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Sound Health Policy Objectives Achieved

CMS Proposes Changes to Medicare Physician Payment in 2019

July 2018

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released the CY 2019 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B [CMS-1693-P], which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). The proposed regulations will be published in the Federal Register on July 27, 2018. Comments are due September 10, 2018.

- *The proposed regulations are available here*
- *The fact sheet is available here*
- *The QPP factsheet is available here*

Our top 10 takeaways for the QPP and other proposals in the 2019 Medicare Physician Fee Schedule follow.

For more information please Sheila Madhani or Mara McDermott.

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On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released the CY 2019 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B [CMS-1693-P], which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). The proposed regulations will be published in the Federal Register on July 27, 2018. Comments are due September 10, 2018.

A topline summary of the major provisions follows.

> **Quality Payment Program**
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> Beginning in 2019, eligible clinicians (including most physicians) will be paid for Medicare Part B services under the new QPP (based on 2017 reporting activities), and they will continue to elect to either be subject to payment adjustments based upon performance under the Merit-based Incentive Payment System (MIPS), or to participate in the Advanced Alternative Payment Model track (APM).
>
> Eligible clinicians choosing the MIPS pathway will have payments increased, maintained or decreased based on relative performance in four categories: quality, use of information technology, clinical improvement activities and cost. Eligible clinicians choosing the Advanced APM pathway will automatically receive a bonus payment once they meet the qualifications for that track.

Physician Fee Schedule (PFS) Changes

CMS describes the 2019 PFS proposed rule as initiating "historic changes to modernize Medicare and restore the doctor-patient relationship." CMS continues to build on a theme that was articulated in the 2018 QPP final rule, namely, that many of the changes the agency made were aimed at reducing burdens and enhancing flexibilities for clinicians. Supporting those goals, CMS estimates that the proposed changes to documentation for evaluation and management services would save 51 hours per year for a clinician whose panel is 40 percent Medicare, and that the QPP-related proposed changes would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

1. 2019 Proposed Medicare PFS Conversion Factor Remains Flat

√ CMS also proposes to update supply and equipment inputs used to calculate PE RVUs.

The 2019 proposed physician conversion factor[1] is $36.0463. This represents a change of less than one cent from the 2018 conversion factor of $35.9996. The proposed anesthesia conversion factor is $22.2986, in comparison to the 2018 conversion factor of $22.1887. The 0.50 percent update specified by the Medicare Access and CHIP Reauthorization Act (MACRA) was reduced to 0.25 percent as a result of a provision in the Bipartisan Budget Act of 2018. The conversion factor was then further reduced by a relative value unit (RVU) budget neutrality adjustment (-0.12 percent).

Physician payment is based on the application of the dollar conversion factor to work, practice expense (PE) and malpractice RVUs, which are then geographically adjusted. PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service. CMS proposes to update input prices for supplies and equipment based upon a large survey conducted by a market research firm under contract to CMS. CMS would phase in these new inputs over a four-year period

[1] The Medicare PFS relies on national relative values that are established for work, practice expense and malpractice, and are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates.

beginning in 2019. These supply and equipment prices were last systematically developed in 2004–2005.

CMS concedes that at the service level, there may be large shifts in PE RVUs for individual codes that happened to contain supplies and/or equipment with major changes in pricing. Codes with a sizable PE RVU decrease would be limited by the requirement to phase in significant reductions in RVUs. The phase-in requirement limits the maximum RVU reduction for codes that are not new or revised to 19 percent in any individual calendar year.

2. CMS Proposes to Overhaul E/M Billing and Advance Telehealth Services

√ A single blended E/M payment rate for new and established patients for office/outpatient services is also proposed.

Evaluation and management (E/M) services make up approximately 40 percent of allowed charges under the PFS (office/outpatient services comprise approximately 20 percent of allowed charges). For years, there has been significant concern around the complexity and burden of documenting E/M services. In the 2018 PFS proposed rule, CMS solicited comments on how to simplify the system. In this rule, CMS is proposing significant changes to the documentation and payment rates for these services.

To reduce the burden of documentation, CMS proposes to allow practitioners to choose to document office/outpatient E/M visits using medical decision making or time instead of applying the highly complex 1995 or 1997 E/M documentation guidelines as currently required. Alternatively, practitioners may continue using the current framework. While maintaining the current E/M codes, CMS proposes a new, single blended payment rate for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services. In its analysis, CMS found that while the impact on many specialties is minimal, this proposed policy would negatively affect clinicians that tend to bill higher level E/M codes, such as certain specialties. Stakeholders from the primary care physician community that care for patients with multiple chronic conditions have also voiced concern regarding the potential impact of this policy.

CMS also proposes payment for several virtual or telehealth services. CMS proposes to pay for virtual check-ins—brief, non-face-to-face appointments via communications technology, and evaluation of patient-submitted photos—and to expand Medicare-covered telehealth services to include prolonged preventive services.

3. CMS Proposes to Reduce Payment for New Part B Drugs

√ Payment would be reduced from WAC plus 6 percent to WAC plus 3 percent for initial 2 quarters.

During the first two quarters that a Part B drug is launched, CMS pays at Wholesale Acquisition Cost (WAC) plus 6 percent. For 2019, CMS proposes to reduce the payment for these drugs to WAC plus 3 percent. Generally, by the third quarter, when more data is available, CMS transitions to Average Sales Price (ASP) plus 6 percent. CMS is not

proposing any changes to ASP pricing methodology. CMS notes that this proposal is consistent with recent recommendations from the Medicare Payment Advisory Commission.

While CMS did not estimate cost savings for this proposed policy, it did express concern about the growth in recent years in spending for Part B drugs. CMS believes this policy could bring prices for new drugs closer to acquisition costs and would also provide beneficiary savings by decreasing copayments. This policy of reducing reimbursement for new Part B drugs fits in with the Trump Administration's overarching goal to lower drug prices. These priorities are distilled in "American Patients First," the president's recently released blueprint for lowering drug prices and reducing out-of-pocket costs.

Proposals Related to the Quality Payment Program

This year's QPP rulemaking continues to slightly escalate the ramp for MIPS-participating clinicians, with CMS proposing to increase the number of clinicians included in MIPS, increase the threshold score for avoiding a MIPS penalty and increase the weight of the MIPS cost component. Advanced APM track policies remained fairly stable, with some slight proposed policy changes intended to streamline the program and reduce burden for participants.

QPP Timeline

CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Year 1 Performance Year	**Year 2** Performance Year	**Year 3** Performance Year	**Year 4** Performance Year	**Year 5** Performance Year
		Year 1 Payment Year	**Year 2** Payment Year	**Year 3** Payment Year

4. CMS Proposes to Expand the Pool of MIPS Eligible Clinicians

√ CMS estimates 650,156 MIPS eligible clinicians for Payment Year 2021.

CMS estimates that 650,156 clinicians will be MIPS eligible in Payment Year 2021. This represents an increase from the 2018 final rule, in which CMS estimated that approximately 622,000 clinicians would be MIPS eligible for Payment Year 2020.

CMS proposes to expand eligibility to participate in MIPS to the following clinician types: physical therapists, occupational therapists, clinical social workers and clinical psychologists. Current eligible clinician types include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include such professionals (required by statute). CMS estimates that this would expand the pool of MIPS eligible clinicians by 18,303.

The Low Volume Threshold (LVT) excludes certain clinicians and groups from participating in MIPS. CMS has proposed adding a third criterion to the low volume exclusion test that would be based on the number of covered professional services provided. The proposed 2019 LVT policy is as follows: To be excluded from MIPS, clinicians or groups would need to meet one of the following three criteria: have ≤ $90K in Part B allowed charges for covered professional services, provide care to ≤ 200

beneficiaries, OR provide ≤ 200 covered professional services under the PFS. CMS estimates that this proposed 2019 policy would remove an additional 1,173 MIPS eligible clinicians in comparison to the 2018 LVT policy.

CMS also proposes a MIPS opt-in policy. Starting in Year 2019, clinicians or groups would be able to opt in to MIPS if they meet or exceed one or two, but not all, of the LVT criteria. CMS estimated an additional 42,025 MIPS eligible clinicians as a result of this policy.

Incremental Change Table for 2021 MIPS Payment Year

Policy Changes	Baseline	LVT Policy	Expansion of Eligible Clinician Types	MIPS Opt-In Policy
Estimated Number of Clinicians Affected by Policy	N/A	-1,173	18,303	42,025
Estimated Number of MIPS Eligible Clinicians	591,010	589,837	608,140	650,165

** This table does not consider the impact of the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration waiver.*
Extracted from Table 97, page 1078, 2019 Proposed PFS (CMS-1693-P, display copy)

5. CMS Proposes to Double Minimum Score Needed to Avoid a Negative MIPS Adjustment

√ MIPS performance threshold would increase from 15/100 points to 30/100 points.

The “performance threshold” represents the score that is necessary to receive a neutral to positive payment adjustment for the year. A score below the performance threshold will result in a negative payment adjustment, while a score above the payment threshold will result in a positive payment adjustment. A score at the payment threshold will result in a neutral payment adjustment.

MACRA also authorized an additional $500 million each year from 2019 to 2024 to award “exceptional performance” bonuses to MIPS providers with the highest composite performance scores. CMS sets a separate exceptional performance threshold to award these higher payment adjustments. CMS proposes to:

+ Increase the performance threshold from 15/100 points to 30/100 points
+ Increase the exceptional performance threshold from 70/100 points to 80/100 points

Change in Performance Threshold from Performance Year 2017–2019

Performance Year	Performance Threshold	Exceptional Performance Threshold
2019	30	80
2018	15	70
2017	3	70

6. CMS Proposes an Increase in the Weight of the Cost Component in MIPS Final Score

√ Weight of Cost Performance Category on MIPS final score would increase from 10 to 15 percent.

The MIPS final score is based on performance in four categories: Quality, Promoting Interoperability (previously known as Advancing Care Information), Improvement Activities and Cost. CMS proposes to increase the weight of the Cost Performance Category for the final MIPS score from 10 percent (2018) to 15 percent (2019). This proposed change would result in the following proposed allocation of the four performance categories for the 2019 Payment Year: Quality (45 percent), Promoting Interoperability (25 percent), Improvement Activities (15 percent) and Cost (15 percent).

Currently the Cost Performance Category is based on two measures: Total Per Capita Cost and Medicare Spending Per Beneficiary. CMS proposes the addition of eight recently developed episode-based cost measures: Elective Outpatient Percutaneous Coronary Intervention (PCI), Knee Arthroplasty, Revascularization for Lower Extremity Chronic Critical Limb Ischemia, Routine Cataract Removal with Intraocular Lens (IOL) Implantation, Screening/Surveillance Colonoscopy, Intracranial Hemorrhage or Cerebral Infarction, Simple Pneumonia with Hospitalization, and ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI).

7. CMS Proposes Changes to Make Quality Reporting More Meaningful and Less Burdensome

√ Changes include deletion of quality measures, revision of the definition of high-priority measures and proposal to implement facility-based reporting.

CMS proposes a number of changes to the inventory of quality measures, including adding 10 new MIPS quality measures that include four patient reported outcome measures; seven high-priority measures; one measure that replaces an existing measure; and two other measures on clinical topics in the Meaningful Measures framework. CMS also proposes to remove 34 other measures.

In response to the opioid epidemic across the United States, CMS proposes to revise the definition of a high-priority measure to include quality measures that relate to opioids and to further clarify the types of outcome measures that are considered high priority. CMS proposes a high-priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure.

CMS is implementing facility-based scoring for 2019, where facility-based clinicians can use their facility's Hospital Value-based Purchasing score as a proxy for their Quality and Cost Performance Category scores. The clinician or group must meet the definition of facility-based to be eligible for this option.

CMS also proposes quality-related changes to the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs). CMS proposes to eliminate 10

measures and to add one measure to the MSSP measure set, resulting in MSSP ACOs being held accountable for 24 measures. These changes are summarized in Tables 25 and 26 of the proposed rule (page 487 in the display copy).

8. CMS Proposals Maintain a Stable Advanced APM Track

√ Minor modifications to Advanced APM pathway include increasing the threshold for CEHRT use and extending the previously finalized generally applicable revenue-based nominal amount standard through 2024.

In general, the proposed policies implementing the Advanced APM pathway remain fairly stable this year. CMS proposes to increase the requirement relating to use of certified electronic health records technology (CEHRT) from 50 percent of eligible clinicians in each APM entity in 2018 to 75 percent of eligible clinicians in each APM entity in 2019. In the proposed rule, CMS states its belief that this change is consistent with what many Advanced APMs already require of their clinicians.

In last year's final rule, CMS finalized a proposal to maintain its generally applicable revenue-based nominal amount standard at 8 percent for the 2019 and 2020 performance periods. The generally applicable nominal amount standard is one measure of the amount of risk an APM bears to satisfy MACRA's requirements that risk be in excess of a nominal amount. In this rule, CMS proposes to amend its regulations to maintain this standard through 2024. The agency states its belief that maintaining this standard over numerous years will provide greater certainty and consistency for Advanced APM participants.

Overall, these changes (along with several other relatively minor adjustments) should create a stable environment for the Advanced APM pathway in the third year of the QPP.

9. CMS Proposes Changes Intended to Streamline Other Payer Advanced APM Criteria

√ The agency makes several relatively modest modifications intended to be responsive to stakeholder concerns and to streamline the Other Payer Advanced APM qualification process.

CMS proposes several changes to the Other Payer Advanced APM option that appear to be geared towards streamlining applications for plans and clinicians electing that option. Beginning in 2019, eligible clinicians may combine their traditional Medicare Advanced APM participation with Advanced APM participation with other payer types to meet increased thresholds for Advanced APM participation. Importantly, participation in a traditional Medicare model is still required.

First, CMS would allow payers and eligible clinicians to submit evidence that CEHRT is used by the required percentage of eligible clinicians in the payment model (50 percent in 2019 and 75 percent in 2020 for the Other Payer Advanced APM option, which differs from the traditional Medicare Advanced APM requirement) without requiring that

CEHRT be documented in the contract. In the Other Payer Advanced APM option, payers or eligible clinicians must submit certain documentation showing that the

arrangement meets the Advanced APM requirements of quality, use of CEHRT and more than nominal financial risk. Many stakeholders had informed CMS that CEHRT is often used in other payer risk arrangements even if it is not expressly required in the contract terms. Instead, under the proposed rule, the payer or eligible clinicians could provide other documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement.

Second, CMS had previously finalized a requirement that Other Payer Advanced APM determinations would remain in effect for only one year, even if the arrangement's terms were longer than one year. In this proposed rule, CMS proposes to allow multi-year determinations. For payment arrangements submitted to CMS that are multi-year arrangements, the submitter would review the submission annually and submit updated information notifying CMS of changes to the arrangement that would be relevant to the Other Payer Advanced APM determination. Absent a submission of updated information, the original determination would apply for each year through the earlier of the end of the agreement or five years. This proposal should streamline the process for Other Payer Advanced APM submitters that otherwise would have had to resubmit their applications each year.

Third, in response to stakeholder requests, CMS proposes to add a third alternative for the calculation of Other Payer Advanced APM participation to allow requests for determinations at the TIN level (in addition to the eligible clinician and APM entity levels).

The Other Payer Advanced APM pathway retains a significant amount of complexity in year three of the program. Because this pathway still requires a fairly significant new disclosure of information to the government and requires participation in a traditional Medicare Advanced APM, it remains unclear how many clinicians will successfully use this pathway to qualify for the 5 percent bonus.

10. CMS Further Details Medicare Advantage Demonstration

√ CMS provides additional details on a demonstration that will allow certain eligible clinicians who contract with MA plans to be exempted from MIPS. Otherwise, the proposed rule is almost silent on the development of new Advanced APMs.

In the proposed rule and on the CMS Innovation Center website, the agency provided additional detail regarding a demonstration project that would allow certain clinicians to be exempt from MIPS based on the amount of risk contracting those clinicians do with Medicare Advantage (MA) plans. The MA Qualifying Payment Arrangement Incentive (MAQI) demonstration is intended to provide an additional avenue for clinicians located in heavy MA enrollment areas to be successful in the QPP. The demonstration is designed to test whether excluding clinicians with sufficient participation in MA risk contracts from MIPS will increase or maintain participation in advanced APMs with MA organizations. CMS will apply requirements similar to those used for the Other Payer Advanced APMs.

Beyond the announcement of this demonstration, the proposed rule is light on discussion about Advanced APMs. Notably, the proposed rule is silent on the future of the Physician-focused Payment Model Technical Advisory Committee (PTAC). The PTAC was created to review stakeholder recommendations for new APMs and to make recommendations to the Secretary of Health and Human Services (HHS) as to which models should be tested. The statute seemed to contemplate an advisory body that would quickly generate new models with the input of the stakeholder community. PTAC models ultimately still must be adopted by HHS and tested. To date, the PTAC has recommended several models, none of which have been advanced by HHS. More information is available in our PTAC model tracker. The lack of mention of the PTAC is notable in particular because the Bipartisan Budget Act of 2018 included a provision modifying PTAC's review of submitted models.

This year's PFS proposed rule contains numerous important policy changes for clinicians. Consistent with CMS's overarching strategy, the rule includes policies intended to reduce burden on clinicians and streamline measure reporting and performance measurement.

The proposals in the rule continue to implement the QPP, in many ways directionally consistent with last year's QPP rulemaking, which was the Trump Administration's first year. The proposed rule would continue to increase requirements in MIPS and build on the first two years of the program.

For a closer look at the proposals discussed here, among other topics, please join us for a live webinar presentation at 3:30 pm EDT on July 24, 2018. For more information, please click here.

For more information please contact Sheila Madhani or Mara McDermott.

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