Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2019.

The calendar year (CY) 2019 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.

Background on the Physician Fee Schedule

Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

PAYMENT PROVISIONS

Conversion Factor

With the budget neutrality adjustment to account for changes in RVUs, all required by law, the proposed 2019 PFS conversion factor is $36.05, a slight increase above the 2018 PFS conversion factor of $35.99.

Practice Expense (PE): Market-Based Supply and Equipment Pricing Update

Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding Malpractice (MP) expenses. We develop PE RVUs for each physicians’ service by considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses.

We worked with a contractor to conduct an in-depth and robust market research study to update the PFS direct PE inputs for supply and equipment pricing for CY 2019. These supply and equipment prices were last systematically developed in 2004-2005. A report from the contractor with updated pricing recommendations for approximately 1300 supplies and 750 equipment items currently used as direct PE inputs is available as a public use file displayed on the CMS website under downloads for the CY 2019 PFS proposed rule.

We are proposing to adopt the updated direct PE input prices for supplies and equipment. We are proposing to phase in our use of the new direct PE input pricing over a 4-year period beginning in 2019 to ensure a smooth transition from the prices we currently include and the payments for the services that include them to the final updated prices and payments in CY 2022.
Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

CMS is proposing a number of coding and payment changes to reduce administrative burden and improve payment accuracy for E/M visits. We propose:

- to allow practitioners to choose to document office/outpatient E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;
- to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
- to expand current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information; and
- to allow practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

We are also soliciting comment on how documentation guidelines for medical decision-making might be changed in subsequent years.

To improve payment accuracy and simplify documentation, we propose new, single blended payment rates 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. As a corollary to this proposal, we propose to apply a minimum documentation standard where Medicare would require information to support a level 2 CPT visit code for history, exam and/or medical decision-making in cases where practitioners choose to use the current framework, or, as proposed, medical decision-making to document E/M level 2 through 5 visits. In cases where practitioners choose to use time to document E/M visits, we propose to require practitioners to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient. Practitioners could choose to document additional information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished. However, we would only require documentation to support the medical necessity of the visit and associated with the current level 2 CPT visit code.

To recognize efficiencies that are realized when E/M visits are furnished in conjunction with other procedures, we propose a multiple procedure payment adjustment that would apply in those circumstances. We also propose new coding to recognize podiatry E/M visits that would more specifically identify and value these services. We propose a new prolonged face-to-face E/M code, as well as a technical modification to the practice expense methodology.

We propose to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit, and solicit public comment on potentially eliminating a policy that prevents payment for same-day E/M visits by multiple practitioners in the same specialty within a group practice. For E/M visits furnished by teaching physicians, we also propose to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

We are soliciting public comment on the implementation timeframe of these proposals, as well as how we might update E/M visit coding and documentation in other care settings in future years. CMS believes these proposals would allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.
Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

We are proposing to pay separately for two newly defined physicians’ services furnished using communication technology:

- Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G011)
- Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code GRAS1)

Practitioners could be separately paid for the Brief Communication Technology-based Service when they check in with beneficiaries via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries. Similarly, the Remote Evaluation of Recorded Video and/or Images Submitted by the Patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information conducted via pre-recorded “store and forward” video or image technology to assess whether a visit is needed.

We are also proposing to pay separately for new coding describing Chronic Care Remote Physiologic Monitoring (CPT codes 90X0, 90X1, and 994X9) and Interprofessional Internet Consultation (CPT codes 99XX6, 99XX0, 99X46, 99X47, 99X48, and 99X49).

Providing Practice Flexibility for Radiologist Assistants

CMS is proposing to revise the physician supervision requirements so that any diagnostic test performed by a Radiologist Assistant (RA) may be furnished under, at most, a direct level of physician supervision, when performed by an RA in accordance with state law and state scope of practice rules. This is in response to stakeholder comments that the current requirement of personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by an RA, and does not allow for radiologists to make full use of RAs; and that reducing the required level of supervision will improve efficiency of care.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System (OPPS) and are instead paid under applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Since CY 2017, payment for these items and services has been made under the PFS using a PFS relativity adjuster based on a percentage of the OPPS payment rate. The PFS relativity adjuster in CY 2018 is 40 percent, meaning that non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. For CY 2019, CMS is proposing to maintain the current PFS relativity adjuster Relatively Adjuster at 40 percent. CMS believes that this PFS Relatively Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

Medicare Telehealth Services

For CY 2019, we are proposing to add the following codes to the list of telehealth services:

- HCPCS codes G013 and G014 (Prolonged preventive service(s))

We are also proposing to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. We propose to add renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities,
and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments. We propose to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Recognizing Communication Technology-Based Services for RHCs & FQHCs

For CY 2019, CMS is proposing payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit. These services would be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous 7 days or within the next 24 hours or at the soonest available appointment. RHCs and FQHCs would be able to bill a newly created RHC/FQHC Virtual Communications G-code, with payment set at the average of the PFS national non-facility payment rates for communication technology-based services and remote evaluation services.

WAC-Based Payment for Part B Drugs: Proposal to Alter Add-on Amount

Many Part B drug payments are based on Average Sales Price (ASP) methodology and, by statute, include an add-on payment of 6 percent of the ASP amount. Some Part B drug payments are based on wholesale acquisition cost (WAC) such as single-source drugs without ASP data. WAC-based payment rates typically exceed rates based on ASP amounts.

CMS believes that reducing the 6 percent add-on for WAC-based Part B drug payments would help curb excessive spending by better aligning payments and drug acquisition costs, especially for drugs with high launch prices. The payment reductions would also decrease beneficiary cost sharing. A reduction of the add-on percentage for these WAC-based payments for Part B drugs is consistent with Fiscal Year 2019 President’s Budget Proposal and MedPAC’s June 2017 Report to the Congress.

Thus, the rule is proposing that, effective January 1, 2019, WAC-based payments for new Part B drugs during the period first quarter of sales when ASP is unavailable, the drug payment add-on would be 3 percent in place of the 6 percent add-on that is currently being used. If this proposal is finalized, we would also update Manual provisions in order to permit Medicare Administrative Contractors to use an add-on percentage of up to 3 percent, rather than 6 percent, when utilizing WAC for pricing new drugs.

Aligning the Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organization (ACO) with the Meaningful Measures Initiative

Recently, 98 percent of Medicare Shared Savings Program ACOs successfully reported quality measures for the 2017 performance period. We are proposing to reduce the total number of measures in the Shared Savings Program quality measure set from 31 to 24 and focus the measure set on more outcome based measures including patient experience of care. Reducing the number of measures on which ACOs are evaluated decreases the number of performance metrics to which they are required to track and eliminates redundancies between measures that target similar populations. This enables ACOs to better utilize their resources toward improving patient care. These proposals further reduce burden by aligning the proposed changes to Merit-based Incentive Payment System (MIPS). At the same time, the addition of two new patient experience of care measures and one new measure to the CMS Web Interface measures that are reported under MIPS makes the Shared Savings Program measure set more outcomes oriented.

Request for Information on Price Transparency

Under current law, hospitals are required to establish and make public a list of their standard charges. In an effort to encourage price transparency by improving public accessibility of charge information, in the fiscal year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule, CMS announced it is updating its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet. However, CMS is concerned that challenges continue to exist for patients due to insufficient price
transparency. We are seeking information from the public regarding barriers preventing providers and suppliers from informing patients of their out-of-pocket costs; what changes are needed to support greater transparency around patient obligations for their out of pocket costs; what can be done to better inform patients of these obligations; and what role providers of health care services and suppliers should play in this initiative.

**Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging**

For CY 2019, CMS proposes to revise the significant hardship criteria in the AUC program to include: 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances. In addition, we are proposing to add independent diagnostic testing facilities (IDTFs) to the definition of applicable setting under this program. This will allow the AUC program to be more consistently applied to outpatient settings. We are also proposing to allow AUC consultations, when not personally performed by the ordering professional, to be performed by auxiliary personnel. This will allow the ordering professional to exercise their discretion to delegate the performance of this consultation.

**Quality Payment Program**

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the Quality Payment Program (QPP), which consists of two participation pathways for doctors and other clinicians – the Merit-based Incentive Payment System (MIPS), which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models (Advanced APMs), in which clinicians may earn an incentive payment through sufficient participation and are excluded from MIPS reporting requirements.

The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of electronic health records (EHRs), including by:

- Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes; and
- Overhauling the MIPS “Promoting Interoperability” performance category to support greater EHR interoperability and patient access to their health information, as well as align this performance category for clinicians with the proposed new Promoting Interoperability Program for hospitals.

Under the requirements of the Bipartisan Budget Act of 2018, CMS is continuing the gradual implementation of certain MIPS requirements to ease administrative burden on clinicians. The proposed changes to the QPP reflect feedback and input from clinician partners and stakeholders and will continue to incorporate that feedback. Also, free and customized support for clinicians from CMS technical assistance networks will continue in 2019.

Aligning with the agency’s goals of improving quality of care, CMS also proposes waivers of MIPS requirements as part of testing a demonstration called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. The MAQI demonstration would test waiving MIPS reporting and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs. The demonstration will look at whether waiving MIPS requirements would increase levels of participation in such MA payment arrangements and whether it would change how clinicians deliver care.

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