

- In the proposed rule, CMS sought comments 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. In the final rule, CMS states that aligning quality metrics across programs will reduce the burden and will allow ACOs to more effectively target their resources

toward improving care. Additionally, CMS finalizes some proposed modifications to the program's current set of quality measures.

#### 14. Application of the Physician Self-Referral Law

- CMS is updating 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 establishes 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 determines 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 rule, CMS finalizes a new MIPS Values Pathway (MVP) framework, that, once implemented, would hopefully provide a more cohesive and meaningful participation experience for clinicians. Further, CMS finalizes numerous other changes to MIPS, including to the four performance categories, 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

- In response to feedback, including from ACEP, that MIPS reporting should be streamlined and more meaningful to clinicians, CMS proposed and finalized the MIPS Value Pathways (MVPs) framework beginning with the 2021 performance/2023 payment year.
  - Ultimately, CMS wants all clinicians to participate in the QPP 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 a specialty, specific episode of care, or health condition.
- CMS requested stakeholder feedback related to the MVPs, including on MVP construction, measure selection, organization, MVP assignment, and the transition to

MVPs in the proposed rule. ACEP submitted a robust response and strongly recommended that CMS slow down its 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.

- However, CMS is finalizing the MVP participation framework that would begin with the 2021 performance period, recognizing stakeholder concerns about this timeline and committing to a smooth transition to the MVPs that does not immediately eliminate the current MIPS framework.
- Notably, CMS has not yet indicated whether participation in an MVP will be mandatory or optional. Feedback and suggestions will be considered as CMS undertakes further rulemaking in future years.

## 2. Performance Category Weighting in Final Score:

- Each performance category in MIPS is weighted at a specific percentage when rolled up into the final score.
- CMS has chosen to keep all four category weights the same in 2020 as they were in 2019:
  - Quality: 45% (same as 2019)
  - Cost: 15% (same as 2019)
  - Promoting Interoperability (EHR): 25% (same as 2019)
  - Improvement Activities: 15% (same as 2019)
- CMS is required by law to set the Cost category percentage to 30 percent beginning in 2022. In the proposed rule, CMS proposed increasing the Cost category incrementally over time to build up to the required 30 percent by 2022.
  - However, based on comments, CMS is keeping the current weights as they are in 2020 and is not finalizing any changes to the weights in future years. The agency states that it will revisit increasing the weight of the Cost performance category in next year's rulemaking to ensure clinicians are prepared for the significant increase in category weight by 2022.

## 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 finalizing its proposal 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 higher threshold that is applied to reward providers for exceptional performance with an additional bonus on top of their upward payment adjustment. CMS is increasing this threshold from 75 points in 2019 to 85 points in 2020 and 2021.
- As required by statute, the maximum negative payment adjustment (penalty) in 2022 (based on performance in 2020) is -9%, and the positive payment adjustment (bonus) can be up to 9% (before any exceptional performance bonus).

But because MIPS is a budget-neutral program, the size of the bonus pool is determined by the amount of money available through the pool of penalties. 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.

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 original 5 percent permissible under law for that performance year).

- In the new rule, CMS estimates that the 9 percent payment update for 2022 (based on 2020 performance) would be scaled down to 1.26 percent, and that the maximum bonus for exceptional performance would be 4.99 percent.
- Therefore, the total maximum payment adjustment a provider could receive in 2022 if they received a perfect MIPS score in 2020 would be 6.25 percent (1.26 percent + 4.99 percent).

#### 4. Quality Performance Category

- Currently, clinicians are required to report on 60 percent of their patients across the 12-month reporting period. CMS is finalizing its proposal to increase the data completeness requirements in 2020 to 70 percent.
- Currently, a quality measure may be considered for removal from the program if the measure is no longer meaningful, such as topped-out measures. CMS will now also remove measures that do not meet case minimum and reporting volumes required for benchmarking for two consecutive years.

#### 5. Cost Category

- CMS is revising the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and will add ten episode-based cost measures. The case minimum will be 10 for procedural episodes and 20 for acute inpatient medical condition episodes.

#### 6. Improvement Activities Category

- CMS is making some modifications to this category, which include slightly modifying the definition of a rural area and adding, modifying, and removing some activities.
  - 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 modifying this policy by now only allowing groups to attest to an improvement activity if at least 50 percent of clinicians in the group participate in or perform the activity during any continuous 90-day period within the same performance year.

#### 7. 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 even 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 a major victory for ACEP, CMS is now modifying this policy by exempting groups from the Promoting Interoperability category if 75 percent of the individuals in the group meet the definition of hospital-based.
- CMS is removing the “Verify Opioid Treatment Agreement” measure and keeping the “Query of PDMP” measure as optional.

## 8. Qualified Clinical Data Registries (QCDR)

- QCDRs are third-party intermediaries that help clinicians report under MIPS. ACEP has its own QCDR called the Clinical Emergency Data Registry (CEDR) which has custom measures that are tailored to emergency physicians.

CMS is finalizing the following new QCDR requirements for 2020:

- Grant QCDR measures that are potentially duplicative with another measure one year of conditional approval. The measures will be removed by CMS 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 finalizing these additional new QCDR requirements:
  - Have the capability to submit data on the Quality, Improvement Activities, AND the Promoting Interoperability categories of MIPS.
  - Include in mandated quarterly reports information on how participants compare to other clinicians who report through the QCDR.
  - Identify 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.
- Based on comments, CMS is not finalizing its proposal to require QCDRs to engage in additional activities that foster improvement in the quality of care, but states that the agency may introduce a similar policy in future rulemaking.
- 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 establishing a policy in which the agency will consider the extent to which a QCDR measure is available to clinicians reporting through QCDRs other than the QCDR measure owner.

- CMS clarifies that “available” means that the QCDR measure owner must provide other QCDRs with the opportunity to enter into a licensing agreement for each measure. If CMS determines that a QCDR measure is not available to these clinicians through a potential licensing agreement, the agency may not approve the measure.

## 9. Physician Compare

- CMS is finalizing a few proposals related to Physician Compare. CMS will aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores, available on Physician Compare beginning with 2018 data.
- CMS will also post on Physician Compare an indicator that displays if a clinician is scored using facility-based measurement, an option for which most emergency physicians are eligible to be scored under.

## 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 creating a new “aligned Other Payer Multi-Payer Medical Home Model” definition, which would expand the ability for clinicians participating in other-payer (i.e. non-Medicare or Medicaid) medical home APMs to potentially qualify for the five percent bonus available under MACRA.

### 2. Other Technical Changes

- CMS is making 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.