Family Medicine Updates

AAFP From the American Academy of Family Physicians

Ann Fam Med 2020;18:84-85. https://doi.org/10.1370/afm.2508.

FEE SCHEDULE SUMMARY: AAFP ADVICE VISIBLE IN CMS FINAL RULE

The American Academy of Family Physicians (AAFP) has released a summary of the final 2020 Medicare physician fee schedule, available at https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/feesched/ES-2020FinalMPFS-110219.pdf, that emphasizes a significant change on the horizon: a payment boost stemming from ongoing Academy advocacy.

Specifically, the combined final rule and interim final rule that Centers for Medicare and Medicaid Services (CMS) issued November 1, 2019 calls for higher payments for evaluation and management codes, and the development of primary care add-on codes, resulting in a 12% increase in total allowed charges for family physicians starting in 2021.

The final 2020 MPFS conversion factor is $36.0896, resulting in no change in total Medicare-allowed charges for family medicine in 2020.

Evaluation and Management Services

The Academy had long advised CMS that undervaluation of evaluation and management (E/M) services slowed crucial investments in primary care. As supported by the AAFP, the final rule aligns E/M coding with changes laid out by the current procedural terminology (CPT) Editorial Panel for office and outpatient E/M visits, starting in 2021. This means that

- 5 levels of coding will be retained for established patients
- The number of levels will be reduced to 4 for office and outpatient E/M visits for new patients
- The times and medical decision-making process for all office-based E/M codes will be revised, and performance of history and exam will be required only as medically appropriate
- Clinicians will be able to choose the E/M visit level based on either medical decision making or time

CMS finalized the adoption of Academy-supported, American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee-recommended values for the office and outpatient E/M visit codes for 2021, as well as a new add-on CPT code for prolonged service time.

Quality Payment Program

As outlined in a CMS executive summary of the 2020 Quality Payment Program, the merit-based incentive payment system will operate with the following performance thresholds and category weights for the 2020 performance period (which equates to the 2022 payment year):

- Performance threshold: 45 points
- Additional performance threshold for exceptional performance: 85 points
- Quality performance category weight: 45%
- Cost performance category weight: 15%
- Promoting interoperability performance category weight: 25%
- Improvement activities performance category weight: 15%

For the 2021 performance period, however, CMS has raised the performance threshold to 60 points, with the additional performance threshold for exceptional performance remaining at 85 points.

Coverage for Opioid Treatment Programs

In a move the Academy backed, the 2020 MPFS establishes Medicare coverage for medication-assisted treatment for opioid use disorder (OUD).

CMS finalized the creation of new coding and payment for a monthly bundle of services for 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.

Outpatient Prospective Payment System

Also on November 1, 2019, CMS also issued "Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs" as a final rule with comment period.

The Academy had encouraged CMS in a September 19, 2019 letter to consider site-of-service payment parity from a broader perspective and to create incentives for services to be performed in the most cost-effective location, such as a physician's office.

The final rule includes a policy that continues to eliminate differential payments between certain outpatient sites of service, completing a 2-year phase-in of the move to reduce unnecessary utilization in outpa-

tient services by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting. This could save Medicare beneficiaries $160 million and the Medicare program $650 million in 2020.

However, CMS did not finalize an Academy-backed proposal to require hospitals to disclose prices for all supplies, tests, and procedures. A separate final rule on the issue is expected in the future, the agency said.

AAFP News Staff

From the American Board of Family Medicine

Ann Fam Med 2020;18:85-86. https://doi.org/10.1370/afm.2506.

THE SOCIAL CONTRACT, PROFESSIONALISM, AND ITS ASSESSMENT: THE STRATEGY OF THE ABFM GOING FORWARD

Society granted physicians status, respect, autonomy in practice, the privilege of self-regulation, and financial rewards on the expectation that physicians would be competent, altruistic, moral, and would address the health care needs of individual patients and society. This "arrangement" remains the essence of the social contract.[1]

Sylvia Cruess and Richard Cruess, 2004

At the foundation of the American Board of Family Medicine's (ABFM's) new strategic plan is a commitment to renew the social contract between family medicine and society across all of the Board's activities. Despite hospital consolidation, despite employment of most family physicians, and despite changes in practice promised by augmented intelligence, genomics, and new technology, family physicians remain bound by an implicit social contract. We benefit from the respect of society, earn more than most Americans, and have substantial autonomy in our work, in return for commitment to improve the health of the public, follow a code of ethics, and self-regulate.

The social contract is fragile. The landmark Bristol case in the United Kingdom serves as a warning for all of us.[2] Over many years, despite compelling data and whistleblowers, physician leadership in the Bristol health district chose not to address significant problems in the quality of care in pediatric cardiac surgery. In response, the Parliament took away some of the power of physicians to review quality of care. As important as improving quality of care is, however, the implications for us today are even broader—they reach inside the exam room to how we interact with patients on a daily basis. A current example comes from the opiate crisis. While the epidemic has had many origins, it seems clear that physicians played an important, though well-intentioned, role in contributing to the crisis and allowing the epidemic to spread. We did not self-regulate effectively: since we did not, many state legislatures have stepped in to regulate how we manage pain, even to the extent of monitoring the exact dosing of narcotics. The social contract is informal and implicit, but it is binding. When the contract is not followed, society will respond, and the solutions will be poorer quality and more restrictive of our roles than if we had addressed the issues ourselves.

What should medicine—and family medicine—do to better fulfill its part in meeting our obligations under the social contract? An important first step is to focus explicitly and publicly on professionalism and the social contract. It is for this reason that we were an early supporter of the Professionalism Charter[3] and recently established the Center for Professionalism and Value in Health Care,[4] with its primary objective of shaping of the clinical work environment to support the professionalism of family physicians and other health professionals. We will continue to champion education about professionalism as we contribute to developing standards for residency education and support evolution in continuing medical education.

The ABFM Certification portfolio itself reflects our commitment to the needs of the public. We require that family physicians engage in lifelong learning and self-assessment, conduct rigorous independent assessments to assure that Diplomates have the cognitive expertise necessary to serve the public, and assure that Diplomates are meaningfully working to improve the quality of care they provide. Most direct is our assessment of professionalism. Like other ABMS Boards, we rely on the Diplomate holding a full active and unrestricted license as a key measure of professionalism. We do not have investigatory powers, so we rely on the state medical board's adjudication process to establish the facts of individual cases. They then provide that information to the Federation of State Medical Boards. From this, ABFM seeks the detailed information from the medical board's order regarding the physician and his/her situation.

ABFM has a thorough review process; due process includes appeals with peer review by physicians on our Board of Directors before making a consequential decision regarding certification. Our guidelines for Professionalism, Licensure and Personal conduct[5] allow our Professionalism committee to respond more flexibly to the facts of individual cases, even when specific license