Medical Group Management Association®

Proposed 2020 Medicare Physician Payment and Quality Reporting Changes
MGMA Member-Exclusive Analysis

The Centers for Medicare & Medicaid Services (CMS) recently proposed changes to both Medicare physician payment and quality reporting program policies that would generally take effect Jan. 1, 2020. The proposed rule would change the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2020. MGMA will submit formal comments in response to the proposed rule and share them with members in the MGMA *Washington Connection* newsletter. If you have any questions or reactions to proposed policies, please reach out to MGMA Government Affairs at govaff@mgma.org.

Medical Practice Executive Insights

Key 2020 Medicare physician fee schedule (PFS) proposals

- CMS estimates the 2020 Medicare PFS conversion factor would be $36.0896. The Anesthesia conversion factor is estimated to be $22.2774.
- CMS proposes coding and payment changes for E/M office visits starting in CY 2021. This includes significant revisions to the policies finalized for CY 2021 in 2019, including that CMS proposes to forgo any blending of E/M payments.

Key 2020 MIPS and APMs proposals

- CMS proposes a new "MIPS Value Pathways" concept starting in CY 2021 with the goal of aligning measures across the siloed MIPS categories.
- The proposed performance threshold for avoiding a payment penalty is 45 points and the proposed exceptional performance threshold is 80 points.
- By statute, the 2022 payment adjustment based on 2020 performance is ±9% and the 10% for exceptional performance is still available.
- Cost measures would count toward 20% of the MIPS final score – an increase from 5% in 2019—and CMS would add 10 new episode-based measures.

2020 PFS Proposals

Physician Payment Update

CMS estimates the 2020 Medicare PFS conversion factor will be $36.0896, a nominal increase of five cents from the 2019 conversion factor of $36.0391. The 2020 conversion factor includes a 0.14% budget neutrality adjustment and does not include an update factor under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA provided an update of 0.5% from 2016 through 2019, a zero percent update from 2020 through 2025, and then a 0.25% update for MIPS participants and 0.75% update for APM participants in 2026 and beyond.[1]

The Anesthesia conversion factor is estimated to be $22.2986.

[1] The Bipartisan Budget Act of 2018 reduced the MACRA update in 2019 to 0.25%.

E/M Services

Under the 2019 PFS, CMS suggested collapsing the five-level payment system for office/outpatient E/M visits by blending levels 2 through 4 into one payment rate (one rate for established patients and another rate for new patients) starting in CY 2021. In response to strong opposition voiced by MGMA and other physician stakeholder groups, CMS now proposes to roll back this blended payment rate policy and instead proposes to adopt solutions suggested by the AMA's RVU Update Committee (RUC). These proposed policies include maintaining separate payment rates for each office/outpatient E/M level visit.

There are no significant updates to E/M coding, payment, or documentation for CY 2020, so the following summarized policies would begin in CY 2021.

Proposed documentation changes for E/M visits in CY 2021

CMS proposes to allow practitioners to select the appropriate level of E/M visit based on medical decision-making (MDM) in the exam or based on time spent with the patient by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). CMS would only require documentation of patient history and a medical examination when clinically appropriate.

Proposed payment changes for E/M visits in CY 2021

CMS proposes to maintain a separate payment rate for all E/M levels, although the agency proposes to delete CPT code 99201 (level 1 new patient office/outpatient E/M visits). In addition to the base E/M visit levels, the agency proposes to create two add-on codes that could be reported with an E/M visit:

- 99XXX would describe prolonged office/outpatient E/M visits when time is used for code level selection and the time for a level 5 office/outpatient visit is exceeded by 15 minutes or more on the date of service. The proposed descriptor is: *Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes. (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).*
- GPC1X would describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious or complex chronic condition. The proposed descriptor for GPC1X is: *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or medical care services that are part of ongoing care related to a patient's single, serious or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).*

CMS proposes to adopt the RUC-recommended work RVUs for all office/outpatient E/M codes, as well as the new prolonged services add-on code:

HCPCS Code	Current Time (mins)	Current wRVU	2021 Proposed Time (mins)	2021 Proposed wRVU
99201	17	.48	N/A	N/A
99202	22	.93	22	.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	.18	7	.18
99212	16	.48	18	.7
99213	23	.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
99XXX	N/A	N/A	15	.61
GPC1X	N/A	N/A	11	.33

Verification of Medical Record Documentation

In 2019, CMS finalized that a teaching physician could review and verify (sign/date) notes made by medical students in a patient record for E/M services, rather than re-document the information. In the 2020 PFS, CMS proposes to expand this policy and permit physicians, physician's assistants (PAs), nurse practitioners, clinical nurse specialists, and certified nurse-midwives to review and verify notes made in the medical record by other members of the medical team, rather than re-document them. This policy would apply across all Medicare covered services under the PFS.

PA Supervision

Medicare currently requires PA services to be furnished under a physician's general supervision, defined as being under the physician's overall direction and control, although not necessarily in the physician's presence. In response to comments promoting greater independence for PAs, CMS proposes to permit PAs to practice in accordance with state law supervisory requirements, rather than Medicare's general supervision requirements. In the absence of state law, the PA supervision requirement could be met by documenting in the medical record the PA's approach to working with the physician.

Payment for Transitional Care Management (TCM) Services

Reimbursement for TCM services is intended to recognize clinicians for the time spent managing a patient's care after the patient leaves the hospital. Use of TCM services has grown from 300,000 professional claims in 2013, the first year the code was covered, to almost 1.3 million claims during 2018. Despite this growth, CMS acknowledges TCM services are underutilized and proposes changes starting in CY 2020 to alleviate administrative billing requirements and improve payment accuracy.

Under current policy, TCM services cannot be billed concurrently with 57 codes during the 30-day period covered by TCM. CMS proposes to allow TCM billing with 14 of those codes previously prohibited from concurrent billing, such as prolonged services without direct patient contact and complex chronic care management services, as described in Table 17 of the proposed rule.

Additionally, CMS proposes to increase payments by adopting the AMA RUC-recommended work RVUs of 2.36 for CPT code 99495 and 3.10 for CPT code 99296. The 2019 work RVUs for these services were 2.11 and 3.05, respectively.

Payment for Chronic Care Management (CCM) Services

CMS began covering non-complex CCM services in 2015 and complex CCM services in 2017. Starting in CY 2020, the agency proposes several changes related to CCM payment and coding policy.

CMS proposes to replace the single existing CPT code describing non-complex CCM (99490) with two G-codes with time-based increments of clinical staff time. The first G-code (GCCC1) would cover the initial 20 minutes of clinical staff time and the second code (GCCC2) would describe each additional 20 minutes thereafter. This change is intended to recognize additional time spent on non-complex CCM.

CMS also proposes to replace existing CPT codes for complex CCM with new G-codes that remove certain billing requirements and clarify what must be included in the "typical care plan" required for complex CCM. If finalized, CMS would replace 99487 with GCCC3 and 99489 with GCCC4 and remove the service component of the substantial care plan revision element. An overview of CCM billing requirements can be found in Table 18 of the proposed rule.

Establishing New Care Management Service

CMS proposes to introduce a new covered code for "principal care management" (PCM) services, which would describe care management for patients with a single complex chronic condition. The full scope of service requirements for CCM services would apply to PCM services.

HCPCS code GPPP1 would describe comprehensive care management services for a single high-risk disease with at least 30 minutes of physician or qualified healthcare practitioner time per month. HCPCS code GPPP2

would describe at least 30 minutes of *clinical staff time* spent on comprehensive management of a single condition.

Medicare Telehealth Services

CMS proposes adding the following services that address opioid use disorder (OUD) to the list of approved telehealth services starting in CY 2020:

- HCPCS code GYYY1: *Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.*
- HCPCS code GYYY2: *Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in subsequent calendar month.*
- HCPCS code GYYY3: *Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).*

Communications-based Technology Services

In 2019, CMS finalized a series of communications-based technology services that involve non-face-to-face care but are not subject to Medicare telehealth billing restrictions, as summarized in MGMA's exclusive member resource.

While the agency does not significantly address these codes in the 2020 proposed rule, CMS is soliciting feedback on how to alleviate burden around the requirement to obtain consent for these services. Specifically, CMS is seeking comment on whether it should allow practitioners to obtain a single advance beneficiary consent for a number of services, and what would be an appropriate interval of time for the single consent to cover (i.e., six months, one year, or a defined number of services).

2020 MIPS Proposals

MIPS Score and Payment Adjustments

CMS estimates approximately 818,000 clinicians will be MIPS eligible clinicians (ECs) in 2020. For the 2020 performance year, ECs and group practices would continue to be scored 0-100 points in MIPS based on data in four performance categories: quality (40 points), cost (20 points), promoting interoperability (25 points), and improvement activities (15 points).

ECs and group practices would need to earn at least 45 points in 2020 to avoid a Medicare payment penalty of up to 9% in 2022. This is an increase from the 2019 threshold of 30 points and payment adjustment of ±7%. CMS estimates payment adjustments for the 2020 MIPS payment year would be approximately $584 million (both positive and negative adjustments for a budget neutral sum). In addition, $500 million would be available for ECs and group practices whose final score meets or exceeds the proposed exceptional performance threshold of 80 points.

CMS proposes to maintain both the complex patient bonus of up to five points (applied to the overall MIPS score) as well as the six-point small practice bonus (applied to the MIPS quality category).

MIPS Value Pathways

In an effort to improve the clinical relevance of MIPS and reduce reporting burden, CMS proposes a new concept called "MIPS Value Pathways" starting in CY 2021. The Value Pathways framework would organize reporting requirements for each MIPS category around either a specific specialty (i.e., ophthalmology), clinical condition (i.e., diabetes), or a priority area (i.e., preventative health). The agency envisions these Pathways would eventually replace the current MIPS reporting structure in that clinicians would either choose or be assigned a Pathway based on clinical factors. Each Pathway may feature a smaller number of quality, cost, and/or improvement activity measures, therefore reducing reporting burden while still offering full

reporting credit. CMS envisions that the Pathways concept would more closely align MIPS with APMs and anticipates Value Pathway participants would receive more robust and timely feedback.

CMS solicits comment on a variety of concepts related to the Value Pathways, including how multi-specialty practices would be measured and around the groupings of measures within a particular Pathway. CMS does not propose any specific Pathways in the 2020 rule but does offer examples through this file.

Low-volume Threshold

CMS proposes no changes to the MIPS low-volume threshold criteria it established in 2019. To be excluded from MIPS in 2020, clinicians or groups would need to meet one of the following three criteria: (1) ≤ $90,000 in Part B allowed charges for covered professional services, (2) provide care to ≤ 200 Medicare beneficiaries, or (3) provide ≤ 200 covered professional services under the PFS.

Additionally, CMS proposes no changes to the opt-in policy it created in 2019, which allows physicians or groups who meet one or two of the low-volume threshold criteria to opt-in to participate in MIPS and receive a final score and payment adjustment. Physicians or groups who meet all three low-volume threshold criteria cannot opt-in and are excluded from MIPS participation.

Quality Category (40%)

CMS proposes to reduce the quality category weight from 45% in 2019 to 40% in 2020, adding the 5% difference to the cost category. Clinicians and groups would continue to report six quality measures, including one outcome or high priority measure. Each measure that meets data completeness requirements, has a minimum of 20 cases, and has a historic benchmark would be measured against the benchmark to receive a performance-based score.

The agency proposes to increase the data completeness threshold from 60% to at least 70% of patient encounters that meet the measure's denominator criteria. Measures that do not meet the data completeness requirements would receive a score of 0, except for small practices that would receive an automatic score of three points for that measure. According to CMS' analysis of year 2017 reporting data, individuals, groups, and small practices submitted quality data with an average completeness of approximately 76%, 85%, and 74% respectively.

Clinicians and groups could continue to submit a single measure via multiple collection types (i.e., registry, EHR). Small practices could continue to submit quality data through Medicare Part B claims, however CMS proposes to only allow this option for those that submitted data via claims for the 2017 reporting period.

Cost Category (20%)

Currently, the cost measure inventory includes a Medicare Spending Per Beneficiary (MSPB) measure and Total Per Capita Cost (TPCC) measure, which were continued from the Value-based Modifier program, as well as eight episode-based measures added in 2019 that compare clinicians on the cost of care clinically related to the initial treatment of a patient and care provided during an ensuing episode of care.

For the MSPB measure, CMS proposes to revise the attribution methodology to distinguish between medical episodes and surgical episodes. CMS also proposes numerous changes to the TPCC measure starting in 2020, including a revised primary care attribution and risk adjustment methodology. The agency would also add service and specialty category exclusions for clinicians who perform non-primary care services and begin evaluating beneficiary costs on a monthly basis rather than annual basis.

The agency proposes to maintain the eight episode-based measures finalized for evaluation in the 2019 performance year and would add 10 new episode-based measures.[2]

[2] Non-Emergent Coronary Artery Bypass Graft (CABG); Femoral or Inguinal Hernia Repair; Lower Gastrointestinal Hemorrhage (only available for group reporting); Elective Primary Hip Arthroplasty; Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels; Hemodialysis Access Creation; Inpatient COPD Exacerbation; Acute Kidney Injury Requiring New

Improvement Activities Category (15%)

Although CMS does not propose significant revisions to the basic requirements of improvement activity reporting, the agency proposes changes relevant to group practice-level reporting. Previously, if one clinician within a group practice performed an activity for 90 days, the entire group could receive credit for the activity if the practice reported at the group, or tax identification number (TIN) level. Starting in 2020, CMS proposes to increase this requirement such that 50% of the group must report the same activity for the same continuous 90-day period in order for the group to claim credit.

Practices designated as a Patient-centered Medical Homes (PCMH) would continue to receive credit in the improvement activities category, however CMS proposes to expand the entities able to qualify as a PCMH. Previously, the agency enumerated four qualifying accreditation organizations; starting in 2020, CMS would update guidelines such that PCMH certification is not exclusive to a CMS-maintained list.

Promoting Interoperability Category (25%)

CMS would maintain the general structure of the promoting interoperability category but proposes modifications and clarifications to several of the measure scores and exclusions.

For groups to be identified as hospital-based and eligible for reweighting of its Promoting Interoperability category, CMS proposes that more than 75% of the national provider identifiers (NPIs) in the group must meet the definition of a hospital-based individual MIPS eligible clinician. This is down from 100% of NPIs in 2019. CMS also proposes to remove the "Verify Opioid Treatment Agreement" measure and keep optional the "Query of PDMP" measure.

MIPS APMs

Previously, CMS relied on an APM's quality measure inventory to score the quality category for clinicians and groups participating in MIPS through a MIPS APMs, rather than allowing MIPS APM participants to select from the generally applicable MIPS quality measure inventory. Starting in 2020, CMS proposes to allow APM entities the option to report on MIPS quality measures for the MIPS quality performance category.

2020 Advanced APM Proposals

Qualifying Participant (QP) Status

CMS estimates that approximately 175,000-225,000 clinicians will become a QP during the 2020 performance period. To become a QP, a clinician must receive at least 50% of Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM entity at one of the determination periods (snapshots). CMS does not propose any changes to the QP standard or snapshots.

A clinician that becomes a QP is excluded from MIPS. This exclusion applies at the National Provider Identifier (NPI) level across all of the clinician's TIN/NPI combinations. This means if a clinician participates in multiple group practice TINs and only achieves QP status through one TIN, they will remain excluded from MIPS even when participating in TINs not in an Advanced APM.

Partial QP Status

To become a Partial QP, a clinician must receive at least 40% of Medicare Part B payments or see at least 25% of Medicare patients through an Advanced APM entity at one of snapshots. All clinicians who become Partial QPs may choose whether or not they want to participate in MIPS. If these clinicians choose to participate, they must meet all MIPS reporting and scoring requirements or receive a payment penalty. If these clinicians

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Inpatient Dialysis; Renal or Ureteral Stone Surgical Treatment; and Lumpectomy, Partial Mastectomy, and Simple Mastectomy.

choose not to participate, they will not be required to report to MIPS and will not receive a MIPS payment adjustment.

Previously, if a clinician achieved Partial QP status through one Advanced APM TIN, the Partial QP designation applied at the NPI level, just like QP status determination. CMS is proposing to revise this policy. Beginning in 2020, CMS proposes to change this policy such that Partial QP status would only apply to the TIN/NPI combination(s) through which an eligible clinician attains QP status.