HMA Summary of 2021 Physician Fee Schedule (PFS) Proposed Rule

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2021 Physician Fee Schedule (PFS) Proposed Rule. The Proposed Rule includes payment policies, payment rates, and other provisions for services furnished under the Medicare PFS on or after January 1, 2021. CMS will accept public comments on the Proposed Rule until October 5, 2020. Key components of the proposed rule include: policies to retain, extend, or end certain telehealth flexibilities implemented in response to the novel coronavirus (COVID-19) public health emergency (PHE), changes to enable certain health care professionals to practice at the top of their licenses, modifications to opioid treatment programs (OTPs), and updates to the Medicare Shared Savings Program (MSSP). Highlights from these proposals are provided below.

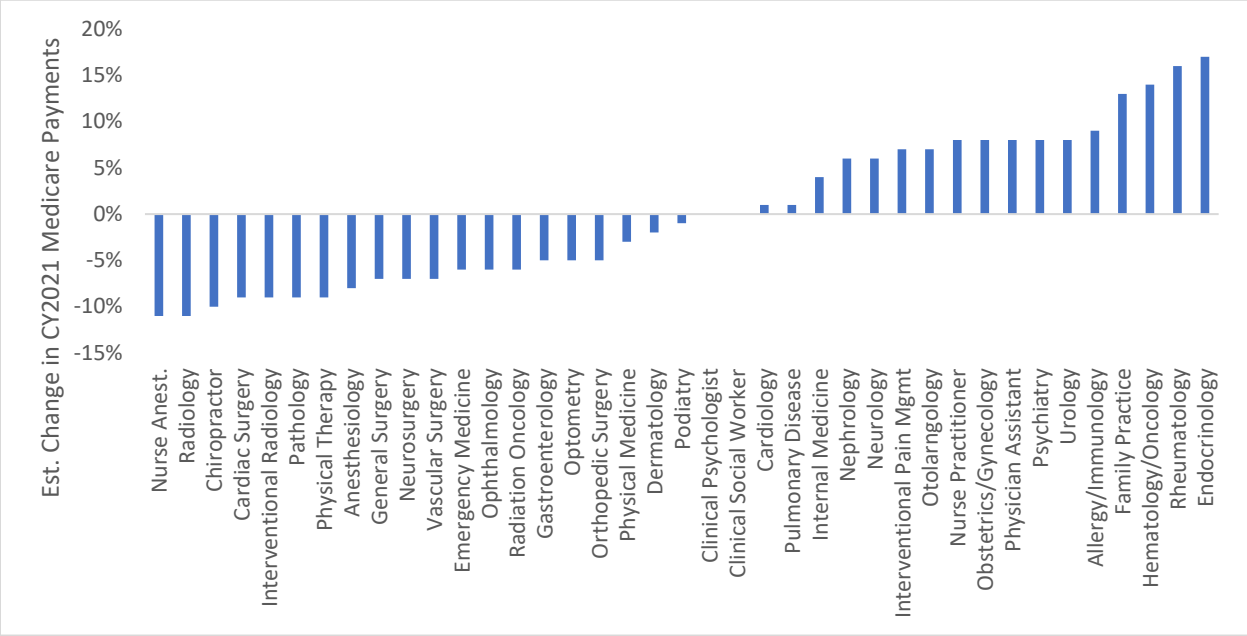
HMA continues to analyze the Proposed Rule as well as other legislative and regulatory developments that impact physicians and other clinicians. For more information or questions about the Proposed Rule or other Medicare physician policies please contact Zach Gaumer (zgaumer@healthmanagement.com), Eric Hammelman (ehammelman@healthmanagement.com), Narda Ipakchi (nipakchi@healthmanagement.com), or Jennifer Podulka (jpodulka@healthmanagement.com).

Payment

CMS estimated the cumulative impact of all proposed changes for CY 2021 will result in a 0 percent change in physician payments, in line with the requirements of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. To achieve this overall impact, CMS is proposing to decrease the CY 2021 conversion factor by 10.61 percent, to $32.2605.

There is significant specialty-specific variability in the expected payment change for CY 2021. The biggest impact comes from the implementation of changes to Evaluation & Management (E&M) services that were finalized in CY 2020. In addition, CMS is in the 3rd year of a 4-year phase-in of new supply and equipment prices, which results in the revaluation of specific codes. Due to these changes, as shown in Figure 1 below, 16 specialties may see a decrease of 7 percent or more in payments, while another 13 specialties could see an increase of 7 percent or more, resulting in one of the most significant redistributions of Medicare physician payments ever implemented by CMS.

Figure 1: Estimated Change in Medicare Payments, Select Specialties



Evaluation & Management Services

In the CY 2020 PFS Final Rule, CMS finalized its proposal to increase payments starting in 2021 for office & outpatient E&M services (CPTs 99202-99215) in-line with recommendations from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC).

CMS also finalized its proposal to introduce a new add-on code (HCPCS GPC1X) for complex care associated with E&M services. In the FY 2021 PFS Proposed Rule, CMS is implementing these policies as previously finalized, and is seeking comment regarding the types of additional details that would be useful for providers to better understand the new add-on code for complex care.

After finalizing the E&M changes last year, CMS heard from multiple stakeholders that additional service codes should be adjusted to maintain the appropriate relative value to office & outpatient E&M services. Specifically, for CY 2021 CMS proposed to increase payments associated with:

- End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP), CPTs 90951-90970
- Transitional Care Management (TCM), CPTs 99495 & 99496
- Maternity services, CPTs 59400-59618
- Assessment and Care Planning for Patients with Cognitive Impairment, CPTs 99483-99493
- Initial Preventive Physical Examination and Annual Wellness Visits, HCPCS G0402, G0438-G0439
- Emergency Department visits, CPTs 99283-99285
- Therapy Evaluations, CPTs 97161-97168
- Psychotherapy services, CPTs 90791, 90792, 90832, 90834, 90837

CMS also received a request to adjust payment for certain ophthalmological services, but the proposed rule notes that it believes these services are not sufficiently connected to E&M services and therefore should not be adjusted.

Telehealth

During the PHE, CMS implemented several temporary changes which drastically expanded Medicare coverage of and payment for telehealth services. CMS proposes to make some of these telehealth policy changes permanent, extend others through either the end of 2021 or through the calendar year in which the PHE ends, and allow others to expire at the end of the PHE. The proposed rule responds to several widely anticipated proposals including: 1) permissibility of audio-only telephone calls; 2) inclusion of patients' homes as originating sites; 3) extensions of various types of Medicare Telehealth Services beyond the PHE; 4) types of clinicians eligible to provide telehealth services; 5) and expansion of the scope of services defined as Communication Technology-Based Services (CTBS). The proposed rule addresses these issues as follows:

- *Audio-only telephone calls not allowed beyond the PHE:* CMS did not propose to make permanent or extend on a temporary basis the use of audio-only telehealth services, citing the lack of legal authority to make this change. CMS stated the statute requires that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology. Although the agency does not have statutory authority to require coverage for audio-only telehealth services, CMS requested comment on whether payment for such services should be a temporary policy to remain in effect for a year or some other period after the end of the PHE or if it should be permanent PFS payment policy.
- *Home will not be a telehealth originating site beyond the PHE:* CMS did not propose to make permanent or extend on a temporary basis the policy that enables the patients' home to serve as a telehealth originating site. Statute requires that the patients' home is not a permissible telehealth originating site unless the patient is being treated for a substance use disorder or has a co-occurring mental health disorder.
- *Medicare Telehealth Services:* CMS proposed to make coverage permanent for a handful of the Medicare telehealth services (e.g., standard in-person physician services conducted via telehealth) that were covered during the PHE, and also proposes to extend temporary coverage for a second set of these service. These services are listed in the table below. In addition, CMS requested comments regarding whether the following services should be covered on a temporary basis: initial and final/discharge interactions, higher level emergency department visits, hospital, intensive care unit, emergency care, and observation stays.

Permanently implemented (beginning in CY 2021)	**Temporarily implemented** (through the end of calendar year the PHE ends or December 31, 2021)	**Not implemented in CY 2021**
- Group psychotherapy, prolonged E&M services - Neurobehavioral status exams - Care planning for patients with cognitive impairment - Short home visits and short rest home visits (only for patients treated for substance abuse disorders or with a co-occurring mental health disorder).	- Lower acuity emergency department visits - Long home visits and long rest home visits (only for patients treated for substance abuse disorders or with a co-occurring mental health disorder) - Nursing facility discharge planning - Certain psychological and neurological testing	This list is extensive, but the most notable services on this list include: - Initial nursing facility visits - Physical therapy - Occupational therapy - Speech-language pathology - Initial hospital care and hospital discharge day management - Critical care services - Higher-level emergency department visits

- *Communication Technology-Based Services (CTBS):* CMS proposed to make permanent the policy to permit physical therapists, occupational therapists, and speech-language pathologists, licensed clinical social workers, and clinical psychologists to bill for CTBS. Relative to Medicare Telehealth Services, these services are defined as brief visits, can be conducted using various forms of technology, are not subject to the same statutory rules, and are paid lower rates.
- *The proposed rule would also:*
    - Make permanent two policies related to remote physiological monitoring (RPM) that were implemented for the PHE. These include, 1) allowing patient consent to be obtained at the time that RPM services are furnished, and 2) permitting auxiliary personnel to provide certain RPM services. CMS also solicits feedback on whether the current RPM codes are sufficient to describe the services being provided to patients in the current environment.
    - Lower the frequency limit on subsequent nursing facility visits conducted via telehealth from one visit every 30 days to one visit every 3 days.
    - Extend on a temporary basis (through the end of calendar year the PHE ends or through December 31, 2021) the PHE policy which enabled direct supervision of an auxiliary clinician by a billing clinician to be provided via telehealth.

Scope of Practice

In response to the PHE, CMS implemented several temporary flexibilities to allow certain health care professionals to practice at the top of their license. CMS is now considering whether some of these flexibilities should be temporarily extended (through the end of the year in which the PHE ends) or be made permanent. In addition to general feedback, CMS requested comment on whether and the extent to which state licensure and facility-level requirements would permit practitioners to implement expanded scope of practice policies if finalized. Specific areas of scope of practice for which CMS is considering extending policies temporarily or permanently include:

- Temporarily extending (through the end of the year in which the PHE ends) CMS's policy of permitting the requirement for the presence of a teaching physician during the key portion of a service furnished with the involvement of a resident to be met using audio/video real-time communications technology;
- Permanently permitting nurse practitioners, clinical nurse specialists, certified nurse-midwives, and physician assistants to supervise diagnostic tests to the extent authorized under state law and licensure (and required statutory relationships with supervising/collaborating physicians are maintained); and
- Permanently permitting a physical therapist or occupational therapist to delegate the performance of maintenance therapy services to a physical therapy assistant or occupational therapy assistant when clinically appropriate.

Opioid Treatment Programs (OTPs)

January 1, 2020, Medicare introduced a new benefit for opioid use disorder (OUD) treatment, including medication-assisted treatment (MAT), furnished by opioid treatment programs (OTPs).

For 2021, CMS proposed several changes to the new OTP program to address issues that have been raised by stakeholders. Proposed changes include:

- Creating add-on codes for nasal naloxone and auto-injector naloxone for overdose.
- Allowing enrollment submission on institutional claims.
- Providing clarification regarding what is required to bill the periodic assessment add-on code –a face-to-face medical exam or bio-psychosocial assessment that can be furnished via two-way, interactive, audio-video telehealth.

CMS states it is also considering stratifying the coding and bundled payment amounts to account for significant differences in resource costs among patients, especially as related to amounts of expected counseling. CMS seeks comments on this possible change and all changes proposed to the OTP.

Medicare Shared Savings Program (MSSP)

For performance year 2020, CMS proposed to provide Accountable Care Organizations (ACOs) with full credit for Consumer Assessment of Healthcare Provider and Systems (CAHPS) patient experience of care surveys. CMS also requested comment on using the higher of an ACO's 2019 or 2020 quality performance score for ACOs that report complete data for 2020 and the mean ACO quality score for ACOs that do not report complete data.

For performance years 2021 and later, CMS proposes to align the Medicare Shared Savings Program (MSSP) quality performance standard and quality reporting requirements more closely with the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) used for other clinicians. These changes include:

- ACOs reporting only one set of quality metrics under both MIPS and the MSSP.
- MSSP ACOs reporting quality measure data via the new the Alternative Payment Model (APM) Performance Pathway (APP), instead of the CMS Web Interface.
- Reducing the total number of ACO quality measures from 23 to six, and the number of measures for which ACOs are required to submit data from 10 to three.

- Requiring ACOs to achieve at least a 40th percentile quality performance score across all categories to share in savings or avoid owing maximum losses.
- Allowing CMS to terminate participation agreements with ACOs that fail to meet the quality performance standard for two consecutive years or three non-consecutive years.

CMS also proposes to include new evaluation and care management (E&M) codes for telehealth and cognitive impairment and chronic care management in the methodology used to assign beneficiaries to ACOs. CMS would also exclude certain services furnished in skilled nursing facilities (SNFs) and the inpatient care setting from the assignment methodology.

For an agreement period starting on January 1, 2022 and later, as well as a one-time opportunity for eligible ACOs that renewed beginning on July 1, 2019 or January 1, 2020, CMS proposes to establish a technical policy that would allow renewing ACOs to decrease their repayment mechanism amount. This proposed approach does not modify actual repayment amounts, if required.

CMS seeks comments on all changes proposed to the MSSP.