CMS Updates Physician Payment System and Finalizes Regulatory Changes

Every year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On December 1, 2020, CMS finalized its rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2021. The final 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 Codes

CMS will implement a new coding and payment structure for office Evaluation and Management (E/M) services. Finalized in the 2020 Medicare Physician Fee Schedule, CMS is 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. In addition to moving forward with the new structure, CMS finalized modifications to the times associated with prolonged E/M services and increased the valuations for certain services that are valued in accordance with E/M services including transitional care management and cognitive impairment assessment and care planning. CMS is also implementing a new add-on code (G2211) to account for the additional complexity associated with certain E/M services, which neurologists should be able to bill for most visits.

E/M services will receive a significant increase starting in 2021, but 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. These finalized policies could be modified by Congress and the AAN continues to actively engage with representatives on this issue. We are supportive of efforts to waive budget neutrality to offset cuts to reimbursement for non-E/M services provided that it would not result in a delay or in any way undermine CMS's decision to fully implement the new E/M payment structure on January 1, 2021.

Telehealth Regulations

Noting the significant expansion of telehealth due to the COVID-19 Public Health Emergency (PHE), CMS is implementing a number of substantial changes 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 adding a broad array of new services to the Medicare telehealth list permanently and will add additional services to the telehealth list temporarily through the end of the calendar year during which the PHE ends.
- CMS is discontinuing payment for audio-only E/M visits upon the termination of the PHE and is implementing, on an interim basis for CY 2021, separate coding and payment for an extended audio-only virtual check-in assessment service.
- CMS will 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 also modifying requirements related to the coverage of remote physiologic monitoring.

Earlier this year, CMS sought feedback from the public in relation to how telehealth services have been in use in various communities during the response to COVID-19. In response, the AAN provided the agency with experiential feedback from AAN members and an overview of the literature as it pertains to telehealth in neurology to guide future policymaking. Given feedback from stakeholders, CMS announced that it has commissioned a study of the telehealth flexibilities provided during the COVID-19 PHE. The study will explore new opportunities for services where telehealth, virtual care supervision, and remote monitoring can be used to more efficiently bring care to patients.

Quality Payment Program

The final rule includes changes for the 2021 Quality Payment Program (QPP) performance year, which includes the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) tracks.

For 2021 MIPS reporting, CMS finalized increasing the performance threshold to 60 points, requiring participants to score at least 60 points to avoid a negative payment adjustment, and maintained the 85-point threshold for an exceptional performance bonus. The MIPS Quality component will decrease to 40 percent from 45 percent and the MIPS Cost component will increase to 20 percent from 15 percent. There are minimal changes to the Improvement Activities and Promoting Interoperability components. Payment adjustments for the 2021 reporting year will continue to range between +/-9%. For the APM track, CMS finalized eliminating the APM scoring standard in 2021 and sunsetting the CMS Web Interface as a reporting option in 2022.

CMS also finalized a maximum 10-point bonus for complex patients in response to the COVID-19 pandemic and extended its Extreme and Uncontrollable Circumstances Policy to all QPP participants—individuals, groups and APM entities—with the option to request waiving any or all components due to COVID-19.

CMS finalized a new performance track to begin in 2021 called the APM Performance Pathway (APP) that will require Medicare Shared Savings Program (MSSP) participants, and be optional for other MIPS-APM participants, to report a fixed set of measures for each performance category in MIPS as an individual, group, or APM entity. The rule also finalized delaying implementation of MIPS Value Pathways (MVPs) until at least 2022 and released guiding principles, development criteria, and a standardized template for MVP proposals.