CY 2020 PHYSICIAN FEE SCHEDULE PROPOSED RULE SUMMARY

Prepared by CRD Associates

On July 29, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) rule for 2020. This proposal updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here.

The proposal is currently open for comment through September 27. The rule's provisions, if finalized, will be effective January 1, 2020 unless stated otherwise. The following summarizes the major policies in the proposal.

Conversion Factor and Specialty Impact

The proposed conversion factor for 2020 is $36.0896, an increase of only 5 cents from 2019. Table 110 (see Appendix A), extracted from the rule, provides a summary of the impact of the changes in the proposed rule by specialty. The changes in the rule are budget-neutral in the aggregate, which explains why the impact for all physicians is shown as zero. The proposed rule shows changes in the range of minus 4 percent to plus 3 percent with endocrinology seeing no reimbursement change in CY 2020.

Payment for Evaluation and Management Visits

For CY 2021, CMS is proposing significant changes to the documentation and payment of outpatient evaluation and management (E/M) services finalized in last year's PFS Rule, which were scheduled to be implemented in CY 2021. Last year, the agency had created a single, blended payment rate for level 2 through 4 visits with simplified documentation requirements in response to stakeholder concerns that the 1995/1997 E/M documentation guidelines were administratively burdensome. In this year's proposed rule, CMS proposes to implement the revised E/M code definitions developed by the AMA CPT Editorial Panel earlier this year that have an effective date of January 1, 2021 and not implement the consolidation of E/M codes as planned.

CMS estimates the specialty level impact of these E/M changes should they be implemented in CY 2021. They can be found in Appendix B, which includes Table 111 extracted from the rule. Based on CMS' analysis, endocrinologists will see a 16 percent increase in reimbursement.

A detailed description of the E/M policies proposed in this rule for implementation in 2021 follows:

E/M PAYMENT: CMS proposes to retain separate payment for the individual E/M services as revised by the CPT Editorial Panel. This includes the elimination of CPT code 99201. CMS proposes to adopt all of the RUC-recommended work RVUs and times for the revised code family and new prolonged add-on code that were based on a survey of over 50 specialty societies. CMS believes these values more accurately account for the time and intensity of these services than the policy finalized in last year's rule.

E/M Payment Comparison			
Visit Level	**Current Payment***	**Proposed Work RVUs**	**Proposed Payment****
99201	$45	N/A – Code would be eliminated	N/A – Code would be eliminated
99202	$76	0.93	$77
99203	$110	1.60	$119
99204	$167	2.60	$177
99205	$211	3.50	$232
99211	$22	0.18	$24
99212	$45	0.70	$60
99213	$74	1.30	$96
99214	$109	1.92	$136
99215	$148	2.80	$190
99XXX (New prolonged service)	N/A	0.61	$34.60
GPC1X (New Complexity Add-on)	N/A	0.33	$18.02

**Current payment for CY 2019*

*** Proposed payment based on the proposed relative value units and the CY 2019 payment rates.*

DOCUMENTATION: CMS is proposing to implement the documentation requirements that were included in the CPT Editorial Panel's revisions to the code set in 2021. They allow physicians to select a code level based on time or medical decision-making and eliminate the history and physical exam as required elements to select a code level. Documentation of these elements must be specific to each code level. Detailed information about these requirements can be found here.

PROLONGED SERVICE: CMS proposes to pay separately for prolonged outpatient E/M services using the new CPT add-on code 99XXX and delete GPRO1 that had been finalized last year for such services. CMS proposes that this code only be available when physicians choose to document based on time and the time for a level 5 visit is exceeded by 15 minutes or more on the date of service. This service could be billed multiple times for each additional 15-minute increment beyond the level 5 visit time. The agency proposed to adopt the RUC-recommended work RVU for this service.

COMPLEXITY ADD-ON CODE: CMS does not believe that the revised code set adequately describes or reflects the resources required for primary care and certain types of specialty care and continues to believe there is a need to capture these additional resource costs with an add-on code. Last year CMS finalized a policy to create two add-on codes, one for primary care and another for types of complex specialty care. In this rule, the agency is proposing to consolidate two services into a single add-on code with a revised descriptor to better describe the work associated with ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. The descriptor for GPC1X has been revised as follows:

> *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition.*

CMS is proposing a work RVU of 0.33 and physician time of 11 minutes. The agency proposes to allow the code to be billed with any level outpatient E/M service. The agency requests comments on these

proposed changes including the revised code descriptor and whether or not more than one add-on code would be necessary.

Global Surgical Packages
CMS rejected the RUC's recommendation to apply the outpatient E/M visit increases to the 10- and 90-day global services. They stated that outpatient E/M visits are not directly included in the valuation of these global services and that the work RVUs are generally valued using magnitude estimation, a technique that ranks work in relation to a reference using a ratio scale, which differs from the process used for E/M in general.

Congress directed CMS to collect data to value surgical services and prohibited the agency from converting all of the 10- and 90-day global packages to 0-day global packages. CMS contracted with RAND to collect this data and discussed the results of this study. RAND provided three reports to CMS, which can all be found here.

CMS will be considering the approach outlined by RAND to revalue surgical procedures as well as other alternatives in future rulemaking.

Request for Comment on Revaluing Outpatient E/M Visits within Transitional Care Management (TCM), Cognitive Impairment Assessment/Care Planning and Similar Services
CMS identified a number of services that are closely tied to E/M values in addition to the surgical global services for re-evaluation. These services are:

- Transitional Care Management Services (CPT codes 99495-6)
- Cognitive Impairment Assessment and Care Planning (CPT code 99483)
- Certain ESRD monthly services (CPT codes 90951-61)
- Initial Preventive Physical Exam (G0438)
- Annual Wellness Visit (G0439)

The agency requests comment on a policy to adjust the RVUs for these services and on systemic adjustments that may be needed to maintain relativity between these services and outpatient E/M services. They note some of these services always include an outpatient E/M visit provided by the practitioner as part of the service or were valued using a direct crosswalk to an outpatient E/M service. CMS also requests comment on whether it would be beneficial to adjust the E/M codes for visits in other settings, including home care visits, or to codes describing more specific kinds of services, like counseling visits.

Care Management Services
Besides addressing the outpatient E/M code valuations and documentation requirements, CMS separately addresses care management services, those codes designed to improve care management and coordination. The agency outlines policies to improve the existing transitional care management (TCM), chronic care management (CCM) and chronic care remote physiologic monitoring (RPM) services. The agency also proposes new codes for principal care management (PCM) services, which are for the care management of patients having a single, serious, or complex chronic condition.

- Transitional Care Management Services: TCM services are designed to capture the care required to manage a patient's transition from an inpatient hospital setting to a community setting. It covers the care delivered in the 30-day period that begins on the patient's discharge date. CMS believes that increasing the utilization of TCM services may improve patient outcomes. Therefore, the agency is proposing to revise the billing requirements for TCM services to allow 14 codes previously prohibited from being billed concurrently with TCM to be separately billed and reimbursed. See Table 17

extracted from the rule below for this list of services. The agency now believes that these codes complement TCM services rather than substantially overlapping with them. CMS seeks comment on whether there is any overlap between TCM services with these 14 services and if the newest CCM CPT code 99491 overlaps with the TCM codes or should be separately reportable. The code descriptor for this CCM services is as follows:

> Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

TABLE 17: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

de Family	PCS Code	scriptor
Prolonged Services without Direct Patient Contact	358	olonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	359	Prolonged E/M service before and/or after direct patient care; each ditional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	792	tient/caregiver training for initiation of home INR monitoring
	793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient tructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	960	ESRD related services monthly with 4 or more face-to-face visits per month; patients 20 years and older
	961	ESRD related services monthly with 2-3 face-to-face visits per month; for tients 20 years and older
	962	ESRD related services with 1 face-to-face visit per month; for patients 20 ars and older
	966	ESRD related services for home dialysis per full month; for patients 20 years d older
	970	ESRD related services for dialysis less than a full month of service; per day; patient 20 years and older
Interpretation of Physiological Data	091	llection & interpretation of physiologic data, requiring a minimum of 30 nutes each 30 days

Complex Chronic Care Management Services	487	mplex Chronic Care with 60 minutes of clinical staff time per calendar nth
	489	mplex Chronic Care; additional 30 minutes of clinical staff time per nth
Care Plan Oversight Services	181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	182	ysician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

- Chronic Care Management (CCM) Services: CCM services are comprehensive care coordination services furnished by a physician or non-physician practitioner (NPP) and their clinical staff for managing the overall care of a patient with two or more serious chronic conditions. These services can be billed once per calendar months. Currently, there are two subsets of codes: one for non-complex chronic care management and one for chronic care management. CMS believes that refinement of these codes is necessary to improve payment accuracy, reduce unnecessary burden, and help ensure that beneficiaries who need these services will continue to have access to them.

Non-Complex CCM Services by Clinical Staff (CPT code 99490, HCPCS code GCCC1 and GCCC2)
There is currently one CPT code for non-complex CCM: CPT code 99490 which describes 20 or more minutes of clinical staff time spent in chronic care management. CMS is proposing two new G-codes with new increments of clinical staff time that can be billed with CPT code 99490.

- GCCC1 describes the initial 20 minutes of clinical staff time and is proposed to have 0.61 work RVU.
- GCCC2 describes each additional 20 minutes and is proposed to have 0.54 work RVU.

CMS seeks comment on whether they should limit the number of times this add-on code can be reported in a given CCM service period for a given beneficiary.

Complex CCM Services (CPT codes 99487 and 99489, HCPCS Codes GCCC3 and GCCC4)
The complex CCM services describe care management for patients whose care requires both clinical staff time and complex medical decision-making. The current CPT codes 99487 and 99489 include a requirement to establish or substantially revise a comprehensive care plan. CMS is proposing to adopt two new G-codes in place of the existing CPT codes because the agency does not believe it is necessary to include substantial care plan revision as a component of these services. These G-codes would remain in place until the CPT Editorial panel is able to revise the existing codes.

CCM Services - Typical Care Plan
CMS is proposing to simplify the definition of, and requirements for, a typical care plan as included in CCM services (Current service requirements can be found online here.) and requests comment on the revised definition that follows:

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.
- When applicable, revision of the care plan

- Principal Care Management Services: CMS is proposing to create this new service to recognize care management services for patients with only one chronic condition that would be provided by a physician or clinical staff under the direction of a physician or other qualified healthcare provider. There are no specialty restrictions on these new services, and they would be available to providers who are managing a patient's total care over a calendar month without any restrictions on a provider's specialty. A qualifying condition would typically be expected to last between three months and a year, or until the death of a the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CMS is proposing to adopt two new G-codes to describe these services: GPPP1 and GPPP2

- GPPP1 describes at least 30 minutes of care in a calendar month provided by a physician or other qualified health care professional. This service is for a single high-risk disease and includes the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

- GPPP2 has the same time requirement over a calendar month and has the same requirements, but is delivered by clinical staff under the direction of a physician or other qualified health care professional.

CMS is proposing 1.28 work RVU and 0.61 work RVU for GPPP1 and GPPP2 respectively. The agency is seeking public comment on whether it would be appropriate to create an add-on code for additional time spent each month (similar to the proposed GCCC2) when PCM services are furnished by clinical staff under the direction of the billing practitioner. To bill a PCM service, CMS is proposing that providers document the patient's verbal consent to the service in the medical record as is required for CCM services.

- Chronic Care Remote Physiologic Monitoring Services: The CPT Editorial Panel recently revised CPT code 99457 (Remote physiologic monitoring treatment, management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes). The panel also created the new add-on CPT code 994X0 for an additional 20 minutes of care that month.

Given the value of CPT code 99457 (0.61 work RVU), CMS did not accept the RUC-recommended value of 0.61 work RVU for new CPT code 994X0. Instead, the agency is proposing a work RVU of 0.50 for the add-on code. CMS is also proposing that these two RPM services may be furnished under general, rather than direct, supervision, the same supervision requirement for other designated care management services.

Reimbursement for Online Digital Evaluation Services (e-Visits)

CMS is proposing to pay six new non-face-to-face codes to describe the care provided for patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office. These new codes are for established patients only and cover the cumulative time over a seven day period required to deliver this care. Three of these codes can be billed by non-physician healthcare providers who cannot independently bill these services, and the other three are for physician services. Below find the descriptors and proposed work values of the three physician codes:

- 9X0X1 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*) – 0.25 work RVU
- 9X0X2 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*) – 0.50 work RVU
- 9X0X3 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*) – 0.80 work RVU

Review and Verification of Medical Record Documentation

Last year CMS finalized policy to allow a physician, resident, or nurse to document in the medical record that the teaching physician was present at the time the service was delivered. They also eliminated the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead to allow the resident or nurse to document the extent of the teaching physician's participation.

CMS is now proposing to provide the same relief for nonphysician practitioners authorized to deliver Part B services, including NPs, CNSs, CNMs and PAs. If finalized, the furnishing practitioner will be able to review and verify, rather than redocument, information included in the medical record by these students. The agency seeks comments on this proposal.

Potentially Misvalued Services

CMS made one nomination and received three additional nominations for potentially misvalued codes, which are available for public comment for CY2020. One nomination from the Endocrine Society was for the thyroid fine needle aspiration services: CPT code 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion) and CPT code 10021 (Fine needle aspiration biopsy, without imaging guidance; first lesion).

CMS finalized the current values of these services in the FY 2019 rulemaking cycle, but now agrees with the comments that these codes are potentially misvalued and will accept public comment on them.

Request for Information (RFI) on Bundled Payments

CMS is interested in new options to establish PFS payment rates or adjustments for services that are furnished together, which are referred to as "bundled payments" in the proposed rule. The agency is exploring ways to apply principles of bundled payment being tested at CMMI, such as establishing per-beneficiary payments for multiple services or condition-specific episodes of care, to other services paid for by the PFS. CMS requested public comment on recommendations to expand bundled payments to apply to physician's services paid under the PFS.

STARK Advisory Opinion Process

CMS issues written advisory opinions on a case-by-case basis about whether a physician referral for certain health services is prohibited under Section 1877 of the Social Security Act (the "Stark Law"). In 2018, CMS issued a Request for Information (RFI) to gather public input on how to address unnecessary burden created by the physician self-referral law, focusing in part, on how it may impede care coordination, a key aspect of value-based healthcare. In response to the RFI, many provider groups urged CMS to update the regulations governing its advisory opinion process on physician referrals to reduce provider burden and uncertainty around compliance with the Stark Law.

In the proposed rule, CMS requests comment on several potential changes to its advisory opinion process to address these stakeholder comments. The agency proposes to reject an advisory opinion request or not issue an advisory opinion if a request does not describe the arrangement at issue with enough detail or the requestor does not respond to CMS' request for additional information in a timely manner.

The agency also proposes to amend §411.370(e)(2), which restricts CMS from issuing advisory opinions if another government agency is already issuing an opinion on a similar request. The proposed change would give CMS more discretion to determine, after consulting with the Office of Inspector General (OIG) and the Department of Justice (DOJ) about whether acceptance of the advisory opinion request is appropriate.

The agency proposes to establish a 60-day timeline for issuing advisory opinions, which would begin on the date that CMS formally accepts a request for an advisory opinion. CMS is also considering allowing requestors the option to request an expedited review, and requests comments on parameters for expedited review in the proposed rule.

For the certification requirement in requests for advisory opinions, CMS proposes to revise the language to clarify that the certification must be signed by an officer that is authorized to act on behalf of the requestor. CMS is also considering eliminating the certification requirement, since federal law already prohibits materially false statements in matters relating to federal agencies. The agency seeks comments on if the existing certification requirements create undue burdens for requestors.

The agency is proposing to adopt an hourly fee of $220 for preparation of an advisory opinion, which reflects the costs incurred by the agency for the work. CMS is also considering adding a provision establishing an expedited pathway for requestors seeking an opinion within 30 days, for which they propose to charge $440 per hour to process.

The agency requests feedback on several proposals to make advisory opinions more useful compliance tools for stakeholders. First, CMS is proposing at Sec 411.387(a) that an advisory opinion would be binding on the Secretary of HHS and that a favorable advisory opinion would preclude the imposition of sanctions against the parties requesting the opinion, as well as any individuals or entities that are "parties to the specific arrangement with respect to which the advisory opinion is issued." The agency also proposes to recognize that individuals and entities may reasonably rely on an advisory opinion as non-binding guidance, which would be aligned with current practice.

Other comments in response to the RFI are expected to be addressed in separate rulemaking.

Open Payments Program

The Open Payments program was established to increase transparency by providing information about financial relationships between pharmaceutical and medical device industry and other types of health care providers. Specifically, the program requires manufactures of covered drugs, devices, biologicals, or medical supplies to annually submit information for the preceding calendar year about certain payments or other transfers of value made to "covered recipients." Examples of payments or other transfers of value

that must be reported include research, honoraria, gifts, travel expenses, meals, grants, and other compensation.

CMS is proposing to expand the definition of a covered recipient, which currently includes physicians and teaching hospitals to be consistent with Section 6111 of the SUPPORT Act to also include "mid-level practitioners," including PAs, NPs, CNSs, CRNAs, and CNMs beginning January 1, 2022.

When reporting payments, applicable manufacturers and applicable GPOs must select the "Nature of Payment" category that most accurately represents the reported payment. CMS proposes to revise these categories by consolidating two duplicative categories for continuing education programs and modify the name to match the statutory language, "medical education programs."

CMS also proposes to add three new "Nature of Payment" categories: debt forgiveness, long-term medical supply or device loan, and acquisitions. The agency also is proposing to require manufactures and applicable group purchasing organizations (GPOs) to provide the device identifiers (DIs) in Open Payments reporting to enhance the usefulness of Open Payments data and provide more precise information about the medical supplies and devices associated with a transaction.

CMS proposes that the above changes become effective for data collection beginning in CY 2021 and reported in CY 2022.

Physician Supervision for Physician Assistant (PA) Services

Currently, the supervision requirement for PAs requires their services to be delivered under a physician's overall direction and control, but the physician's presence is not required during the performance of these services. The CY 2018 PFS proposed rule included an RFI on CMS flexibilities and efficiencies and in response to this RFI, CMS received feedback about recent changes in the practice of medicine for PAs regarding physician supervision which has resulted in changes made to scope of practice laws for PAs across state lines.

CMS now proposes to revise the physician supervision requirement for PA services under Medicare. Specifically, CMS proposes to grant PAs the flexibility to practice in accordance with state law requirements rather than the current general supervision requirement. In the absence of a state law, CMS proposes that the physician supervision requirement be met by "documentation in the medical record of the PA's approach to working with physicians in furnishing their services."

Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS) Provisions

A high-level summary of the proposed changes to the QPP follow. A more detailed summary will be provided separately.

Request for Information on a new MIPS Value Pathways initiative

CMS proposes a new MIPS Value Pathways (MVP) framework that would connect measures and activities across the 4 MIPS performance categories (Quality, Cost, Improvement Activities and Promoting Interoperability) to be implemented in 2021. MVP would incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information provided to patients.

By 2021, CMS proposes to move from reporting on activities under the four performance categories under MIPS and transition to the new MVP framework with a unified set of measures centered around a specific condition or specialty. Under the MVP framework, clinicians would report on a smaller set of measures that are outcomes-based, specialty-specific and more closely aligned with the Advanced APMs. The agency specifically requested comment on four key issues relating to the development of MVPs:

- How to construct MVPs, including approach, definition, development, specification, and examples;
- How to solicit measures and activities for MVPs;
- How to determine MVP assignment, for clinicians and for multispecialty groups; and
- How to transition to MVPs.

In the proposed rule, CMS provides four examples to illustrate the construction and assignment of measures and activities for MVPs. Two examples for primary care/general medicine include preventive health and diabetes prevention and treatment. For procedural specialties, the examples are for major surgery and general ophthalmology. Each example presents no more than four quality or cost measures or improvement activities for each performance category, and prioritized outcome and patient reported measures, non-topped out measures, and eCQMs. Population health measures and the measures in the Promoting interoperability performance category would also apply to all MVPs. The agency requests feedback on the examples of possible MVPs, as well as options to promote interoperability.

Key MIPS Proposals

Proposed Changes to MIPS Performance Category Measures and Scoring

CMS proposed to increase the performance threshold from 30 points in 2019 to 45 points in 2020 and 60 points in 2021. In order to meet the requirements, set out by Congress for the sixth year of the program, the agency also proposed to increase the additional performance threshold for exceptional performance to 80 points in 2020 and to 85 points in 2021.

Additional proposals for the MIPS performance categories include:

- Reduce the Quality performance category weight to 40 percent in 2020, 35 percent in 2021, and 30 percent in 2022
- Increase the Cost performance category weight to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022

Other MIPS Changes

CMS proposes to strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS to require measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. The proposed revisions to the QCDR measure requirements and approval process will more closely align with MIPS measure policies, which should reduce clinician's concerns with the complexity of the available measures. The agency will also require, when possible, future QCDR measures to establish a link between quality, cost and improvement activities. CMS is also proposing to require QCDRs to provide performance feedback to clinicians at least 4 times per year, with specific feedback on how they compare to other clinicians on a given measure.

The agency proposed several changes to the measures for 2020. CMS proposes to add new specialty sets of measures for Audiology, Pulmonology and Endocrinology, among others. The agency proposes to remove several standard-care and process measures, consistent with the Meaningful Measures Initiative. CMS also proposes adding ten new episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide, and proposes changes to the interoperability measures.

MIPS Measures

Each year CMS proposes changes to the MIPS measures set. The changes below apply to the Endocrine Society's members.

Proposed MIPS Quality Measures for 2022 MIPS Payment Year and Future Payment Years

- All-Cause Unplanned Admission for Patients with Multiple Chronic Diseases

Proposed Changes to Specialty Measure Sets for 2022 MIPS Payment Year and Future Payment Years

Endocrinology---Proposed Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had HbA1c > 9.0% during the measurement period.	Intermediate Outcome/Effective Clinical Care	NCQA
Screening for Osteoporosis for *Women Aged 65-85 Years of Age:* Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis	Process/Effective Clinical Care	NCQA
Diabetes Eye Exam	Process/Effective Clinical Care	NCQA
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -Diabetes or Left Ventricular Systolic D	Process/Effective Clinical Care	American Heart Association
Diabetes: Medical Attention for Nephropathy	Process/Effective Clinical Care	NCQA
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Examination	Process/Effective Clinical Care	American Podiatric Medical Association
Preventive Care and Screening—BMI Screening and Follow-up Plan	Process/Community + Population Health	CMS
Documentation of Current Medications in the Medical Record	Process/Patient Safety	CMS
Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process/Community + Population Health	CMS
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/Community + Population Health	PCPI
Controlling High Blood Pressure	Intermediate Outcome/Effective Clinical Care	NCQA
Closing the Referral Loop: Receipt of Specialist Report	Process/Communication + Care Coordination	CMS
Osteoporosis Management in Women who Had a Fracture	Process/Effective Clinical Care	NCQA
Station Therapy for the Prevention and Treatment of Cardiovascular Disease	Process/Effective Clinical Care	CMS

Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Process/Effective Clinical Care	Oregon Urology Institute
Adult Immunization Status	Process/Community + Population Health	NCQA

Key Alternative Payment Model Proposals

The agency proposes refining the APM scoring standard to improve flexibility for participants, and requests comment on APM scoring for future years of the QPP. CMS also proposes to extend the existing uncontrollable circumstances policies to MIPS eligible clinicians participating in APMs, if they are subject to the APM scoring standard and would report on MIPS quality measures. The agency also clarifies definitions and reporting requirements for APM participants.

ENDOCRINE SOCIETY

APPENDIX A

TABLE 110: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	0%	0%	0%	0%
Anesthesiology	$1,993	0%	0%	0%	0%
Audiologist	$70	0%	0%	0%	1%
Cardiac Surgery	$279	-1%	-1%	0%	-1%
Cardiology	$6,595	0%	0%	0%	0%
Chiropractor	$750	0%	0%	-1%	-1%
Clinical Psychologist	$787	1%	2%	0%	3%
Clinical Social Worker	$781	0%	3%	0%	3%
Colon And Rectal Surgery	$162	0%	1%	0%	1%
Critical Care	$346	0%	0%	0%	1%
Dermatology	$3,541	0%	1%	-1%	0%
Diagnostic Testing Facility	$697	0%	-2%	0%	-2%
Emergency Medicine	$3,021	1%	0%	1%	1%
Endocrinology	$488	0%	0%	0%	0%
Family Practice	$6,019	0%	0%	0%	0%
Gastroenterology	$1,713	0%	0%	-1%	-1%
General Practice	$405	0%	0%	0%	0%
General Surgery	$2,031	0%	0%	0%	0%
Geriatrics	$187	0%	0%	0%	0%
Hand Surgery	$226	0%	0%	0%	1%
Hematology/Oncology	$1,673	0%	0%	0%	0%
Independent Laboratory	$592	0%	1%	0%	1%
Infectious Disease	$640	0%	0%	0%	0%
Internal Medicine	$10,507	0%	0%	0%	0%
Interventional Pain Mgmt	$885	0%	0%	0%	1%
Interventional Radiology	$432	0%	-2%	0%	-2%
Multispecialty Clinic/Other Phys	$148	0%	0%	0%	0%
Nephrology	$2,164	0%	0%	0%	1%
Neurology	$1,503	-1%	3%	0%	2%
Neurosurgery	$802	0%	0%	-1%	-1%
Nuclear Medicine	$50	0%	1%	0%	1%
Nurse Anes / Anes Asst	$1,291	0%	0%	0%	0%
Nurse Practitioner	$4,503	0%	0%	0%	0%
Obstetrics/Gynecology	$620	0%	1%	0%	1%
Ophthalmology	$5,398	-2%	-3%	0%	-4%
Optometry	$1,325	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	$71	0%	0%	-1%	-2%
Orthopedic Surgery	$3,734	0%	0%	0%	1%
Other	$34	0%	0%	0%	1%
Otolaryngology	$1,225	0%	0%	0%	0%
Pathology	$1,203	0%	0%	0%	0%
Pediatrics	$62	0%	0%	0%	0%
Physical Medicine	$1,110	0%	0%	0%	0%
Physical/Occupational Therapy	$4,248	0%	0%	0%	0%
Physician Assistant	$2,637	0%	0%	0%	0%
Plastic Surgery	$369	0%	0%	0%	0%
Podiatry	$1,998	0%	1%	0%	1%

ENDOCRINE SOCIETY

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Portable X-Ray Supplier	$94	0%	0%	0%	0%
Psychiatry	$1,120	0%	0%	0%	1%
Pulmonary Disease	$1,658	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,756	0%	0%	0%	0%
Radiology	$4,971	0%	0%	0%	-1%
Rheumatology	$534	0%	0%	0%	0%
Thoracic Surgery	$352	-1%	0%	0%	-1%
Urology	$1,739	0%	1%	0%	1%
Vascular Surgery	$1,203	0%	-2%	0%	-2%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.

ENDOCRINE SOCIETY

APPENDIX B

TABLE 111: Estimated Specialty Level Impacts of Proposed E/M Payment and Coding Policies if Implemented for CY 2021

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	$236	4%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-7%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-8%
Cardiology	$6,595	2%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-7%	0%	0%	-7%
Clinical Social Worker	$781	-7%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	-1%	-1%	-4%
Critical Care	$346	-5%	-1%	0%	-6%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	-1%	-4%	0%	-4%
Emergency Medicine	$3,021	-6%	-2%	1%	-7%
Endocrinology	$488	11%	5%	1%	16%
Family Practice	$6,019	8%	4%	1%	12%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	2%	1%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	8%	4%	1%	12%
Independent Laboratory	$592	-3%	-1%	0%	-4%
Infectious Disease	$640	-3%	-1%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-3%	-3%	0%	-6%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-4%	0%	0%	-5%
Nurse Anes / Anes Asst	$1,291	-7%	-2%	0%	-9%
Nurse Practitioner	$4,503	5%	3%	0%	8%
Obstetrics/Gynecology	$620	4%	3%	0%	7%
Ophthalmology	$5,398	-4%	-5%	0%	-10%
Optometry	$1,325	-2%	-3%	0%	-5%
Oral/Maxillofacial Surgery	$71	-1%	-1%	-1%	-4%
Orthopedic Surgery	$3,734	-1%	0%	0%	-2%
Other	$34	-3%	-2%	0%	-5%
Otolaryngology	$1,225	3%	2%	0%	5%
Pathology	$1,203	-5%	-3%	-1%	-8%
Pediatrics	$62	3%	2%	0%	6%
Physical Medicine	$1,110	-2%	0%	0%	-2%
Physical/Occupational Therapy	$4,248	-4%	-3%	0%	-8%
Physician Assistant	$2,637	4%	2%	0%	7%
Plastic Surgery	$369	-3%	-1%	-1%	-5%

ENDOCRINE SOCIETY

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Podiatry	$1,998	0%	1%	0%	1%
Portable X-Ray Supplier	$94	-1%	-3%	0%	-4%
Psychiatry	$1,120	4%	3%	0%	7%
Pulmonary Disease	$1,658	0%	1%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-2%	-2%	0%	-4%
Radiology	$4,971	-5%	-3%	0%	-8%
Rheumatology	$534	9%	5%	1%	15%
Thoracic Surgery	$352	-5%	-2%	-1%	-7%
Urology	$1,739	4%	4%	0%	8%
Vascular Surgery	$1,203	-2%	-3%	0%	-5%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

** Column F May Not Equal The Sum Of Columns C, D, And E Due To Rounding.*