AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAFP Summary of the 2020 Final Medicare Physician Fee Schedule

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) released a final rule and interim final rule on the 2020 Medicare Physician Fee Schedule (MPFS). This regulation also impacts the Quality Payment Program (QPP). CMS released a related fact sheet and press release. The AAFP commented on the 2020 proposal in a September 18, 2019 letter.

2020 Medicare Physician Payment
The final 2019 MPFS conversion factor is $36.0391. Reflecting the same values estimated in the proposed rule, the final 2020 MPFS conversion factor will be $36.0896.

Based on CMS' final rule, there would be no change in total Medicare allowed charges for family medicine in 2020, but total allowed charges for family medicine would increase 12% in 2021.

Evaluation and Management
In 2019 rulemaking, CMS finalized changes to simplify billing and coding requirements for office-based Evaluation and Management (E/M) services.

As the AAFP supported, CMS finalized its proposal to align E/M coding with changes laid out by the CPT Editorial Panel for office/outpatient E/M visits beginning in 2021. Thus, CMS finalized to:

- Retain 5 levels of coding for established patients;
- Reduce the number of levels to 4 for office/outpatient E/M visits for new patients;
- Revise the times and medical decision-making process for all office-based E/M codes and require performance of history and exam only as medically appropriate; and
- Allow clinicians to choose the E/M visit level based on either medical decision making or time.

The AAFP supported and CMS finalized the adoption of the American Medical Association (AMA) Relative Value Scale Update Committee (RUC)-recommended values for the office/outpatient E/M visit codes for 2021 and the new add-on CPT code for prolonged service time.

With the AAFP's support, CMS also finalized the proposal to consolidate the Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care that was finalized in 2019 for implementation in 2021 into a single code describing 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.

For 2020, when coding and billing E/M visits to Medicare, practitioners may use one of two versions of the E/M Documentation Guidelines for a patient encounter, the "1995" or "1997" E/M Documentation Guidelines.

Despite rampant opposition by some, the AAFP and MedPAC supported and CMS subsequently finalized policy to not adjust the values for surgical codes with 10- and 90-day global periods to reflect the values for stand-alone E/M visits. CMS discusses that it would be imprudent at this point to adjust

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the values for surgical codes with 10- and 90-day global periods to reflect the values for stand-alone E/M visits and would continue to evaluate data.

Care Management Services
For 2020, CMS finalizing the proposal to increase payment for transitional care management (TCM) services which are care management services provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays.

Also for 2020, CMS created a Medicare-specific code for additional time spent beyond the initial 20 minutes allowed in the current coding for chronic care management (CCM) services, which are services provided to beneficiaries with multiple chronic conditions over a calendar month.

Recognizing that clinicians across all specialties manage the care of beneficiaries with chronic conditions, CMS created a new coding for principal care management (PCM) services, for patients with only a single serious and high-risk chronic condition. In the AAFP's comments, the Academy opposed the PCM codes citing concern that the addition of PCM codes would move away from the continuous, comprehensive, and coordinated value-based care and primary care CMS has otherwise encouraged. The AAFP offered better ways to fill the identified gap in coding and payment for care management services for patients with only one chronic condition.

Review and Verification of Medical Record Documentation
CMS finalized modifications to the documentation policy so that physicians, physician assistants, and advanced practice registered nurses (APRNs – nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists) can review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team.

Physician Supervision Requirements for Physician Assistants (PAs)
In accordance with state law and state scope of practice, CMS finalized a revision to current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services.

Medicare Telehealth Services
For 2020, CMS is adding HCPCS codes G2086, G2087, G2088, which describe a bundled episode of care for treatment of opioid use disorders, to the list of telehealth services.

Coverage for Opioid Treatment Programs
With the AAFP's support, CMS finalized Medicare coverage to pay opioid treatment programs (OTPs) for delivering Medication-Assisted Treatment (MAT) to people with Medicare suffering from Opioid Use Disorder (OUD). OTPs must be accredited by the Substance Abuse and Mental Health Services Administration. CMS finalized the definition of OUD treatment services to include:

- FDA-approved opioid agonist and antagonist treatment medications,
- The dispensing and administering of such medications (if applicable),
- Substance use counseling,
- Individual and group therapy,
- Toxicology testing which includes both presumptive and definitive testing,
- Intake activities, and
- Periodic assessments.

CMS finalized the creation of new coding and payment for a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling, as well as an add-on code for additional counseling.

The Quality Payment Program (QPP)
As part of the final rule, CMS issued a 9-page executive summary of the 2020 updates to the Quality Payment Program (QPP) starting January 1, 2020. In addition, the agency published a 28-page fact sheet on the 2020 QPP.

For the Merit-based Incentive Payment System (MIPS), CMS finalized policies that establish the following performance thresholds and category weights for the 2020 performance period (which equates to the 2022 payment year) as:

- Performance threshold: 45 points
- Additional performance threshold for exceptional performance: 85 points
- Quality performance category is weighted at 45%
- Cost performance category is weighted at 15%
- Promoting Interoperability performance category is weighted at 25%
- Improvement Activities performance category is weighted at 15%

Policy Area	CY 2019 Policy	CY 2020 Policy
Performance Category Weights	• Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	**No change:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%

CMS finalized that the performance threshold is 60 points for the 2021 performance period. The additional performance threshold for exceptional performance is 85 points.

CMS had proposed a new way for clinicians to participate in the MIPS. Called the MIPS Value Pathways (MVPs), it would allow clinicians to report much less than the current MIPS framework. CMS finalized a modified proposal to define MVPs as a subset of measures and activities. CMS will work with stakeholders to further develop MVPs.

For APMs, CMS finalized several updates.

- For the APM Scoring Standard, the agency finalized quality reporting options for APM participants. Beginning in 2020, CMS will allow APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS Quality performance category. APM Entities will receive a calculated score based on individual, TIN, or APM Entity reporting.
- CMS will apply a minimum score of 50 percent, or an "APM Quality Reporting Credit" under the MIPS Quality performance category for certain APM entities participating in MIPS, where APM quality data are not used for MIPS purposes.
- CMS will apply the existing MIPS extreme and uncontrollable circumstances policies to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standard and who would report on MIPS quality measures.

Questions or comments on the 2020 final MPFS? Please email regulations@aafp.org.