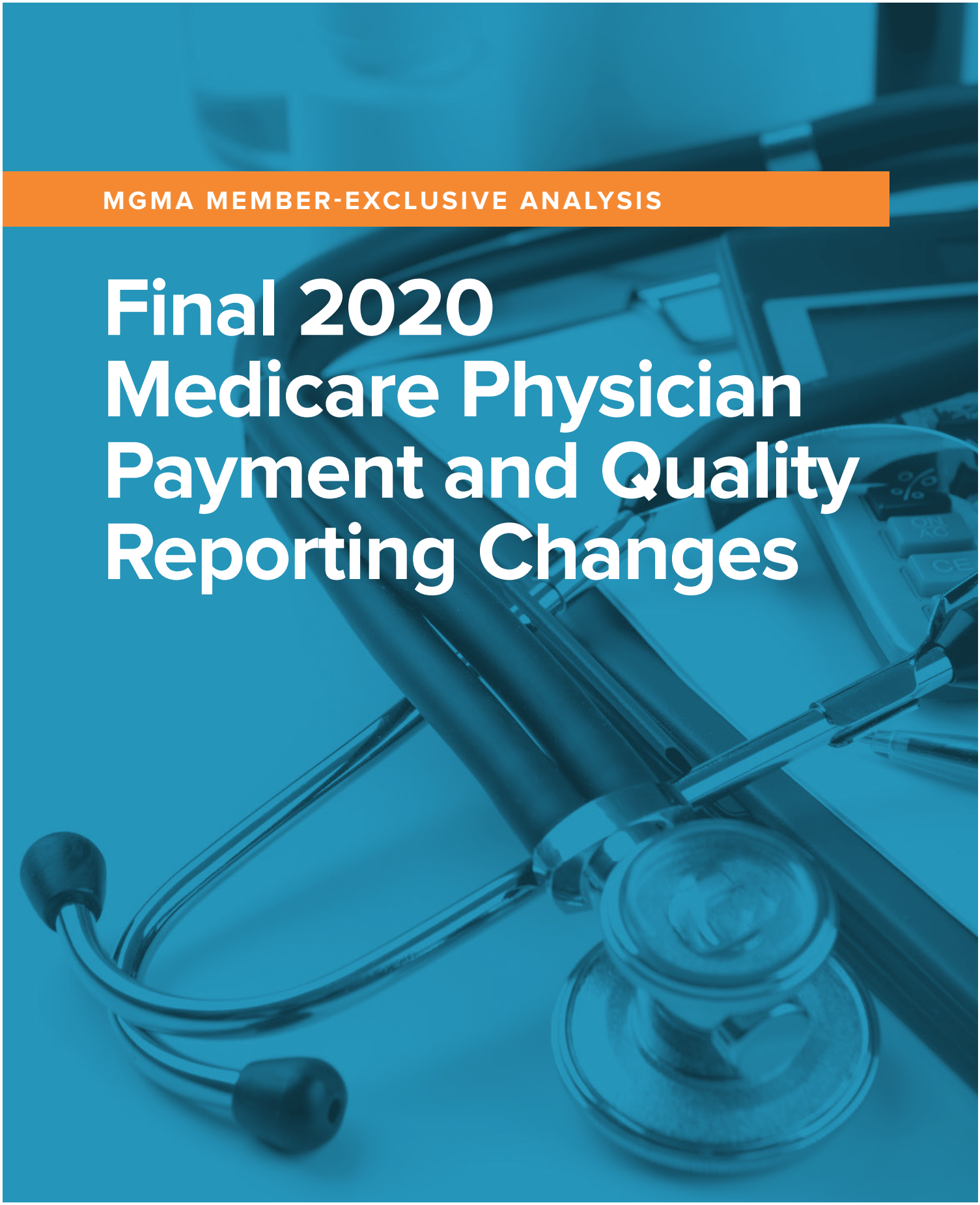
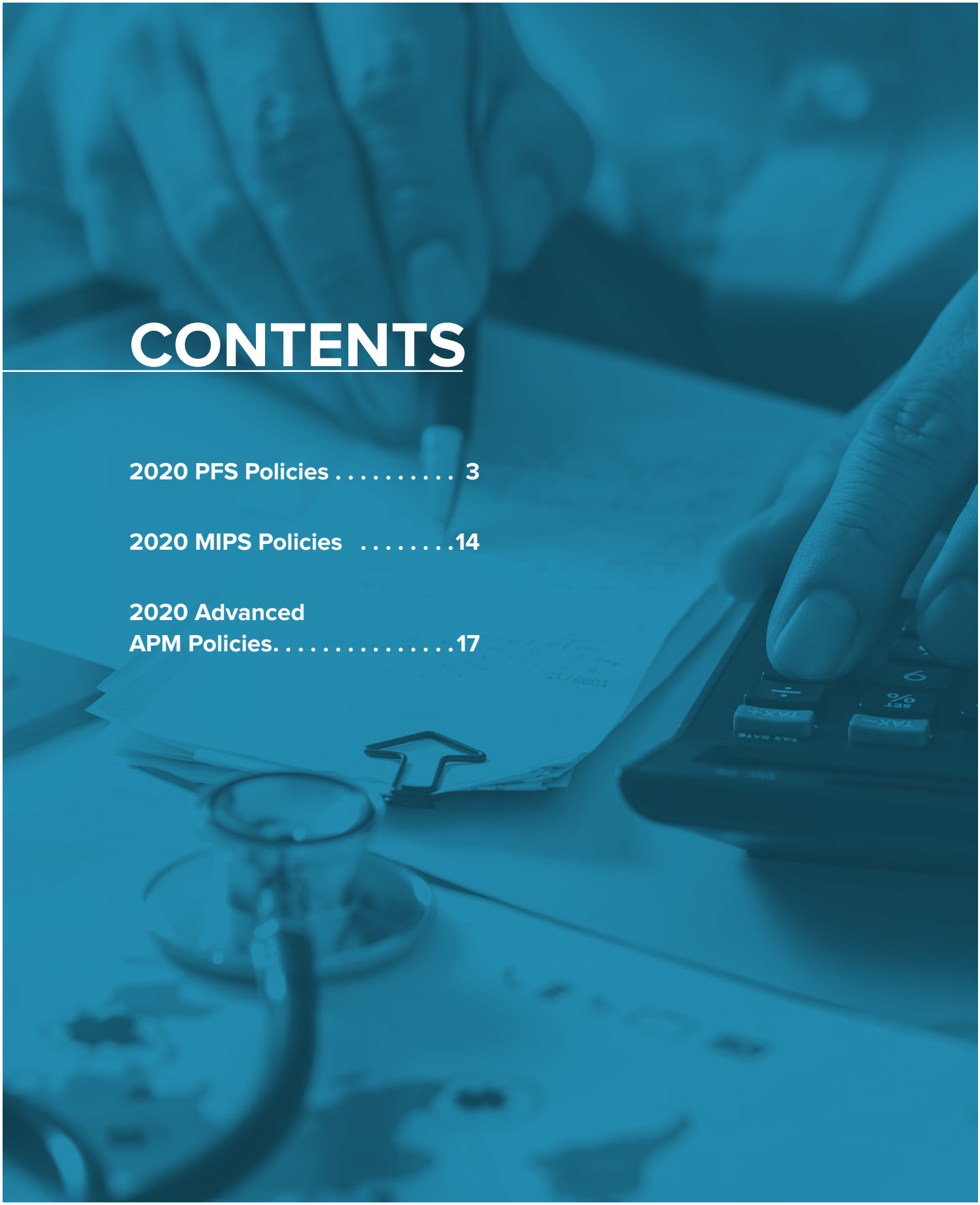
MGMA MEMBER-EXCLUSIVE ANALYSIS

Final 2020 Medicare Physician Payment and Quality Reporting Changes





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The Centers for Medicare & Medicaid Services (CMS) finalized changes to both Medicare physician payment and quality reporting program policies that generally take effect Jan. 1, 2020. The final rule updates the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2020. If you have any questions or reactions to these finalized policies, please reach out to MGMA Government Affairs at govaff@mgma.org.

2020 PFS Policies

Medical Practice Executive Insights
Key 2020 Medicare physician fee schedule (PFS) policies • The 2020 Medicare PFS conversion factor is $36.0896. The Anesthesia conversion factor is $22.2016. • Starting in 2021, CMS will make changes to E/M documentation requirements, retain separate E/M office visit payments, and increase work value units.
Key 2020 MIPS and APMs policies • The performance threshold to avoid a payment penalty is 45 points, and the exceptional performance threshold is 85 points. • By statute, the 2022 payment adjustment based on 2020 performance is ±9%, and the 10% for exceptional performance is still available.

Physician Payment Update

The 2020 Medicare PFS conversion factor is $36.0896. The 2020 conversion factor does *not* include an update under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA provided a mandatory positive update to the conversion factor of 0.5% from 2016 through 2019, a 0% 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] Once available, CMS will release updated PFS value files on its website.

CY 2020 PFS Conversion Factor		
CY 2019 Conversion Factor		36.0391
Statutory Update	0.00 percent	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Conversion Factor		**36.0896**

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

The Anesthesia conversion factor is $22.2016, a decrease from the 2019 Anesthesia conversion factor ($22.2730).

CY 2020 Anesthesia Conversion Factor		
CY 2019 Anesthesia Conversion Factor		22.2730
Statutory Update	0.00 percent	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Anesthesia Practice Expense and Malpractice Adjustment	-0.46 percent (.9954)	
CY 2020 Conversion Factor		**22.2016**

TAKEAWAY

The 2020 PFS conversion factor ($36.0896) represents an increase of just a nickel over 2019 ($36.0391). This modest update unfortunately continues a concerning trend of relatively flat Medicare payment updates that are not keeping up with the costs of inflation or furnishing care to Medicare beneficiaries. MGMA is advocating for Congress to step-in and require positive updates to help ensure the financial stability of America's medical group practices and patient access to quality care.

E/M Services

Effective **Jan. 1, 2021**, CMS will adopt revised CPT coding, prefatory language, and interpretive guidance developed by the AMA's CPT Editorial Panel on E/M office/outpatient visits. **There are no significant updates to E/M coding, payment, or documentation for CY 2020.** The CY2021 policies only apply to office/outpatient E/M visits.

Documentation

Beginning on Jan. 1, 2021, instead of using the history and exam elements traditionally used to select the appropriate E/M level visit, clinicians will select the appropriate E/M level based on either: (1) medical decision making (MDM) in the exam or (2) time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). Review the revised CPT guidelines linked on MGMA's physician reimbursement webpage for more information.

Payment

CMS will maintain separate payments for all E/M levels for new and established patients. Beginning in CY2021, CMS will eliminate level 1 visits for new patients (CPT code 99201) as a corollary to its revised documentation policy since the only differences between level 1 and 2 visits for new patients are related to history and exam. This results in four visit levels for new patients (levels 2 through 5) and five levels for established patients (levels 1 through 5). In addition to the base E/M visit levels, CMS will implement an add-on code for visit complexity associated with certain visits (GPC1X) and an add-on code for extended visits (99XXX).

Specifically, GPC1X describes 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. CMS states that although use of this code is not restricted to use by specific specialties, the agency assumes that certain specialties will report this add-on code with 100% of their office visits, essentially making this a bonus payment for: family medicine, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease. It is estimated that the add-on payment for GPCIX will be approximately $18 per visit.

99XXX describes 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.

CMS also adopted the AMA RUC-recommended values for all E/M codes (with a minor exception), which will increase payment for E/M visits. CMS estimates the specialty payment impact in Table 120 of the final rule, which can be downloaded from our physician reimbursement webpage. CMS will not to apply the office visit increases to the global surgery packages.

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

TAKEAWAY

New E/M coding guidelines are intended to be more intuitive, reduce unnecessary documentation, and increase flexibility. Fully integrating documentation revisions into practice management and clinical workflows will take time and may entail coordination with third-party vendors, such as your EHR vendor, to make technical adjustments or consult coding experts. Furthermore, the requirements around E/M documentation may become more flexible for purposes of Medicare billing; however, the practical or aggregate impact of these changes is unknown, since physicians must continue to document in such a way that protects them from medical liability or inadvertent overbilling.

Verification of Medical Record Documentation

In the 2019 PFS, CMS finalized that a teaching physician's participation in services involving residents may be demonstrated in notes in the medical record made by a physician, resident, or nurse, rather than the previous policy where the information had to be documented by the teaching physician themselves. CMS further eased requirements by allowing teaching physicians to review and verify (sign/date) notes made by students in a patient record for E/M services, rather than re-document the information.

Beginning Jan. 1, 2020, CMS extends these flexibilities to other practitioners. Specifically, CMS will allow physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs; e.g., nurse practitioners, clinical nurse specialists and managers, and clinical registered nurse anesthetists) who furnish and bill for their professional services to verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, and other members of the medical team. This medical record documentation policy applies broadly to all services, regardless of the type of service (e.g., E/M, procedure, diagnostic test) or the setting in which the service is furnished.

TAKEAWAY

CMS does not define the scope of which staff qualify as "members of the medical team" but instead defers to the discretion of the physician, PA, or APRN to identify members of the medical team, such as scribes, dieticians, or nutritionists. Group practices should watch for any sub-regulatory guidance from CMS on this policy.

PA Supervision

Starting in 2020, CMS finalized a modification to PA supervision policy to permit PAs to practice in accordance with state law supervisory rules, rather than Medicare's general supervision requirements. In the absence of state law outlining PA supervision, supervision requirements for Medicare will be met when the PA has a working relationship with one or more physicians to supervise the delivery of healthcare services. Such supervision is evidenced by documenting at the practice level the PA's scope of practice and working relationships the PA has with the supervising physician(s) when furnishing professional services.

TAKEAWAY

This change in policy aligns physician supervision requirements for PA services with the physician collaboration requirement for NPs and clinical nurse specialists (CNSs) and reduces practical differences in PA and NP/CNS utilization. It does not make any changes to requirements for payment under Medicare Part B for PA professional services, such as changes to incident to billing.

Payment for Transitional Care Management (TCM) Services

Under existing policy, TCM services cannot be billed concurrently with 57 codes during the 30-day period covered by TCM. Starting in 2020, CMS will allow TCM billing with 16 codes previously prohibited from concurrent billing, such as prolonged services without direct patient contact and chronic care management (CCM) services. For a full list of the 16 codes, review this table.

Additionally, CMS increases 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.

TAKEAWAY

The removal of 16 codes from concurrent billing prohibitions may alleviate burden for practices already billing Medicare for TCM, particularly for groups that also bill CCM services that were previously not reimbursed during the TCM window. However, this change will not be reflected in 2020 CPT guidance, which could create confusion and inconsistent billing requirements across other payers. For example, practices following Medicare billing guidelines should watch for denials from commercial payers that have not updated their billing policies.

Payment for CCM Services

CCM services are defined as non-face-to-face services provided to Medicare beneficiaries who have two or more significant chronic conditions. Covered CCM codes are divided into non-complex (CPT code 99490) and complex CCM (CPT codes 99487 and 99489). Complex CCM services include a base code (99487) to describe the initial 60 minutes of clinical staff time, as well as an add-on code (99489) to account for each additional 30 minutes. In 2019, Medicare only covers one base code for non-complex CCM (99490) that describes the initial 20 minutes.

Starting in 2020, CMS finalized a new add-on code to account for additional time spent on non-complex CCM services (G2058). Group practices can use 99490 to account for the initial 20 minutes of non-complex CCM and receive payment under G2058 for additional 20-minute increments. G2058 can be billed a maximum of two times during a given service period (e.g., one month) for a given beneficiary.

CMS also makes modest revisions to CCM billing guidelines. For all CCM services, CMS requires a "comprehensive care plan." Among other changes, CMS clarifies that it does not impose a set of strict requirements that must be included in every care plan to meet CCM billing requirements. Instead, CMS offers a list of elements that are included in the "typical" care plan.

TAKEAWAY

For group practices already billing for CCM services, the addition of the new add-on code for non-complex CCM should offer additional reimbursement opportunity. Like the complex CCM add-on code, G2058 should be reported in conjunction with the non-complex base code. However, practices should note that, unlike the complex CCM add-on code, there is a frequency limitation on G2058. Clarifications around the care plan requirement may not have any practical impact on group practices. Furthermore, while MGMA has urged the agency to eliminate the coinsurance requirement for CCM services, CMS states it lacks the authority to do so. We are strongly urging Congress to step in and eliminate the coinsurance requirement through active legislation.

Establishing New Care Management Services

CMS finalized coverage for a new code describing "principal care management" (PCM) services, which are similar to CCM services but intended for patients with only one complex chronic condition. Starting Jan. 1, 2020, G2064 will describe care management for patients with a single complex chronic condition.

CMS describes that "in a majority of instances" PCM will be billed when a single condition is of such a complexity that it cannot be effectively managed in a primary care setting and instead requires management by a second, more specialized practitioner. The agency does not, however, prohibit primary care practitioners from billing this code. CMS expects this code would be triggered by an exacerbation of a patient's complex condition or a recent hospitalization that warrants disease specific management.

TAKEAWAY

Given that requirements for PCM services are similar to CCM (i.e., beneficiary consent and cost-sharing apply), administrative billing requirements may prevent practices from being reimbursed for this service. MGMA requested clarification as to which conditions CMS considers to be qualifying complex chronic conditions for purposes of PCM and CCM; however, the agency expressly declined to provide additional guidance.

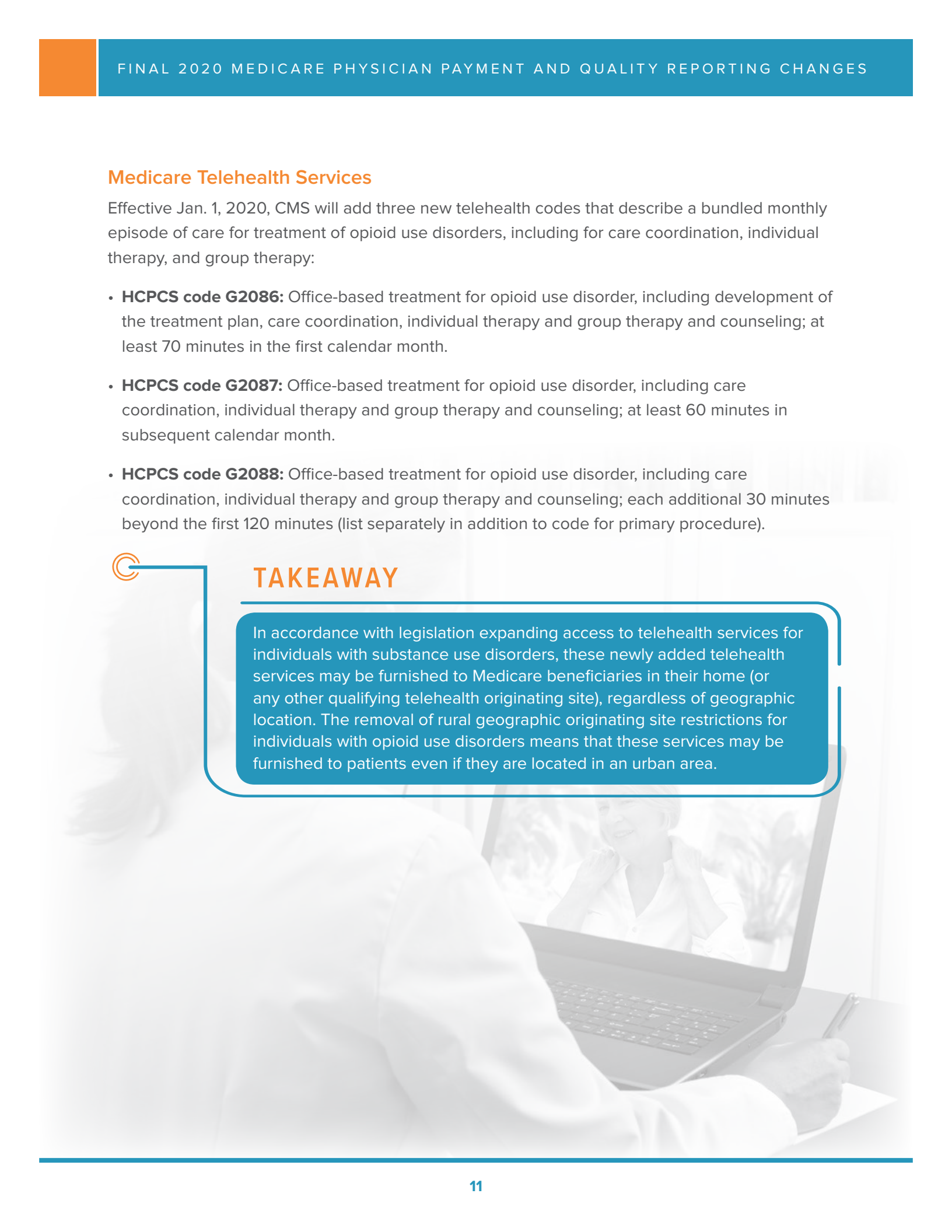
Medicare Telehealth Services

Effective Jan. 1, 2020, CMS will add three new telehealth codes that describe a bundled monthly episode of care for treatment of opioid use disorders, including for care coordination, individual therapy, and group therapy:

- **HCPCS code G2086:** 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 G2087:** 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 G2088:** 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).

TAKEAWAY

In accordance with legislation expanding access to telehealth services for individuals with substance use disorders, these newly added telehealth services may be furnished to Medicare beneficiaries in their home (or any other qualifying telehealth originating site), regardless of geographic location. The removal of rural geographic originating site restrictions for individuals with opioid use disorders means that these services may be furnished to patients even if they are located in an urban area.



Consent for Communication Technology-based Services

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

In the 2020 PFS, CMS finalized a policy to permit a single advanced beneficiary consent for multiple communications-based technology and consultation services that will cover a one-year period.

TAKEAWAY

Practices furnishing these services may now obtain consent annually, rather than each time they furnish the service. Cost-sharing will still apply each time the service is billed, so practices should consider how to best educate patients receiving these services to reduce instances of unexpected bills.

Coinsurance for Colorectal Cancer Screening

Colorectal cancer screening tests are "preventative services" paid 100% by Medicare without beneficiary cost-sharing. CMS does not, however, consider flexible sigmoidoscopies or colonoscopies to be preventative services if, during the course of a screening, a clinician determines a polyp must be removed. As a result, CMS interprets these tests to be diagnostic in nature, requiring beneficiary coinsurance (20% or 25% depending on the care setting). CMS considered in the proposed 2020 PFS whether to require clinicians furnishing colorectal cancer screenings to notify the patient in advance that the screening procedure could become a diagnostic service and that coinsurance may apply.

In the final 2020 PFS, CMS does not impose a consent or notice requirement for colorectal cancer screenings. Instead, the agency states it will review its own educational materials intended for the Medicare beneficiary community.

TAKEAWAY

The final 2020 PFS does not result in any changes around these screens; however, group practices may want to look out for any education published by Medicare for the beneficiary population if they are getting questions from patients on this matter and want to use the materials in the office.

Stark Law Advisory Opinions

Under current regulations, CMS accepts requests for advisory opinions on the Physician Self-referral (Stark) Law that involve existing arrangements or arrangements the requestor plans to enter. Starting in 2020, CMS finalized a policy to clarify that a request for an advisory opinion must "relate to" (rather than "involve") an existing arrangement or one the requestor plans to enter. The agency specifically declines to expand the scope of advisory opinion requests to hypothetical fact patterns, stating that doing so would "overwhelm" the agency.

CMS finalized an expedited timeline for issuing an advisory opinion from 90 days to 60 days, in addition to other minor procedural changes.

TAKEAWAY

To date, CMS has only issued 15 advisory opinions on the Stark Law unrelated to a specific physician-owned hospital topic. Meaningfully expanding the advisory opinion process would have likely required that CMS accept hypothetical fact patterns. Even under the revised rules, to receive an advisory opinion, group practices seeking clarification must either be in a current arrangement or provide sufficient detail regarding an arrangement they plan to enter.

2020 MIPS Policies

MIPS Score and Payment Adjustments

CMS estimates 879,966 clinicians will be MIPS eligible clinicians (ECs) in 2020. For the 2020 performance year, ECs and group practices will continue to be scored 0-100 points in MIPS based on data in four performance categories: quality (45%), cost (15%), promoting interoperability (25%), and improvement activities (15%). In a win for MGMA advocacy, CMS did not finalize a proposal to increase the weight of the cost category to 20%.

ECs and group practices must 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 2022 MIPS payment year will be approximately $433 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 exceptional performance threshold of 85 points. CMS estimates that the maximum positive adjustment in the 2022 payment year will be 6.2% after considering the MIPS payment adjustment and additional exceptional performance bonus.

CMS will 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 finalized a new concept called “MIPS Value Pathways” starting in the 2021 performance year. The Value Pathways framework will organize reporting requirements for each MIPS category around an episode of care or clinical condition.

CMS does not outline specific details around MVP implementation but emphasizes the need to reduce burden and to emphasize clinical relevance.

Low-volume Threshold

There are no changes to the MIPS low-volume threshold criteria in 2020. To be excluded from MIPS in 2020, clinicians or groups 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.

Quality Category (45%)

The quality category will remain weighted at 45% of the overall MIPS score in 2020, as CMS did not finalize its proposal to decrease the weight to 40%. General reporting requirements for this category will remain the same as in 2019 except for the following notable changes:

- The data completeness threshold will increase from 60% to at least 70% of patient encounters that meet a measure's denominator criteria.
- CMS will remove measures that do not meet the case minimum or volume requirements to calculate a benchmark for two consecutive years.
- CMS will apply flat percentage benchmarks, rather than the standard policy to establish benchmarks based on historic performance, when the agency determines that the standard benchmark methodology could result in inappropriate treatment. For the 2020 performance year the flat percentage methodology applies to the following two measures: MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control (>9%) and MIPS #236 (NQF #0018): Controlling High Blood Pressure.

Cost Category (15%)

The agency did not finalize a proposal to increase the category weight to 20% in 2020. CMS agrees with MGMA that the cost category weight should not be increased until CMS can provide more detailed and actionable feedback to MIPS participants.

The inventory of cost measures will continue to include the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures, with revised methodologies. Additionally, CMS will maintain the eight episode-based measures finalized for evaluation in the 2019 performance year and add 10 new episode-based measures.[2]

CMS revises the TPCC measure attribution methodology to add service and specialty category exclusions for clinicians in specialties unlikely to be responsible for providing primary care to a patient.

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

Improvement Activities Category (15%)

CMS finalized two notable changes to the improvement activities category. First, it is increasing the participation threshold for group reporting from a single clinician to 50% of clinicians in the practice. Clinicians in the group practice can perform the selected activity during any continuous 90-day period, meaning not every clinician needs to choose the same reporting period.

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

Promoting Interoperability Category (25%)

CMS finalized removal of the Verify Opioid Treatment Agreement Measure and made the Query of PDMP optional in 2020. The reweighting policy for hospital-based clinicians is also modified, such that clinicians are eligible for reweighting of this category when more than 75% of clinicians in the group meet the definition of hospital-based. Table 55 of the final rule describes how CMS would redistribute category points when the promoting interoperability category or any other categories are reweighted.

MIPS TAKEAWAYS

Group practices should review quality measure tables in the Appendix to the final rule to assess whether measures they have historically reported are still available and/or whether they have been substantially changed. **Table A** lists new MIPS quality measures, **Table C** lists removed measures, and **Table D** lists substantively changed measures. While vendors should incorporate these changes into 2020 measure sets, sometimes this can take months, so being aware of measure changes ahead of time can prevent headaches later in the reporting period. Groups should also review new episode-based cost measures to evaluate whether they address clinical episodes encountered by the group practice. For improvement activities, those that report at the group practice/TIN level should ensure they meet the new 50% threshold that's required for the group to attest to a given activity. This effectively means that 50% of the group's clinicians must report the same activity (but not necessarily during the same 90-day period) for the group to attest to completing the activity. Lastly, practices looking to pick up bonus points in the promoting interoperability category should note that the "Query of PDMP" measure is optional but offers the opportunity for bonus points for reporting.

2020 Advanced APM Policies

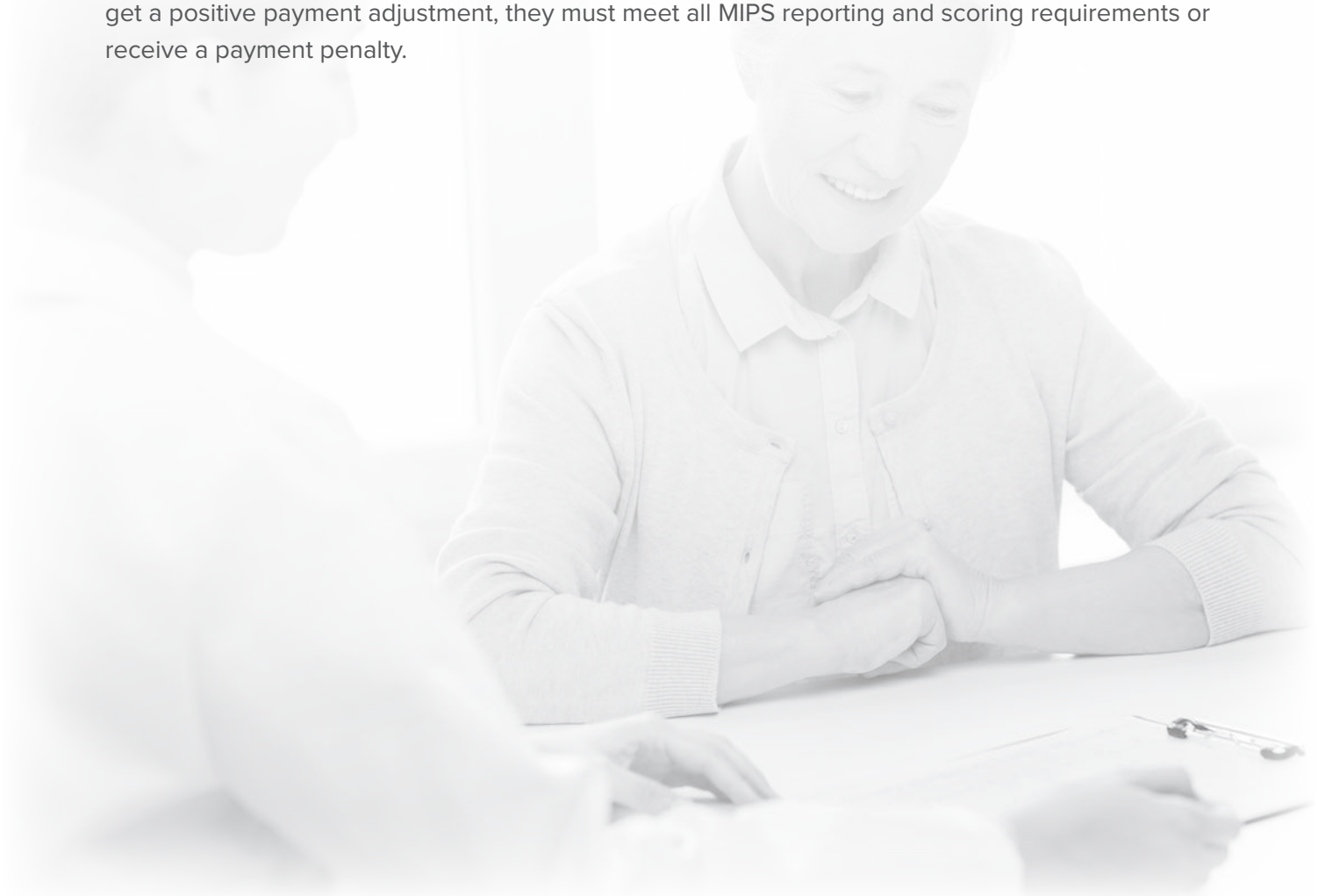
Qualifying Participant (QP) Status

CMS estimates that approximately 210,000 and 270,000 clinicians will become QPs 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). There are no changes to this policy.

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 they want to participate in MIPS. If these clinicians choose not to participate, they will not be required to report to MIPS and will not receive a MIPS payment adjustment. However, if these clinicians choose to participate to try and get a positive payment adjustment, they must meet all MIPS reporting and scoring requirements or receive a payment penalty.



FINAL 2020 MEDICARE PHYSICIAN PAYMENT AND QUALITY REPORTING CHANGES

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