

## Aug. 7, 2020: Advocacy spotlight on 2021 Medicare Physician Payment Schedule and Quality payment program proposed rule

### 2021 Medicare Physician Payment Schedule and Quality payment program proposed rule

On Aug. 3, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes updates to payment policies, payment rates and quality provisions for services furnished under the Medicare Physician Payment Schedule effective on or after Jan. 1. At the same time, the Administration issued an Executive Order on Improving Rural and Telehealth Access. While AMA staff continues an in-depth review of the proposed rule, here are some key points:

- The proposed CY 2021 PFS **conversion factor** is \$32.26, a significant decrease of \$3.83 below the CY 2020 PFS conversion factor of \$36.09. This represents an almost 11% decrease in the conversion factor compared to last year. The proposed CY 2021 anesthesia conversion factor is \$19.96, a decrease of \$2.25 from the CY 2020 conversion factor of \$22.20. The CMS proposed conversion factors include budget neutrality adjustments.
- The drastic **11% reduction in the Medicare conversion factor** is necessitated by proposed additional spending of \$10.2 billion. The AMA/Specialty Society RVS Update Committee (RUC)'s recommendations account for only half of this additional spending, and therefore, half of the reduction. The remaining spending increases and resulting conversion factor reduction is attributed to various CMS proposals to increase valuation for specific services.
- CMS proposes to implement finalized CPT descriptors, guidelines, and payment rates on Jan. 1, which will be a significant modification to the coding, documentation and payment of **evaluation and management (E/M) services** for office visits. While CMS recognized the increases in the payment bundles for maternity care and a few other select services, the visits within the 10-day and 90-day global surgical payment bundle remains unchanged. The AMA strongly supports CMS' adoption of the office visit changes and continues to urge CMS to incorporate the office visit payment increases into the global surgery packages.
- CMS has proposed to permanently keep several codes that were temporarily added to the **Medicare telehealth** list during the COVID-19 Public Health Emergency (PHE), including the prolonged office or outpatient E/M visit codes and certain home visit services. CMS also

proposes to keep additional services, including certain emergency department visits, on the Medicare telehealth list until the end of the calendar year in which the PHE ends to allow more time to study the benefit of providing these services using telecommunications technology outside the context of a pandemic.

CMS proposes to continue to gradually implement **Merit-based Incentive Payment System (MIPS)** in 2021 and postpones the MIPS Value Pathways participation option until 2022 at the earliest to allow additional time for stakeholder feedback about the MVP framework. CMS is also proposing a new MIPS pathway for participants in alternative payment models (APM) called the APM Performance Pathway (APP). The performance threshold would increase from 45 points in 2020 to 50 points in 2021, a more gradual increase instead of the 60 points as had been previously proposed. CMS also proposes to lower the weight of the Quality Category performance score from 45% to 40% of the MIPS final Score, and increase the weight of the cost performance category from 15% of the MIPS final score to 20%.

For performance year 2021, CMS is proposing that Accountable Care Organizations (ACO) participating in the **Medicare Shared Savings Program** be required to report quality measure data for purposes of the Shared Savings Program via the APP, instead of the CMS Web Interface. The total number of measures in the ACO quality measure set would be reduced from 23 to 6 measures.

CMS did not address the **Appropriate Use Criteria (AUC)** program in the proposed rule, which means the program would move forward with the Jan. 1 start date. This program requires physicians to consult AUC using clinical decision support tools prior to ordering advance imaging services for Medicare beneficiaries, which is then appended to claims for those services.

Under the Executive Order, CMS will develop a new model to test innovative payment mechanisms with flexibilities from existing Medicare rules to allow **rural health care providers** to provide the necessary level and quality of care. The EO calls for the establishment of predictable financial payments and encourages the movement into high-quality, value-based care. The model is to be announced within 30 days of the Executive Order.

Although CMS has permitted many **Medicare Diabetes Prevention Program (MDPP)** services to be provided virtually during the COVID-19 public health emergency, it still requires the first core session to be provided in-person, which prevents any new patients from participating. The proposed rule would drop that requirement and allow all MDPP services to be delivered virtually during the current emergency as well as in future declared emergencies. CMS also proposes to allow patients to report their weight through virtual means, such as Bluetooth scales. The proposed rule, however, stops short of allowing providers of virtual-only DPP services to enroll as MDPP suppliers.

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