spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

2019 Medicare Physician Fee Schedule Proposed Rule

OVERVIEW

On July 12th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update the Physician Fee Schedule (PFS) and a number of other Medicare payment policies and programs, including updates to the Medicare Shared Savings Program and the Quality Payment Program. Proposed changes below impact numerous areas of Medicare reimbursement and reporting, including telehealth, selected non-physician services, technology standards and quality measures.

The PFS sets physician payment rates by establishing relative value units (RVUs) and converting them into rates through a conversion factor. The rule proposes a 2019 PFS conversion factor of $36.05, which is an increase of 0.13% from the 2018 PFS conversion factor. The increase is determined by a statutory 0.25% base increase adjusted by a 0.12% overall RVU reduction to meet budget neutrality requirements. Variation in RVU adjustments by specialty for 2019 range from -5% to +4%, with Allergy/Immunology receiving the greatest reduction and Obstetrics/Gynecology the largest increase.

CMS will accept comments on the rule until September 10th. The proposed rule is available here.

Telehealth Expansion

Medicare has historically imposed extensive restrictions on telehealth services reimbursement. Access to telehealth is currently restricted primarily to rural areas and regions designated as health professional shortage areas, with exceptions for certain providers at financial risk for the cost of care. Sections of the Bipartisan Budget Act (BBA) of 2018 modified or removed restrictions on geography and patient setting for specific services, including end-stage renal disease, services rendered by practitioners in some Accountable Care Organizations, and acute stroke-related services. The proposed rule would implement these changes. The proposed rule would also expand access to Medicare telehealth benefits by:

- Adding codes for prolonged preventive services to the list of telehealth services;
- Adding renal dialysis facilities and the homes of end-stage renal disease (ESRD) beneficiaries receiving home dialysis as originating sites and not applying the originating site geographic requirement for furnishing home dialysis monthly ESRD-related clinical assessments from hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes;
- Adding mobile stroke units as originating sites and not applying geographic requirements for services delivered to diagnose, evaluate, or treat symptoms of acute stroke; and
- Paying separately for the following communication technology-based services as long as they are not closely associated with an in-person visit:
    - Brief Communication Technology-based Service, e.g. Virtual Check-in;
    - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient;
- Including codes for the following services to be separately payable under the PFS as non-telehealth services:
    - Chronic Care Remote Physiologic Monitoring; and

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Interprofessional Internet Consultation.

The new Virtual Check-in and Remote Evaluation services would be billed at a lower rate than in-person services, and are expected to be both patient-initiated and permitted only with physicians who have an existing relationship with the patient. These services would be separately billable if not preceded by a related in-person visit within 7 days, or followed by an in-person visit within 24 hours or at the soonest available appointment (Virtual Check-in) or as a result of the assessment of the image or video (Remote Evaluation).

CMS is requesting comment on a number of features of these technology-based services, including whether to limit the number of services in a given time period, whether consent to the receipt of services must be recorded in the electronic medical record, and how the timeframes for separate billable services should be constructed to accomplish clinical objectives without encouraging gaming.

CMS also proposes payment for communication technology-based services and remote evaluation services provided by practitioners in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) when there is no closely associated billable visit. RHCs and FQHCs would be able to bill a newly created Virtual Communications G-code. This would allow payment, set at the average of the PFS national non-facility payment rates for communication technology-based services and remote evaluation services.

New Part B Drug Payments

Most Part B drugs are paid based on a methodology using the Average Sales Price (ASP), but new Part B drugs that do not have a sufficient amount of sales price data to calculate an ASP currently are paid based on the Wholesale Acquisition Cost (WAC) with an add-on payment of 6%. The proposed rule would reduce the add-on payment for new Part B drugs during the first three months of sales to 3% of the WAC.

Practice Expense RVUs

Practice expenses (PEs) cover general categories of direct and indirect expenses (such as medical supplies and administrative labor), but exclude malpractice expenses. PE RVUs are created for each physician's service and take into account the resources necessary to equip each service. The proposed rule would implement new direct PE input prices in calculating PE RVUs for supplies and equipment over a 4-year period starting in 2019.

New Bundled Payment Models

CMS is soliciting information on the establishment of a bundled payment episode of care management and counseling treatment for substance use disorders. Specifically, CMS is seeking comment on regulatory and sub-regulatory changes that could be implemented to address the opioid crisis and methods for identifying non-opioid alternatives to pain treatment.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Outpatient Therapy Reporting Requirements

The Middle Class Tax Relief and Jobs Creation Act of 2012 required that all providers of outpatient therapy services report on a beneficiary's functional limitation category and functional status in their claims for therapy services throughout an episode of care, including PT, OT, and SLP. The proposed rule would discontinue functional status reporting requirements for outpatient therapy. Eliminated requirements would include reporting of HCPCS G-codes and modifiers.

Non-Physician Provisions

In addition to physicians, the PFS establishes payment and requirements for a number of other providers, including nurse practitioners, physician assistants, physical therapists, and radiologist assistants. Provisions specifically affecting non-physician providers include:

- *Therapy Assistants* – The Bipartisan Budget Act (BBA) of 2018 requires that outpatient therapy services delivered by a physical or occupational therapy assistant be decreased to 85% of the amount Medicare pays for ancillary professionals. As such, the proposed rule establishes new therapy modifiers for when services are delivered in-whole or in-part by a physical therapy assistant or an outpatient therapy assistant.
- *Radiologist Assistants* – The proposed rule would revise Medicare supervision requirements so diagnostic imaging tests conducted by a Radiologist Assistant could be conducted under the *direct supervision* of a physician, rather than the *personal supervision* of a physician (personal supervision requires that the physician be in the same room, while direct supervision requires that the physician be present on the same campus while the service is conducted).

Off-Campus Provider-Based Hospital Departments

Prior to January 1, 2017, certain items and services that were rendered by off-campus provider-based departments of a hospital were covered under the Hospital Outpatient Prospective Payment System (OPSS). CMS established the PFS as the applicable payment system for nonexempted items and services rendered as of CY 17 using a PFS relativity adjuster. The proposed rule would keep the PFS Relativity Adjuster at 40 percent, meaning that under the applicable payment system, nonexempted services would be paid 40 percent of the amount that they would be paid under the OPSS.

Evaluation and Management (E/M) Visit Payments

To justify Medicare payment for E/M visits, CMS requires that providers follow guidelines established in the 1990s to document patient history, medical examination, and clinical decision making. The proposed rule aims to reduce reporting burdens and improve payment accuracy by allowing providers to use medical decision-making or time to document E/M visits, rather than following the current documentation guidelines. Providers would be able to use time as the governing factor for documenting E/M visits, regardless of whether counseling or care coordination was the primary focus of the visit.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

The proposed rule would implement a number of other provisions to ease E/M reporting requirements:

- Providers would no longer be required to re-document information and could instead update patient information by reporting on how the patient's condition has changed or remained the same;
- The rule would allow providers to verify the chief complaint and patient history in the medical record that is entered by ancillary staff or the beneficiary without having to re-enter it;
- Providers would no longer be required to justify the medical necessity of a home visit in lieu of an office visit; and
- The rule would no longer require that teaching physicians enter notations into medical records that have already been reported by residents or other members of the care team.

CMS is also proposing to establish new, single blended payment rates for office/outpatient E/M level 2 through 5 CPT visit codes. Rather than having five different payment rates for levels 1 through 5, the proposed payment rate would have two levels, each with its own price: level 1 would have one price and levels 2 through 5 would have another. Two separate sets of prices are proposed, with one set for new patients and another for established patients. The payment rate would include a series of add-on codes to account resources used to deliver primary care non-procedural specialty services.

Finally, CMS seeks comment on allowing payment for same-day E/M visits by multiple practitioners in the same specialty within a group practice.

Ambulance Services

Add-on payments for Medicare ambulance services were scheduled to end on December 31, 2017. As required by the BBA of 2018, the proposed rule would extend temporary add-on payments for ground ambulance services through 2022. The add-on payments would vary as follows:

- Urban areas would receive an add-on payment increase of 2%;
- Rural areas would receive an add-on payment increase of 3%;
- Super-rural areas would receive an add-on payment increase of 22.6%; and

The proposed rule would also increase the payment reduction from 10% to 23% for non-emergency basic life support transports for beneficiaries with end-stage renal disease for renal dialysis services, starting October 1st, 2018.

CLINICAL LABORATORY FEE SCHEDULE

As of January 1, 2018, The Clinical Laboratory Fee Schedule (CLFS) is determined using the weighted median of private payer rates from laboratories assessed as *applicable laboratories*. CMS is looking to expand the data it gathers from applicable laboratories to calculate a CLFS that is representative of the breadth of laboratories nationally without placing undue burden.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Under the proposed rule, laboratories that serve a significant number of beneficiaries in Medicare Part C could meet the Medicare revenues threshold to qualify as an applicable laboratory that would report data to CMS.

REQUEST FOR INFORMATION (RFI)

Included as part of the rule are two RFIs: Promoting Interoperability and Electronic Healthcare Information Exchange, and Price Transparency.

Promoting Interoperability and Electronic Healthcare Information Exchange

CMS seeks comment on how it could use health and safety standards required for providers and suppliers participating in Medicare and Medicaid programs, such as the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care (LTC) facilities, to further advance the electronic exchange of information between hospitals and community providers. CMS also seeks stakeholder feedback on new or revised CoPs, CfCs, and RfPs for interoperability and electronic health information exchange.

Price Transparency

The rule also includes an RFI on Price Transparency. CMS is considering ways to improve accessibility and usability of current charge information. To achieve this, CMS seeks comments from all providers and suppliers on topics including how to define “standard charges” and whether providers and suppliers should provide certain information (e.g., Medicare out-of-pocket costs) to patients. CMS also seeks comment on improving a Medigap patient’s understanding of out-of-pocket costs prior to receiving services.

CMS is concerned that challenges continue to exist for patients, including surprise out-of-network bills for physicians (e.g., anesthesiologists, radiologists) who provide services at in-network hospitals and other settings and recognizes that charge data may not be helpful for patients in determining what they are likely to pay for a particular service or facility encounter.

As per the 2019 Inpatient Prospective Payment system rule issued earlier this year, current charge data must be publicly posted by hospitals in a machine-readable format starting January 1, 2019.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

The proposed rule would reduce the total number of MSSP quality measures from 31 to 24 to increase focus on outcome-based measures, including patient experience, and to reduce duplication in measures and align remaining measures with other programs, such as the MIPS quality reporting requirements. Three new scored quality measures would be added in the 2019 performance year. The scoring would be pay-for-reporting in the first two years and pay-for-performance starting in performance year 2021.

Below are charts outlining the quality measures to be removed and added starting in performance year 2019.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Removed Measures

Domain	ACO Measure #	Measure Title	Method of Data Submission
Care Coordination/ Patient Safety	ACO-35	Skilled Nursing Facility 30-Day Readmission (SNFRM)	Claims
	ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	Claims
	ACO-37	All Cause Unplanned Admissions for Patients with Heart Failure	Claims
	ACO-12	Medication Reconciliation Post-Discharge	Web Interface
	ACO-13	Falls: Screening for Future Fall Risk	Web Interface
	ACO-44	Use of Imaging Studies for Low Back Pain	Claims
Preventative Health	ACO-15	Pneumonia Vaccination Status for Older Adults	Web Interface
	ACO-16	Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Web Interface
Diabetes	ACO-41	Diabetes: Eye Exam	Web Interface
Ischemic Vascular Disease	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Web Interface

Added Measures

Domain	ACO Measure #	Measure Title	Method of Data Submission
Patient /Caregiver Experience	ACO-45	CAHPS: Courteous and Helpful Office Staff	Survey
	ACO-46	CAHPS: Care Coordination	Survey
Care Coordination /Patient Safety	ACO-47	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	CMS Web Interface

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

QUALITY PAYMENT PROGRAM (QPP)

Included with the PFS rule released on July 12th, CMS issued a proposed rule that would update QPP for Year 3 of the program (performance year 2019). Beginning in 2019, the amounts paid to eligible providers through the PFS will be adjusted according to the provider's participation in, and performance on, one of two QPP tracks:

- The Merit-based Incentive Payment System (MIPS); and
- Advanced Alternative Payment Models (Advanced APMs).

As required by statute, the maximum MIPS penalty is 7% of Medicare fee-for-service (FFS) revenue for performance year 2019, and the maximum MIPS bonus is 7%. However, total bonus payments will be reduced as necessary to equal total actual penalties and ensure budget neutrality. Providers that qualify as Advanced APMs will have reduced reporting requirements compared to MIPS and receive a 5% bonus on Medicare FFS revenues without budget neutrality restrictions.

The proposed rule would continue to implement the QPP, but aims to ease reporting requirements, modify MIPS opt-in policy, expand the provider types eligible for QPP, add new episode-based measures, restructure the Promoting Interoperability performance category, and permit facility-based clinicians to use facility rather than individual measures.

Eligible Providers

Effective in the 2019 performance year (which determines payment adjustments made in the 2021 MIPS payment year), the proposed rule adds four new types of clinicians to the list of QPP participants: clinical social worker, clinical psychologist, physical therapist, and occupational therapist. No participating categories were removed.

For 2018, providers or groups with less than $90,000 in Medicare-allowable charges or fewer than 200 Medicare beneficiaries were excluded from participating in MIPS. For 2019, a third exclusion category is proposed: providers or groups that provide fewer than 200 covered services under the Medicare PFS. However, low-volume threshold providers would be able to opt-in to MIPS if they exceed two of the three thresholds. CMS estimates that approximately 650,000 clinicians will be MIPS-eligible providers in performance year 2019, an increase from the previous year's estimate of 600,000.

To encourage MIPS participation among providers in small practices and rural or health professional shortage areas, a Virtual Groups Participation option was added in 2018. Single providers or groups of up to 10 providers may form a Virtual Group with at least one other provider or a group or providers to participate in MIPS. For the 2019 performance year, the virtual group eligibility determination period aligns with the first segment of data analysis under the MIPS eligibility determination period.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

MIPS Measurement Standards

MIPS Performance is evaluated according to four measures: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly "Advancing Care Information").

For 2019, the Promoting Interoperability measure will no longer allow the use of 2014 Certified Electronic Health Record Technology (CEHRT), and will employ one reduced measure set based on the 2015 CEHRT standard. The rule proposes a new scoring methodology that eliminates distinct base, performance, and bonus scores and aligns with the requirements of the Medicare Promoting Interoperability Program for eligible hospitals and Critical Access hospitals to accommodate increased sharing of CEHRT with hospitals. The proposed scoring methodology includes measures drawn from a set of four objectives that are scored based on performance:

- e-Prescribing;
- Health Information Exchange;
- Provider to Patient Exchange; and
- Public Health and Clinical Data Exchange.

Providers would be required to submit selected measures within each objective and would have some flexibility in which measures to submit. The rule proposes to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP); and Verify Opioid Treatment Agreement.

In the proposed rule, the weight of the Cost performance category in the final score will be flexible for three additional years. Instead of requiring a weight of 30% in 2019, the weight is required to be not less than 10% and not more than 30% until 2021. In addition, the rule proposes to add eight episode-based measures to the Cost performance category beginning in 2019.

In addition, the small practice bonus is reduced from a 5-point addition on the final score to a 3-point addition in the numerator of the quality component of the final score. In calculating the final Performance Score, the relative weight of Quality is reduced by 5% to 45% and the weight of Cost is increased by 5% to 15%. The weights of Promoting Interoperability and Improvement Activities are unchanged from 2018.

Performance threshold flexibility is extended for three additional years (program years 3, 4, and 5) to ensure a gradual and incremental transition to the estimated performance threshold for the sixth year of the program based on the mean or median of final scores from a prior period. For 2019, the proposed performance threshold is 30 points.

MIPS Quality Measures

The rule proposes to remove process measures that are not considered high priority for clinicians in the MIPS quality measure set. Beginning with the 2019 performance period, the rule proposes to incrementally remove process measures based on the following considerations:

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Whether the removal of the process measure impacts the number of measures available for a specific specialty;
- Whether the measure addresses a priority area highlighted in the Measure Development Plan;
- Considerations and evaluation of the measure's performance data;
- Whether the measure is designated as high priority or not; and
- Whether the measure has reached a topped-out status within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.

In order to address the opioid epidemic impacting the United States, beginning in the 2019 MIPS performance year quality measures related to opioids are proposed to be included in the category of high priority measures. As such, the proposed rule defines a high priority measure as an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.

The rule also proposes to add 10 new MIPS quality measures, including patient reported outcome measures and high priority measures, and remove 34 quality measures. In addition, CMS is specifically requesting comments on a tiered scoring system for quality measures in which measures are classified as a particular value (i.e., gold, silver, or bronze) and will be awarded points based on their assigned value.

MIPS Facility-Based Physicians

An option within the quality and cost performance categories that allows facility-based clinicians to be scored according to their facility's performance will begin in the 2019 performance year. The proposed rule specifies that for a clinician to be eligible for a facility-based measurement, the clinician must furnish 75% or more of his or her covered professional services in sites of service identified by the place of service codes as an inpatient hospital, on-campus outpatient hospital, or emergency room setting. This percentage would be assessed on claims for a 12-month segment beginning on October 1 of the calendar year two years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period with a 30-days claims run out. According to the proposed rule, clinicians and groups that are scored under the facility-based measurement scoring methodology will not have a separate data submission requirement.

Advanced APMs

The rule proposes to extend the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024. CMS contends that this amount represents an appropriate standard for financial risk and that maintaining a consistent standard for the next few years will help APM entities plan for future participation in the program and allow CMS to measure their success across this timeframe.

The proposed rule specifies that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

The Advanced APM track provides incentive payments based on quality measures that are comparable to those used in the MIPS quality performance category and are evidence-based, reliable, and valid. The proposed rule aims to streamline and reduce requirements for MIPS-comparable quality measures in both Medicare and Other Payer Advanced APMs for performance year 2019 by including all measures submitted in response to the MIPS Call for Quality Measures as meeting the quality criterion. Effective January 1, 2020, a new proposal will require that at least one of the quality measures upon which an Advanced APM bases payments must be:

- Finalized on the MIPS final list of measures;
- Endorsed by a consensus-based entity; or
  Otherwise determined by CMS to be evidence-based, reliable, and valid.

The rule maintains the revenue-based nominal risk amount standard for Other Payer Advanced APMs at 8% through performance year 2024.

Medicare Advantage (MA) Qualifying Payment Arrangement Incentive (MAQI)

In conjunction with this proposed rule, CMS announced the MAQI demonstration to test an initiative to promote value-based contract arrangements in MA. Specifically, the MAQI Demonstration will exclude MIPS eligible clinicians who participate sufficiently in Advanced APM-like contracts with MA Plans from the MIPS reporting requirements and downward payment adjustment. These APM-like arrangements would be consistent with the requirements for Other Payer Advanced APMs.

Providers who meet threshold requirements for MA Advanced APM revenue or patient volume will avoid MIPS penalties and reporting requirements by meeting the APM requirement without the need for a minimum percent of traditional Medicare volume in Advanced APMs. For example, using the revenue-based standard, currently 50% of all Medicare revenue in 2019 (traditional and MA) must be in qualifying Advanced AM-like arrangements and at least 25% of all traditional Medicare revenue must be in Advanced APMs for a provider to avoid MIPS penalties and reporting. Under the proposed rule, the 25% traditional Medicare Advanced APM requirement would be removed and the 50% could come entirely from MA contracting.

However, it remains the case that in order to be designated as a Qualifying APM Participant (QP) and receive the 5% Part B payment bonus as a QP, providers would still need to meet the 25% Advanced APM threshold in traditional Medicare in 2019.