Health Capital Topics
Volume 11
Issue 7
July 2018
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2019 Physician Payment Proposed Rule – Cutting the Red Tape

On July 12, 2018, the *Centers for Medicare & Medicaid Services* (CMS) proposed historic changes to both fulfill President Trump's promise to "*cut the red tape of regulation*"[1] as it relates to Medicare and restore the doctor-patient relationship while shifting healthcare reimbursement from a *volume*-based to a *value*-based system.[2] The 1,473 page proposed rule, entitled, *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*,[3] was posted in the Federal Register on July 27, 2018, and CMS will receive comments on its proposal through September 10, 2018.[4] The rule includes proposed updates to payment policies, payment rates, and quality provisions for services rendered under the *Medicare Physician Fee Schedule* (MPFS).[5]

In 2015, the *Medicare Access and CHIP Reauthorization Act* (MACRA) ended the untenable *sustainable growth rate* (SGR) formula for determining physician payment under Medicare Part B; it then established an incentive program, known as the *Quality Payment Program* (QPP).[6] This program provides two ways for physicians to participate, through: (1) the *Merit-based Incentive Payment System* (MIPS); or, (2) advanced *Alternative Payment Models* (APMs).[7] CMS issued the *2019 Proposed Rule for QPP Year 3* on July 12, 2018 (as part of the 2019 MPFS proposed rule), which is focused on improving quality of care and interoperability, while approaching MIPS and APMs with simplification and burden-reduction initiatives.[8]

The proposed changes to the MIPS policies include: expanding the eligible clinician types who can participate; and, adding physical and occupational therapists, clinical social workers, and clinical psychologists to the Year 2 clinician type list.[9] To be excluded from MIPS based on a *Low-Volume Threshold* (LVT), a third allowable criterion (number of covered professional services provided) was added to the Year 2 list, adding to the two current threshold criteria of: (1) billing less than $90,000 in Part B payments; or, (2) providing care to less than 200 beneficiaries.[10] Of note, this is the second year in a row that these criterion have been changed, resulting in fewer eligible clinicians.[11] Also starting in Year 3, clinicians who meet one or two of the LVT criterion, but not all, will be able to *opt-in* to MIPS; this design furthers CMS's effort to reduce burden and offer flexibilities to aid in successful clinician participation, with a special focus on small practices.[12] Ten new quality measures for MIPS have also been proposed, with four of them being patient reported, seven being high priority; conversely, 34 of the current measures been proposed to be removed.[13]

The proposed changes to the APM policies include: establishing a *Certified Electronic Health Records Technology* (CEHRT) use criterion threshold (previously known as "*advancing care information*") for Advanced APMs, so that it can require 75% of eligible clinicians to use CEHRT to document and coordinate care with patients and other healthcare professionals.[14] Also proposed was:

(1) Extending the 8% revenue-based nominal amount standards for Advanced APMs through 2024;

(2) Increasing flexibility for the *All-Payer Combination Option* and *Other Payer Advanced APMs* for non-Medicare payers in order to be able to participate in QPP; and,

(3) Streamlining definitions and clarifying requirements for assessing performance based on quality measures and cost/utilization.[15]

Regarding the proposed payment updates, a positive adjustment of 0.13% has been proposed to be applied to the MPFS *conversion factor* (CF) used to calculate payments for physician services; this adjustment is lower than the 2018 CF adjustment of 0.31% and like last year, the CF used to calculate payments for anesthesia services includes a separate adjustment based on practice expense and malpractice.[16] The 2019 CF includes a statutory update factor of 0.25% and a Relative Value Unit (RVU) Budget Neutrality Adjustment of -0.12% to the 2018 CF, resulting in the 2019 CF of 36.0463; CMS explains, "*where the aggregate…RVUs within a code family change but the overall actual physician work associated with those services does not change, we make…budget neutrality adjustments to hold the aggregate…RVUs constant within the code family, while maintaining the relativity of values for the individual codes within that set*."[17]

Importantly, and perhaps most controversially, the 2019 MPFS proposed rule contains a provision to radically change the way Medicare pays for an essential physician service – the office visit.[18] This specific proposal would "*level the playing field*" among all physician specialties,

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making it so that physicians are paid roughly the same amount for an office visit, regardless of a patient's medical need or complications; however, physicians are concerned that this proposal would underpay physicians who treat the sicker, more vulnerable patients.[19] Current Medicare payment rates account for five levels of office visits, with Level 1 being for mostly non-physician services, Level 2 (uncomplicated) office visits awarding $76, and Level 5 office visits, usually involving longer evaluations and chronic conditions, awarding $211; per the proposal, the government would pay $135 per visit for new patients and $93 per visit for established patients.[20] The Administration's goal with this proposal is to simplify physician burdens by requiring minimal documentation requirements and thus, freeing up additional time to be spent with the patient (in fact, CMS estimates those time savings to total 51 hours per physician each year).[21] In another proposed office visit change, CMS proposed the development of new codes for communication technology-based services (e.g., telemedicine), allowing for a small reimbursement ($14 per visit in Year 1, and then subsequent payment increases of 0.2%) for e-visits.[22]

In addition to these myriad changes, CMS is seeking review of, and comments related to, a number of other topics. For example, CMS has identified seven procedures they believe to be over-reimbursed (total hip arthroplasty; total knee arthroplasty; esophagogastroduodenoscopy biopsy single and multiple; colonoscopy with lesion removal; CT imaging of head without contrast; electrocardiogram, complete; and, transthoracic echocardiogram with doppler, complete), and have requested a review of these payment policies.[23] Additionally, CMS seeks ideas regarding how to potentially include *electronic health record* (EHR) utilization performance into the Physician Compare tool.[24]

The U.S. healthcare system's shift from *volume* to *value* has resulted many proposed changes, which are occurring, albeit slowly; to date, current physician compensation levels have felt little impact from this shift (most recently as a result of MACRA), staying relatively flat in 2017 compared to 2016.[25] This indicates that the steady growth in physician compensation, as seen in the past, may have started to slow, with the possible exception of primary care physicians, who are experiencing bigger pay gains (in certain situations) because of their strong demand.[26] Many physicians are preparing "*for the transition to value-based payment models despite uncertainties that still linger around what impact Medicare reimbursement changes will have on their incomes*;"[27] Medicare officials estimate that the 2019 IPPS proposed rule will have a *relatively modest* impact on most physicians, with obstetricians and gynecologists gaining the most, and dermatologists, rheumatologists, and podiatrists losing the most.[28]

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1 "Sniffles? Cancer? Under Medicare Plan, Payments for Office Visits Would Be Same for Both" By Robert Pear, NY Times, July 22, 2018, https://www.nytimes.com/2018/07/22/us/politics/medicare-payments-trump.htmlQSMGcKpn22nxYnvE6iBjgbpcQjchmlUt7E7ltnkLA&_hsmi=64637784 (Accessed 7/23/18).

2 "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program" Centers for Medicare and Medicaid Services, Department of Health and Human Services, July 12, 2018, https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf, p. 1 (Accessed 7/20/18).

3 "7 ways the CMS wants to change the Medicare physician fee schedule" By Paul Barr, Modern Healthcare, July 13, 2018, http://www.modernhealthcare.com/article/20180713/NEWS/180719946 (Accessed 7/23/18).

4 CMS, Department of Health and Human Services, July 12, 2018.

5 "Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019" Centers for Medicare and Medicaid Services, Department of Health and Human Services, July 12, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html (Accessed 7/20/18).

6 "Proposed Rule for the Quality Payment Program Year 3" Centers for Medicare and Medicaid Services, Department of Health and Human Services, July 12, 2018, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf, p. 1 (Accessed 7/20/18).

7 *Ibid.*

8 *Ibid.*

9 *Ibid*, p. 6.

10 *Ibid.*

11 In 2017, these thresholds were increased: (1) from $30,000 to $90,000 in Part B payments; and, (2) from 100 to 200 beneficiaries. "MIPS Participation Fact Sheet" Centers for Medicare & Medicaid Services, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/MIPS-Participation-Fact-Sheet-2017.pdf (Accessed 7/24/18).

12 "Proposed Rule for the Quality Payment Program Year 3" July 12, 2018.

13 "7 ways the CMS wants to change the Medicare physician fee schedule" By Paul Barr, Modern Healthcare, July 13, 2018, http://www.modernhealthcare.com/article/20180713/NEWS/180719946 (Accessed 7/23/18).

14 "Proposed Rule for the Quality Payment Program Year 3" July 12, 2018.

15 *Ibid.*

16 CMS, Department of Health and Human Services, July 12, 2018; "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program" Federal Register Vol. 82, No. 219 (November 15, 2017) p. 53344-45.

17 CMS, Department of Health and Human Services, July 12, 2018.

18 Pear, July 22, 2018.

19 *Ibid.*

20 *Ibid.*

21 *Ibid.*

22 Barr, July 13, 2018.

23 *Ibid.*

24 *Ibid.*

25 "Physician pay increases may be slowing" By Steven R. Johnson, Modern Healthcare, July 21, 2018, http://www.modernhealthcare.com/article/20180721/NEWS/180719883/physician-pay-increases-may-be-slowing (Accessed 7/23/18).

26 *Ibid.*

27 *Ibid.*

28 Pear, July 22, 2018.

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