Proposed Rule: CMS Updates Physician Payment System and Proposes Regulatory Changes

Every year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On August 3, CMS issued a proposed rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2021. The proposed rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients. For next year, CMS expects payments across the specialty of neurology to increase by six percent with variations depending on the individual provider's practice.

Evaluation and Management (E/M) Codes

CMS intends to move forward with its planned implementation of a new coding and payment structure for office Evaluation and Management (E/M) services. Finalized in the 2020 Medicare Physician Fee Schedule, CMS will be aligning the agency's E/M visit coding and documentation policies with changes laid out by the CPT Editorial Panel. The AAN is highly supportive of the new coding and payment structure and lauds the agency for moving forward with implementation without delay or significant modification. In addition to moving forward with the new structure, CMS is proposing modifications to the times associated with prolonged E/M services, revaluing certain services that are analogous to E/M services including transitional care management, and is requesting additional stakeholder feedback on the GPC1X complexity add-on code.

Although E/M services will receive a significant increase starting in 2021, the AAN notes that due to budget neutrality, the increase in payment for E/M services results in an across the board cut to all other services. Although neurology as a specialty is expected to experience a significant increase in reimbursement due to the E/M changes, some neurologists may experience payment reductions if they provide few E/M services.

Telehealth Regulations

Noting the significant expansion of telehealth due to the COVID-19 Public Health Emergency (PHE), CMS is proposing substantial modifications to its existing telehealth reimbursement and regulatory policies. It is important to note that these changes do not supersede the regulatory flexibilities that are in place for the duration of the PHE. Key updates include:

- CMS is proposing to add a number of new services to the Medicare telehealth list permanently and is proposing to add additional services to the telehealth list temporarily through the end of the calendar year during which the PHE ends.
- CMS is not proposing to make permanent separate payment for audio-only telephone E/M services. CMS is instead seeking comment on whether the agency should develop coding and payment for a service similar to the audio-only virtual check-in but for a longer unit of time and with greater reimbursement.
- CMS is proposing to allow direct supervision to be provided to members of the care team using real-time, interactive audio and video technology through the latter of the end of the PHE or December 31, 2021.
- CMS is proposing several modifications related to coverage of remote physiologic monitoring.

In addition to the proposed modifications to telehealth policy, CMS is seeking feedback from the public in relation to how telehealth services have been in use in various communities during the response to COVID-19. Specifically, the agency seeks to understand how the use of telehealth services may have contributed to the quality of care provided to beneficiaries during the PHE so that CMS can understand which services should be retained on the Medicare telehealth services list after the PHE has ended.

Quality Payment Program

The rule includes proposed updates to the Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) tracks.

For the MIPS track, CMS is proposing to increase the 2021 performance threshold to 50 points and maintain the 85-point threshold for an exceptional performance bonus. CMS proposes decreasing the weight of the MIPS Quality component to 40 percent from 45 percent and increasing the weight of the MIPS Cost component to 20 percent from 15 percent. In the rule, CMS also proposes to include telehealth services in measures in the Quality and Cost components. There are minimal changes proposed for the Improvement Activities and Promoting Interoperability components. The rule also includes flexibilities for the current 2020 performance period related to COVID-19. In addition to CMS considering Extreme and Uncontrollable Circumstances exception applications for MIPS participants, the rule proposes a maximum 10-point bonus for complex patients in the Quality component.

The rule proposes to delay implementation of the MIPS Value Pathways (MVP) track until at least 2022 due to the COVID-19 public health emergency. CMS also proposes an additional performance track called APM Performance Pathway (APP), similar to MVPs, that would allow MIPS-APM participants to report a fixed set of measures for each performance category in MIPS as an individual or group.

For the APM track, CMS is proposing to eliminate the APM scoring standard and sunset the CMS Web Interface as a reporting option. Instead of the CMS Web Interface, Accountable Care Organizations (ACOs) participating in the Shared Savings Program will be required to report quality measure data via the newly proposed APP track.