NAACOS Analysis of the Proposed 2020 Medicare Physician Fee Schedule

Executive Summary

In late July, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2020 Medicare Physician Fee Schedule (MPFS) rule and related MPFS factsheet. This proposed regulation includes a number of policies affecting Medicare physician payment, quality measure changes for Medicare Shared Savings Program (MSSP) ACOs, and Quality Payment Program (QPP) requirements for 2020. Some of the key proposals affecting ACOs are outlined below and further detailed in this analysis. NAACOS is seeking member input on the proposals in this rule, which will help us shape our comments to CMS. Please share your feedback by emailing us at advocacy@naacos.com.

Medicare Physician Fee Schedule Policies:

- Update the MSSP quality measure set, removing one measure and adding another for 23 total quality measures proposed for ACOs in 2020. CMS also requests feedback on changing the way ACOs are scored on quality to better align with the Merit-Based Incentive Payment System (MIPS) quality scoring methodology for ACOs
- Reverse its policy to collapse Evaluation and Management (E/M) services levels 2 through 4, which was scheduled to go into effect in 2020
- Implement a revised approach to updating E/M services based on a framework from an American Medical Association Current Procedural Terminology (AMA CPT) Workgroup on E/M
- Establish a general principle to allow providers to review and verify (sign/date), rather than re-document, information included in a patient's medical record
- Introduce new Principal Care Management (PCM) services for care management for one serious chronic condition
- Replace Chronic Care Management (CCM) codes with G codes to better account for time spent furnishing services and to remove a requirement related to a comprehensive care plan
- CMS proposes to make certain remote patient monitoring services billable under general supervision, rather than the currently required direct supervision

Quality Payment Program (QPP) Proposals

- Set a 45-point performance threshold and 80-point exceptional performance threshold for MIPS
- Modify how the agency evaluates whether an APM meets Advanced APM risk requirements by allowing the agency to factor in what expenditures would have been in the absence of the APM
- Require Partial QPs to report MIPS for TIN/NPI combinations not related to attaining their Partial QP status
- Add a Medical Home Model option to the All-Payer Combination Option
- Provide flexibility with how CMS assesses marginal risk rates for All-Payer APMs and consider new flexibility with full capitation arrangements in the All-Payer Combination Option

PHYSICIAN FEE SCHEDULE POLICIES

Medicare Shared Savings Program Quality Measure Changes

CMS proposes to add group practice reporting option (GPRO) measure ACO-47, Adult Immunization Status, and remove ACO-14, Preventive Care and Screening Influenza Immunization, from the MSSP quality measure set. ACO-47 is a composite measure with multiple components, which evaluate the percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria or tetanus, diphtheria and acellular pertussis, zoster, and pneumococcal vaccines. More detailed information for this measure is available on page 40706of the proposed rule. This would result in 23 quality measures for MSSP ACOs for the 2020 performance year (PY) as outlined in Table 32. Table 33 outlines the number of measures and total points for each domain within the MSSP quality performance standard as proposed for 2020.

TABLE 32: Measure Set for Use in Establishing the Shared Savings Program Quality Performance Standard, Starting with Performance Years during 2020

Domain	ACO Measure #	Measure Title	New Measure	NQF #/ Measure Steward	Method of Data Submission	Pay for Performance Phase-In R – Reporting P – Performance PY1	PY2	PY3
AIM: Better Care for Individuals								
Patient/ Caregiver Experience	ACO – 1	CAHPS: Getting Timely Care, Appointments, and Information		NQF N/A AHRQ	Survey	R	P	P
	ACO – 2	CAHPS: How Well Your Providers Communicate		NQF N/A AHRQ	Survey	R	P	P
	ACO – 3	CAHPS: Patients' Rating of Provider		NQF N/A AHRQ	Survey	R	P	P
	ACO – 4	CAHPS: Access to Specialists		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO – 5	CAHPS: Health Promotion and Education		NQF #N/A AHRQ	Survey	R	P	P
	ACO – 6	CAHPS: Shared Decision Making		NQF #N/A AHRQ	Survey	R	P	P
	ACO – 7	CAHPS: Health Status/Functional Status		NQF #N/A AHRQ	Survey	R	R	R
	ACO – 34	CAHPS: Stewardship of Patient Resources		NQF #N/A AHRQ	Survey	R	P	P
	ACO – 45	CAHPS: Courteous and Helpful Office Staff		NQF #N/A AHRQ	Survey	R	R	P
	ACO – 46	CAHPS: Care Coordination		NQF #N/A AHRQ	Survey	R	R	P
Care Coordination/ Patient Safety	ACO – 8	Risk-Standardized, All Condition Readmission		Adapted NQF #1789 CMS	Claims	R	R	P
	ACO – 38	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions		NQF#2888 CMS	Claims	R	R	P
	ACO – 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) (version with additional Risk Adjustment)		AHRQ	Claims	R	R	P
	ACO – 13	Falls: Screening for Future Falls		NQF #0101 NCQA	CMS Web Interface	R	P	P

AIM: Better Health for Populations								
Preventive Health	ACO – 47	Adult Immunization Status	√	NQF #N/A NCQA	CMS Web Interface	R	R	P
	ACO – 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		NQF #0028 AMA-PCPI	CMS Web Interface	R	P	P
	ACO – 18	Preventive Care and Screening: Screening for Depression and Follow-Up Plan		NQF #0418 CMS	CMS Web Interface	R	P	P
	ACO – 19	Colorectal Cancer Screening		NQF #0034 NCQA	CMS Web Interface	R	R	P
	ACO – 20	Breast Cancer Screening		NQF #2372 NCQA	CMS Web Interface	R	R	P
	ACO – 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		NQF #N/A CMS	CMS Web Interface	R	R	R
Clinical Care for At Risk Population – Depression	ACO – 40	Depression Remission at Twelve Months		NQF #0710 MNCM	CMS Web Interface	R	R	R
Clinical Care for At Risk Population – Diabetes	ACO – 27	Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%))		NQF #0059 NCQA	CMS Web Interface	R	P	P
Clinical Care for At Risk Population – Hypertension	ACO – 28	Hypertension: Controlling High Blood Pressure		NQF #0018	CMS Web Interface	R	P	P

TABLE 33: Number of Measures and Total Points for Each Domain within the Shared Savings Program Quality Performance Standard, Starting with Performance Years during 2019

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	Domain Weight
Patient/Caregiver Experience	10	10 individual survey module measures	20	25%
Care Coordination/ Patient Safety	4	4 measures	8	25%
Preventive Health	6	6 measures	12	25%
At-Risk Population	3	3 individual measures	6	25%
Total in all Domains	23	23	46	100%

CMS also notes changes to ACO-43, Ambulatory Sensitive Condition Acute Composite, from the measure steward, the Agency for Healthcare Research and Quality (AHRQ) for PY 2020. Specifically, the measure will include only bacterial pneumonia and urinary tract infection, removing dehydration. Due to these changes, the measure would be pay-for-reporting in 2020 and 2021.

As a result of NAACOS advocacy, CMS notes ACO-17, Smoking Cessation, will be a pay-for-reporting measure in 2018 due to measure specification changes that occurred in 2018. However, we are disappointed to see in this rule, CMS proposes ACO-17 will be a pay-for-performance measure in 2019. CMS states they feel they have sufficient data to determine a reliable benchmark for the measure. NAACOS will reiterate our concerns with the changes to ACO-17 and advocate for this measure to be pay-for-reporting in 2018 and 2019.

CMS Seeks Comment on Aligning ACO Quality Scoring with MIPS Quality Scoring Methodology
In an effort to better align quality scoring methodologies across programs, CMS seeks comment on whether the agency should alter the current quality scoring approach for MSSP ACOs to instead adopt the quality scoring approach used in the Merit-Based Incentive Payment System (MIPS). (Note: These proposals are specifically referring to the quality scoring methodology; CMS does not propose changes to the quality reporting mechanism currently used by ACOs.)

In the proposed rule, CMS outlines several different approaches they are considering to better align scoring methodologies across the MSSP and MIPS. One such proposal would include maintaining the minimum attainment level to complete and accurate reporting for ACOs in their first performance year of their first agreement period and change the for pay-for-performance years quality standard, requiring a quality performance score at or above the fourth decile across all MIPS quality performance category scores in ordered to be eligible to share in savings generated by the ACO. CMS would use the MIPS quality performance score converted to a percentage of points earned out of total points available as the ACO's MSSP quality score. As a comparison, ACOs are currently required to meet minimum attainment levels, defined as the 30th percentile benchmark for pay-for-performance measures, on at least one measure in each domain to be eligible to share in any savings generated. Therefore, this proposed new approach using MIPS scoring methodology for ACO quality performance scores would hold ACOs to a higher standard than is currently required in MSSP. Another approach discussed would remove the pay-for-reporting year provided currently to ACOs in their first year of their first agreement. Under this proposal, all ACOs would be measured on all measures as pay-for-performance measures in all program years.

CMS notes that section 1899(b)(3)(C) of the Social Security Act gives the agency discretion to establish quality performance standards for the MSSP and indicates CMS should seek to improve the quality of care furnished by ACOs over time by specifying higher standards. CMS also notes that for PY 2017, the only year for which CMS has complete data, the weighted mean MIPS quality performance category score for ACOs in the MSSP which do not meet the definition of an Advanced APM was 45.01 and the weighted median MIPS quality performance score for these ACOs was 46.8 out of a possible 50 points assigned for the quality performance category of MIPS. Due to this high level of performance among ACOs, CMS is also considering setting a higher threshold, such as the median or mean quality performance category score across all MIPS quality category scores for determining eligibility to share in savings under MSSP.

As an alternative, CMS also is considering an option in which CMS would determine MIPS quality performance category scores for all MSSP ACOs as it currently calculates MIPS quality scores for non-ACO group reporters using the CMS Web Interface. This approach would allow ACOs to receive a score for each of the measures they report and zero points for those measures they do not report. This would be a change from the current methodology, which requires ACOs to report all Web Interface measures in order to satisfy the complete and accurate quality reporting standard.

With respect to administrative claims measures, ACOs are currently evaluated on claims-based quality measures ACO-8, All Conditions Readmissions, ACO-38, Acute Admissions Rate for Patients with Multiple Chronic Conditions, and ACO-43, Ambulatory Sensitive Conditions Acute Composite. In this proposal, CMS considers instead to evaluate ACOs on administrative claims measures used in MIPS, the MIPS 30-Day All Cause Hospital Readmissions Measure and possibly the Multiple Chronic Conditions measure.

Additionally, CMS would continue to assess ACOs on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey, but quality performance would be calculated by MIPS methodologies used in calculating the CAHPS for MIPS survey score. The scoring and benchmarking approach for the CAHPS for MIPS is to assign points based on each summary survey measure and then average the points for all the scored survey measures to calculate the overall CAHPS score. In contrast, ACOs currently receive up to two points for each of the ten summary survey measures for a total of 20 points.

Finally, with respect to awarding extra points for quality improvement, CMS is considering an option under which the agency would use the MIPS quality improvement scoring methodology as an alternative to the current MSSP quality improvement approach. Under current MSSP rules, ACOs not in their first performance year can earn a quality improvement reward in each of the four quality domains. Under the MIPS approach, improvement points are awarded if a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period, fully participates in the quality performance category and submits data under the same identifier for two consecutive performance periods. Additionally, under MIPS improvement is evaluated at the performance category level rather than the individual measure level. The MIPS quality improvement score is equal to the absolute improvement/the previous year quality category percent score prior to bonus points multiplied by ten. Up to ten percentage points are available for improvement.

Determination of Work, Practice Expense (PE), and Malpractice Relative Value Units (RVUs)

As is typical in the MPFS, CMS outlines its proposed 2020 work and PE RVU updates. The agency proposes to add two new specialties to this process, Medical Toxicology and Hematopoietic Cell Transplantation and Cellular Therapy, as these specialties were recognized in 2018. CMS proposes to clarify the expected specialty assignment for a series of cardiothoracic services; affected codes are shown on pages 40487-40488. CMS detailed its ongoing effort to better understand direct PE inputs for supply and equipment pricing and provided a list of updates for certain supply and equipment items, available on page 40503. CMS also stated its intention to continue its current policy of identifying the services most affected by the indirect PE allocation anomaly, which does not allow for a site-of-service differential that accurately reflects the indirect costs of services furnished in a non-facility setting. This adjustment is being implemented over a four-year transition period, and CMS will continue this transition in calendar year (CY) 2020. CMS is also updating its malpractice RVUs for 2020 and proposes to utilize a specialty-weighted approach, including a risk factor for each specialty.

Geographic Practice Cost Indices (GPCIs)

CMS updates the GPCIs every three years and 2020 is an update year. CMS has posted the proposed CY 2020 updated GPCIs, which are displayed here. CMS is proposing two technical refinements to the methodology by which the agency calculates GPCIs, stating that these refinements will yield improved mathematical precision. The refinements are applicable to the work GPCI, the employee wage index, and purchased services index components of the PE GPCI. First, CMS proposes to weight by total employment when computing county median wages for each occupation code, citing the fact that the occupation wage can vary by industry within a county. Secondly, CMS proposes to use a weighted average when calculating the final county-level wage index, reasoning that this change would remove the possibility that a county index would imply a wage of 0 for any occupation group not present in the county's data.

Evaluation and Management (E/M) Services

CMS has long acknowledged the need to revise payment, guidelines, and documentation requirements for billing E/M services. As summarized in this NAACOS analysis, CMS finalized numerous changes in the final 2019 MPFS with many scheduled for implementation in 2021. The agency noted it would consider additional stakeholder feedback, which it did this year, giving particular consideration to an American Medical Association Current Procedural Terminology (AMA CPT) Workgroup on E/M. In this rule, the agency proposes to revise a number of their previously finalized policies. Highlights include agency proposals to:

- Adopt new coding, prefatory language, and interpretive guidance framework issued by the AMA CPT for office/outpatient E/M visits;

- Assign separate payment, rather than a blended rate, to office/outpatient E/M visit codes 99202-99215 (CPT is deleting 99201 for new patients) and the new prolonged visit add-on CPT code 99XXX;
- Delete the HCPCS add-on code finalized last year for CY 2021 for extended visits (GPRO1); and
- Simplify, consolidate, and revalue the HCPCS add-on codes finalized last year to reflect additional resources for certain visits.

If finalized, these changes would be effective January 1, 2021.

Specifically, CMS proposes to abandon its policy to collapse levels 2,3, and 4 office/outpatient E/M visits for new and established patients. The agency would instead adopt the RVS Update Committee (RUC) recommended work RVUs for all of the office/outpatient E/M codes and the new prolonged services add-on code. These proposed changes in coding and values reflect the revised office/outpatient E/M code set and a new 15-minute prolonged services code. That code set is effective beginning in CY 2021, and the proposed values would go into effect at that time. On page 40676, TABLE 27B shows a side-by-side comparison of work RVUs and physician time for the office/outpatient E/M services code set, and the new prolonged services code (current versus revised).

Under the new framework, history and exam would no longer determine the level of code selection for office/outpatient E/M visits. Instead, an office/outpatient E/M visit would include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems and areas reviewed and examined under history and exam would no longer apply. These components would only be performed when clinically appropriate and to the extent medically necessary. Level 1 visits would only describe or include visits performed by clinical staff for established patients. For levels 2 through 5, the code level would be decided based on either the level of medical decision making (as redefined in the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). CMS would adopt the new time ranges within the CPT codes as revised by the CPT Editorial Panel. There would be a single add-on CPT code, 99XXX, for prolonged office/outpatient E/M visits that would only be reported when time is used for code level selection and the time for a level 5 office/outpatient visit (the floor of the level 5 time range) is exceeded by 15 minutes or more on the date of service. Table 26 on page 40674shows how prolonged office/outpatient E/M visit time would be reported.

CMS states that it remains important to have add-on codes to reflect additional resources used for E/M codes. CMS proposes to adopt the RUC-recommended values for the new prolonged visit add-on code, 99XXX. The agency proposes to simplify coding by consolidating two add-on codes, GPC1X and GCG0X, so that only GPC1X remains. CMS would also revise the single code descriptor, shown in Table 28 on page 40678, to better 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. CMS would allow the new consolidated code to be reported with all office/outpatient E/M visit levels.

Review and Verification of Medical Record Documentation

In recent years, CMS made changes aimed at alleviating burdensome medical record documentation requirements. The agency intends to further ease burdens by proposing to establish a general principle to allow physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives who furnish and bill for their professional services to review and verify (sign/date), rather than re-document, information included in the patient's medical record by physicians, residents, nurses, students or other members of the medical team. This would include notes documenting the practitioner's presence and participation in the service and would apply across settings for all Medicare-covered services paid under the PFS.

Care Management Services

In recent years, CMS has introduced and updated care management and care coordination codes, including those shown in Table 16 on pages 40548- 40549. The agency proposes changes designed to increase use of these codes. Specifically, CMS proposes to allow for payment of 14 codes, shown in Table 17 on pages 40549- 40550, concurrently with payment for Transitional Care Management (TCM) services. CMS seeks comment on the overlap with these services and TCM, which the agency states could be complementary to one another. The agency also proposes a higher payment, resulting from increasing the work RVUs, for both TCM services, CPT codes 99495 and 99496.

CMS proposes to recognize additional time spent on non-complex Chronic Care Management (CCM), CPT code 99490, which currently is paid when at least 20 minutes of clinical staff time per month is spent furnishing this service. Therefore, the agency proposes to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code. The first G code, GCCC1, would describe the initial 20 minutes of clinical staff time, and the second G code, GCCC2, would describe each additional 20 minutes thereafter.

CMS also proposes notable changes to complex CCM, CPT codes 99487 and 99489. These codes require establishment or substantial revision of the comprehensive care plan, which the agency notes may be unnecessary. Therefore, CMS proposes to adopt two new G codes that would be used for billing that would not include the service component of substantial care plan revision. Instead of CPT code 99487, CMS proposes to adopt HCPCS code GCCC3. Instead of CPT code 99489, CMS proposes to adopt HCPCS code GCCC4. The agency notes that it intends for the four CCM G codes to be temporary until CPT codes are potentially revised.

CCM scope of service includes a patient-centered care plan, a requirement that stakeholders have said can be burdensome and duplicative with other work. CMS responds to those concerns by clarifying that the numerous elements described in the care plan are “typical” elements and are not requirements that must all be included in a care plan for purposes of billing for CCM services. Therefore, the agency clarifies that the comprehensive care plan for all health issues typically includes, but is not limited to, the following elements: problem list; expected outcome and prognosis; measurable treatment goals; cognitive and functional assessment; symptom management; planned interventions; medical management; environmental evaluation; caregiver assessment; interaction and coordination with outside resources and practitioners and providers; requirements for periodic review; and when applicable, revision of the care plan.

Current CCM codes require patients to have two or more chronic conditions. CMS is proposing separate coding and payment for Principal Care Management (PCM) services, which describe care management services for one serious chronic condition. A qualifying condition would typically be expected to last between three months and a year, or until the death of the patient, and may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. While there is not a proposed restriction based on specialty for billing these services, they would most often be billed by specialists focused on managing patients with a single complex chronic condition requiring substantial care management.

CMS expects initiation of PCM would often be triggered by an exacerbation of the patient’s complex chronic condition or recent hospitalization such that disease-specific care management is warranted. Further, PCM services would typically be billed when a single condition is so complex that it could not be managed as effectively in the primary care setting and instead requires management by another, more specialized, practitioner. It is possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously. The proposed PCM codes, GPPP1 and GPPP2, are described in more detail on page 40553.

CMS also proposes that the full CCM scope of service requirements, shown in Table 18 on pages 40554-40555, apply to PCM, including documenting the patient's verbal consent in the medical record.

Physician Supervision of Physician Assistant (PA) Services
CMS proposes that the statutory physician supervision requirement for PA services would be met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services. CMS notes that PAs are currently required to be supervised by physicians under the "general supervision" standard.

Therapy Services
CMS proposes to require that claims for services furnished by physical and occupational therapy assistants must include a modifier (CQ and CO, respectively), starting in CY 2020. Services will be considered furnished by these assistants if they exceed 10 percent of the total minutes of those visits. Additionally, the agency proposes to pay for therapy delivered by assistants at 85 percent of Medicare rates, starting in January 2022. The reduced payment amounts won't apply to services delivered by Critical Assess Hospitals, who aren't paid based on the MPFS. CMS also proposes to add a requirement that the treatment notes explain, by way of a short phrase or statement, why the modifier was or wasn't used for each service furnished that day.

Beneficiary Notification Requirements for Home Infusion Therapy
CMS proposes to implement a statutory requirement for home infusion providers, which requires patient notification of the options available (e.g. home, physician office, hospital outpatient department) prior to furnishing home infusion therapy. CMS is soliciting comments on the form, manner, and frequency of such notifications.

Deferring to State Scope of Practice Requirements
CMS proposes to amend the Ambulatory Surgical Center (ASC) Conditions for Coverage to allow either a physician or an anesthetist to examine a patient immediately before surgery to evaluate the risk of anesthesia and the risk of the procedure to be performed. CMS proposes to permit a hospice to accept drug orders from a physician, a nurse practitioner (NP), or a PA, subject to state scope of practice requirements and hospice policy. This proposal follows the passage of Section 51006 of the Bipartisan Budget Act, which added PAs to the statutory definition of a hospice attending physician. CMS also proposes that the PA must be the patient's attending physician, and may not have an employment or contractual arrangement with the hospice. CMS included a number of queries regarding the role of non-physician practitioners (NPPs) in hospice care, available on pages 40725-40726.

Advisory Opinions on the Application of the Physician Self-Referral Law
CMS proposes a number of modifications to its process to accepting and responding to advisory opinion requests related to the application of the Physician Self-Referral Law or "Stark Law". CMS is currently prohibited from accepting an advisory opinion request if CMS is aware of pending or past investigations or proceedings involving a course of action that is "substantially the same" as the arrangement or proposed arrangement. CMS proposes to modify its regulations to allow the agency more discretion to make this determination in coordination with the Department of Health and Human Services Office of Inspector General and U.S. Department of Justice, as applicable. However, CMS would retain its prohibition on advisory opinions in instances where there is an active investigation involving the same matter.

CMS also proposes a number of changes to the process for handling advisory opinion requests, such as shortening the timeframe for the agency to respond to a request from 90 to 60 days, modifying who is

eligible to sign a certification related to the validity of information provided by the requestor, and adjusting fees related to requesting advisory opinions.

CMS proposes modifications it its current policies which would allow parties to the arrangement in question (for example, a physician) to rely on the CMS advisory opinion; currently the regulations only provide that the Secretary will not pursue sanctions against CMS advisory opinion requestors. CMS further proposes that they will not pursue sanctions against "any individuals or entities that are parties to an arrangement that CMS determines is indistinguishable in all material aspects from an arrangement that was the subject of the advisory opinion". Finally, CMS requests comment on whether it should limit its current ability under regulation to rescind or revoke an advisory opinion after its issuance.

CMS Seeks Comment on Opportunities for Bundled Payment Rates Under the Physician Fee Schedule
Under the MPFS, Medicare typically makes a separate payment for each individual service furnished to a beneficiary consistent with section 1848 of the Social Security Act, which requires CMS to establish payment for physicians' services based on the relative resources involved in furnishing the service. The statute defines "services" broadly, with reference to the uniform procedure coding system established by CMS for the purpose of Medicare fee-for-service payments, called the Healthcare Common Procedure Coding System (HCPCS). Therefore, CMS is interested in exploring new options for establishing MPFS payment rates or adjustments for services that are furnished together. CMS refers to this circumstance where a set of services would be grouped together for purposes of rate setting and payment as a "bundled payment" (such as establishing per-beneficiary payments for multiple services or condition-specific episodes of care). In this rule, CMS seeks comment on opportunities to expand the concept of bundling payments to recognize efficiencies among physicians' services paid under the PFS.

Medicare Coverage of and Payment for Opioid Use Disorder Treatment
To implement section 2005 of the SUPPORT Act, CMS proposes to establish rules to govern Medicare coverage of and payment for Opioid Use Disorder treatment services furnished in Opioid Treatment Programs. In addition, CMS outlines requirements for Medicare enrollment of treatment programs and seeks public feedback on additional means of preventing fraud, waste, and abuse in these settings.

Under § 424.535(a)(14), CMS may revoke a physician's or other eligible professional's enrollment if he or she has a pattern or practice of prescribing Part D drugs that is abusive, and/or represents a threat to the health and safety of Medicare beneficiaries, or fails to meet Medicare requirements. Given the nationwide opioid epidemic and the need to reduce opioid abuse, CMS proposes to revise §424.535(a)(14) to no longer be restricted to Part D drugs but extend to all Medicare drugs, including Part B drugs.

Telehealth Services
CMS proposes to make certain remote patient monitoring services (CPT codes 99457 and 994X0), done mostly through the collection, analysis, and interpretation of digitally collected physiologic data, billable under general supervision. Currently, CMS requires direct supervision, which may limit the utility of the codes that were introduced in January 2019.

After creating several new codes for "virtual check-ins," "communication technology-based Services," and other telehealth-related services in the final 2019 MPFS, CMS this year proposes to add just three new telehealth codes for 2020, all of which describe a bundled episode of care for treatment of opioid use disorders. These include HCPCS codes for treatment plan development, therapy, and care coordination for at least 70 minutes in the first calendar month (GYYY1); therapy and care coordination for at least 60 minutes in a subsequent month (GYYY2); and therapy and care coordination for each additional 30 minutes beyond the first 120 minutes (GYYY3).

Open Payments
Per the 2018 SUPPORT Act, which Congress passed in an effort to combat the opioid epidemic, CMS proposes several changes to its "Open Payments" program, which requires the public reporting of certain payments made by drug and device makers and group purchasing organizations (GPOs) to physicians and teaching hospitals. Payments are reported annually to CMS by drug and device manufacturers and GPOs, then reviewed for accuracy by providers, before being posted online.

In the proposed 2020 MPFS, CMS seeks to add PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives to the list or providers the Open Payments program applies to. The changes would apply to payments starting in CY 2021. CMS also proposes to add debt forgiveness, long-term medical supply or device loan, and buyout payments made to clinicians in relation to the acquisition of a company as categories under which payments will be publicly reported. Furthermore, accredited and unaccredited continuing education programs, which are currently two categories, would be consolidated into one, if the CMS rule were finalized. Lastly, CMS proposes to include medical device identifiers to be reported in conjunction with publicly reported payments.

QUALITY PAYMENT PROGRAM (QPP) CHANGES

Advanced Alternative Payment Model (APM) Policies

Projected flat growth of those in Advanced APMs
CMS estimates between 175,000 and 225,000 Qualifying Advanced APM Professionals (QPs) in PY 2020, which would result in projected total lump sum APM incentive payments of between $500 million to $600 million for the 2022 payment year. These estimates are similar to projections for PY 2019 (2021 payment adjustment year), reflecting a relatively flat projected growth of QPs in 2020.

Advanced APM Criteria and QP Determinations
CMS proposes a modification to how the agency determines whether an APM meets the requirement for accountability of more than nominal risk, which would allow the agency to factor in what expenditures would have been in the absence of the APM participation. This change, if finalized, would apply to APMs with benchmark-based risk which pertains to many ACO models.

CMS proposes, beginning with PY 2020, that Partial QP status would only apply to the TIN/NPI combination through which the Partial QP status is attained. Therefore, Partial QPs would be required to report on MIPS and be subject to MIPS payment adjustments for TIN/NPI combinations outside the APM Entity, and their APM Entity would still elect whether to participate in MIPS for the TIN(s) associated with the APM Entity. CMS also proposes an eligible clinician (EC) would not be able to retain QP status if it stems from participation in an APM Entity that terminates its APM participation after the QP performance period ends August 31 but before bearing financial risk under the APM. This proposal, if finalized, would go into effect starting with PY 2020.

Adding Medical Home Model to All-Payer Combination Option
CMS proposes to add an "Aligned Other Payer Medical Home Model" to the All-Payer Combination Option. This new term would include the same characteristics as the definition of Medical Home Model but would apply to Other Payer APM arrangements. Specifically, it would refer to a payment arrangement (not including a Medicaid payment arrangement) operated by an Other Payer that formally partners with CMS through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU), in a CMS Multi-Payer Model that is a Medical Home Model. The arrangement must be determined by CMS to have characteristics such as having a primary care focus (based on clinicians and services), empanelment of each patient to a primary clinician; and at least four of the following: Planned coordination of chronic and preventive care; Patient access and continuity of care; Risk-stratified care management;

Coordination of care across the medical neighborhood; Patient and caregiver engagement; Shared decision-making; and/or Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments). CMS also proposes to apply the Medicaid Medical Home Model financial risk and nominal amount standards, Other Payer quality and electronic health record (EHR) use requirements and a 50 eligible clinician (EC) limit.

Assessing Risk of Other Payer APM Arrangements

As with the proposal described above pertaining to the Medicare APM risk evaluation, CMS proposes the same change would apply to the Other Payer APMs with benchmark-based arrangements. Therefore, CMS proposes that if expected expenditures (that is, benchmarks) under the payment arrangement exceed the expenditures that the participant would be expected to incur in the absence of the payment arrangement, such excess expenditures would not be considered when CMS assesses financial risk under the payment arrangement for Other Payer Advanced APM determinations.

CMS proposes to allow an Other Payer APM arrangement to meet the 30 percent marginal risk rate requirement based on an average, which the agency would compute by adding the marginal risk rate at each percentage of level to determine participants' losses, and dividing it by the percentage above the benchmark to get the average marginal risk. This would allow APMs to qualify under the All-Payer Combination Option if they have a marginal risk rate that varies based on losses, as long as the average marginal risk rate is at least 30 percent.

CMS seeks feedback on whether it is appropriate for the agency to allow Other Payer full capitation arrangements to exclude certain items and services and still be considered a full capitation arrangement. If appropriate, the agency seeks comments on what would qualify as permissible exclusions.

Merit-Based Incentive Payment System (MIPS) Policies

Overview

CMS proposes a number of changes to MIPS for PY 2020, which will dictate 2022 payment adjustments. Notably, CMS does not propose significant changes to the APM Scoring Standard, which is used to evaluate ACOs subject to MIPS. Therefore, ACOs will continue to receive favorable benefits from their APM participation in MIPS such as no additional quality reporting, no Improvement Activities Performance Category reporting, and no cost evaluation. CMS also proposes to raise the performance threshold from 30 points to 45 points and the exceptional performance threshold from 75 points to 80 points for PY 2020. With this increase in the performance threshold and the maximum penalty amount rising from 7 percent to 9 percent, the maximum projected payment adjustment amount for a perfect score of 100 points is estimated to be approximately 5.78 percent in PY 2020/2022 payment year. Based on the proposals summarized below, CMS estimates 818,000 clinicians will be subject to MIPS in PY 2020.

Comparison of Performance Category Weights for ACOs vs. MIPS Eligible Clinicians

	ACOs	**MIPS ECs**	**MIPS ECs**
	PY 2020	PY 2019	PY 2020
Quality	50%	45%	40%
Cost	0%	15%	20%
Improvement Activities	20%	15%	15%
Promoting Interoperability	30%	25%	25%

MIPS Performance Thresholds
CMS proposes to increase the MIPS performance threshold from 30 points for 2019 to 45 points in 2020. Therefore, an EC would need to meet or exceed 45 points in MIPS to avoid penalties in the program. CMS also proposes increases to the exceptional performance threshold from 75 points for 2019 to 80 points in 2020. The Medicare Access and CHIP Reauthorization Act (MACRA) originally required CMS to increase the MIPS performance threshold to either the mean or median performance beginning with PY 2019. However, the Bipartisan Budget Act of 2018 granted the agency additional flexibility in raising the performance threshold over time to provide clinicians with an additional three years to transition to use of mean/median performance as the established threshold in MIPS. NAACOS has consistently urged CMS to continue its commitment to transitioning clinicians to value-based payments by increasing the performance thresholds and criteria in MIPS as required by MACRA.

MIPS Low Volume Exclusion
CMS proposes no changes to the low volume exclusion criteria for MIPS. Therefore, those who meet at least one of the current three low-volume threshold criteria would be excluded from MIPS: 1) those who see 200 or fewer Medicare patients or (2) those who have $90,000 or fewer Medicare Part B charges during the specified measurement period or (3) provide less than or equal to 200 covered professional services under the PFS. Please note that the low volume exclusion does not apply to clinicians and practices in an ACO. Instead, an ACO is evaluated at the ACO entity level, therefore, it is highly unlikely that an ACO would meet this exclusion criteria.

Quality
CMS does not propose any changes in 2020 to the quality performance category for ACOs. ACOs will continue to be exempt from any additional quality reporting requirements in MIPS. CMS will continue to rely on the ACO's MSSP and Next Generation ACO Model quality reporting for purposes of MIPS.

Clinical Practice Improvement Activities
CMS does not propose any changes to the way ACOs are evaluated in the Clinical Practice Improvement Activities performance category for 2020. The agency will continue to post an evaluation annually to determine what credit is provided automatically to each APM. ACOs earn full credit in this performance category automatically due to the improvement efforts inherent in participating in the ACO.

Promoting Interoperability (PI)
CMS proposes to continue to require the use of 2015 certified EHR technology in PY 2020 for a 90-day continuous reporting period. As a reminder, beginning in 2019, CMS allows clinicians in ACOs to report PI measures either as an individual or as a group (i.e., TIN). In 2020, CMS proposes a change to the exclusion criteria for hospital-based clinicians for the PI performance category. Specifically, CMS proposes that 75 percent or more of NPIs in a TIN must meet the definition of hospital-based in order to be excluded from this performance category. Previously, CMS required 100 percent of clinicians in a TIN to meet this criterion to be excluded. As a reminder, CMS does not include providers excluded from PI in an ACO's weighted average PI score.

Table 41 on page 40771 reviews the proposed objectives and measures for the PI performance category in 2020.

TABLE 41: Objectives and Measures for the Promoting Interoperability Performance Category in 2020

Objective	Measure	Numerator	Denominator	Exclusion
e-Prescribing: Generate and transmit permissible prescriptions electronically	e-Prescribing: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.	Number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
e-Prescribing: Generate and transmit permissible prescriptions electronically	Query of PDMP (bonus): For at least one Schedule II opioid electronically prescribed using CEHR T during the performance period, the MIPS eligible clinician uses data from CEHR T to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	N/A (measure is Y/N)	N/A (measure is Y/N)	N/A
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.	Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care using CEHR T; and (2) electronically exchanges the summary of care record.	Number of transitions of care and referrals in the denominator where the summary of care record was created using CEHR T and exchanged electronically.	Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the	Support Electronic Referral Loops by Receiving and Incorporating Health Information: For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care	Number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three	Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient	Any MIPS eligible clinican who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.

receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.	or referrel, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical informaiton reconciliation for medication, medication allergy, and current problem list.	clinical information sets: (1) Medications – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy – Review of the patient's known medication allergies; and (3) Current Problem List – Review of the patient's current and active diagnoses.	encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.	
Provider to Patient Exchange: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information	Provide Patients Electronic Access to Their Health Information: For at least one unique patient seen by the MIPS eligible clinician: 1. The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and 2. The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (APT) in the MIPS eligible clinician's CEHRT	Number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download and transmit to a third party and to access using an application of their choice this is configured to meet the technical specifications of the API in the MIPS eligible clinicians CEHRT.	Number of unique patients seen by the MIPS eligible clinician during the performance period.	N/A
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Immunization Registry Reporting: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: l. does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period; OR 2.operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3. operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to

				receive immunization data as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Syndromic Surveillance Reporting: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician l.ls not in a category of health care providers from which ambulatory syndromic data is collected by their jurisdiction's syndromic surveillance system; OR 2.operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required to meet the CEHRT definition at the start of the performance period; or 3. Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from MIPS eligible clinicians as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency of clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Electronic Case Reporting: The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1. Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period; or 2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition a the start of the performance period; or 3. Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Public Health Registry Reporting: The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1. Does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS eligible clinician's jurisdiction during the performance period; OR 2. Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period OR 3. Operates in a jurisdiction where no public health registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or	Clinical Data Registry Reporting: The MIPS eligible clinical is in active engagement to submit data to a clinical data registry	N/A (measure is Yes/No)	N/A (measure is Yes/No)	The MIPS eligible clinician: 1. Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period; OR 2. Operates in a jurisdiction for which no

clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.				clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the performance period OR 3. Operates in a jurisdiction where no clinical data registry for which the MIPS eligible clinician is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.

Table 42 on page 40775 reviews the proposed scoring methodology for the PI performance category in 2020.

TABLE 42: Proposed Scoring Methodology for the Performance Period in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing**	10 points
	Query of PDMP	5 points (*bonus*)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information**	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information**	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting** Electronic Case Reporting** Public Health Registry Reporting** Clinical Data Registry Reporting** Syndromic Surveillance Reporting**	10 points

** Exclusion available.

Cost

CMS does not propose changes to its current policy that excludes ACOs from receiving a cost category score in MIPS. For non-ACOs, the cost performance category weight increases from 15 percent for PY 2019 to 20 percent for PY 2020. CMS will increase the cost performance category weight by 5 percent each year until the cost category is worth 30 percent of a MIPS EC's overall score.

In addition to the Total Per Capita Cost and Medicare Spending Per Beneficiary measures, CMS evaluates non ACOs on certain episode cost measures. In 2020, CMS proposes to add 10 new episode cost measures (for non-ACOs). The episode cost measures proposed for 2020 are listed in Table 40 on page 40761.

Other changes

CMS proposes a new "MIPS Value Pathways" approach to the program which would begin in 2021 and aims to streamline reporting for certain specialties, clinical conditions, or priority areas. When electing such a pathway, there could be fewer total measures to report overall and the concept strives to make reporting more relevant for certain specialties or clinical conditions. This would be applicable to non-MIPS APMs only, therefore this would not apply to ACOs. CMS seeks comment on this concept.

Final MIPS Score and Resulting Payment Adjustments

The MIPS 2020 performance year will dictate 2022 payment adjustments earned for clinicians subject to MIPS. CMS estimates approximately $584 million will be available in the budget-neutral pool for MIPS based on these proposals, which is in addition to the $500 million in the exceptional performance incentive payment pool for those that meet or exceed the proposed 80-point exceptional performance threshold. This amount ($584 million) is an increase from 2019 ($310 million) due to performance thresholds rising and maximum penalty amounts rising. For more information, please refer to Figure 1 on page 40805of the proposed rule. Based on these projections, CMS estimates those earning a perfect MIPS score of 100 in 2020 would earn a 5.78 percent MIPS payment adjustment in 2022.