



## **Summary: CMS Proposed 2020 Physician Fee Schedule and Quality Payment Program Rule**

**July 30, 2019**

On July 29, 2019, the Centers for Medicare and Medicaid Services (CMS) released the agency's 2020 Physician Fee Schedule and Quality Payment Program proposed rule. Click [here](#) for the fact sheet and [here](#) for the 1,704 page proposed rule. Here is a summary of the proposed rule:

### **Payment Update**

The update to the physician fee schedule conversion factor is 0.20% before other adjustments are applied. Specifically, the conversion factor for 2020 is \$36.09, a slight increase over \$36.04.

### **Evaluation and Management (E/M) Codes**

CMS proposes to walk back its previous year proposal to collapse E/M level codes 2 through 5 and reimburse a blended rate for levels 2 through 4. The agency now proposes to keep 5 code levels for established patients and 4 code levels for new patients. The agency further proposes to allow providers to code E/M patients based on medical decision or time. The agency also proposes to add a new Current Procedural Terminology (CPT) for prolonged time E/M visits. In sum, CMS is following the AMA's CPT Editorial Panel recommendations.

### **Merit-Based Incentive Payment System (MIPS)**

- The performance threshold for 2020 is proposed at 45 points and for 2021, 60 points.
- The exceptional performance threshold for 2020 is proposed at 80 points and 85 points for 2021.
- Quality will make up 40% of the MIPS composite score, cost at 20%, improvement activities at 15% and promoting interoperability at 25% for 2020.
- The data completeness threshold is proposed at 70% of Part B patients, Qualified Clinical Data Registry (QCDR) measures and MIPS clinical quality measures (CQMs) and 60% for electronic clinical quality measures (eCQMs).
- CMS proposes to create MIPS Value Pathways (MVPs) intended to better align measure sets with clinical scope of practice. Eligible clinicians would participate in one MVP or one MVP bundle or track that connects measures and activities across all four performance categories.
- Related to the Medicare Shared Savings Program (MSSP), CMS is soliciting comments regarding aligning quality reporting/scoring methodologies between ACOs and MIPS.

### **Alternative Payment Models**

- CMS proposes to allow MIPS-APMs the option to report on MIPS quality measures. Scores could be calculated via individual eligible clinician, APM entity or TIN.
- Among changes to Advanced APMs, CMS proposes to determine partial qualifying participant (QP) status through Taxpayer Identification Number (TIN) - National Provider Identifier (NPI) combinations only rather than across all of a clinician's TIN/NPIs.

### **Opioid Crisis**

In order to implement the SUPPORT Act [Public Law 115-271], CMS proposes to create a monthly bundled payment arrangement for the management, care coordination and behavioral health counseling in treating patients with an opioid use disorder. The proposal would also include adding three new telehealth Healthcare Common Procedure Coding System (HCPCS) codes to help improve care for these patients.

- **Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs) (pg. 113, ff)**

Section 2005 of the SUPPORT Act established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services, including medications for medication-assisted treatment (MAT), furnished by opioid treatment programs (OTPs). To meet this statutory requirement, CMS is proposing:

- Definitions of OTP and OUD treatment services;
- Enrollment policies for OTPs;
- Methodology and estimated bundled payment rates for OTPs that vary by the medication used to treat OUD and service intensity, and by full and partial weeks;
- Adjustments to the bundled payments rates for geography and annual updates;
- Flexibility to deliver the counseling and therapy services described in the bundled payments via two-way interactive audio-video communication technology as clinically appropriate; and
- Zero beneficiary copayment for a time limited duration.

### **Bundled Payments under the PFS for Substance Use Disorders (pg. 193, ff)**

In the 2019 PFS proposed rule, CMS sought comment on creating a bundled episode of care for management and counseling treatment for substance use disorders. In response, CMS proposes to create new coding and payment for a bundled episode of care for management and counseling for OUD. The new proposed codes describe a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling. One code describes the initial month of treatment, which would include administering assessments and developing a treatment plan; another code describes subsequent months of treatment; and an add-on code describes additional counseling.

CMS proposes that individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as Medicare telehealth services using communication technology as clinically appropriate. CMS is also seeking comment on bundles describing services for other SUDs and on the use of MAT in the emergency department setting, including initiation of MAT and the potential for either referral or follow-up care, as well as the potential for administration of long-acting MAT agents in this setting, to help inform whether they should consider proposing to make separate payment for such services in future rulemaking.

### **Transitional Care and Chronic Care Management Codes**

CMS proposes to increase payment for Transitional Care Management (TCM).

CMS also proposes a set of developed HCPCS G codes for certain Chronic Care Management (CCM) services, specifically the agency proposes to replace a number of the CCM codes with specific codes to allow clinicians to bill incrementally to reflect additional time and resources required in certain cases and better distinguish complexity of illness as measured by time. CMS also proposes to create new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single serious and high risk condition.

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