2019 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule: Overview & Key Provisions for Family Medicine

September 5, 2018

---

Agenda

- Participation Instructions
- Introductions & Overview
- Medicare Physician Fee Schedule
- AAFP Response to MPFS Proposed Rule
- Questions on MPFS
- Quality Payment Program
- Questions on MPFS

---

Click the orange arrow to open and close the control panel

Type your question into the question log.
2019 Medicare Physician Fee Schedule
Includes MACRA QPP Changes

- On July 12, 2018, CMS released a proposed rule on 2019 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B.
  - Combines the 2019 Medicare Physician Fee Schedule and MACRA’s Quality Payment Program changes and updates
- Comments are due September 10, 2018

For the past 6 weeks, the AAFP policy team has reviewed the proposed rule for its impact on family medicine. We will be submitting our official comment letter to CMS today.

Key Provisions for Family Medicine

<table>
<thead>
<tr>
<th>Medicare Physician Fee Schedule</th>
<th>MACRA QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updates to Conversion Factor</td>
<td>Updates to MIPS</td>
</tr>
<tr>
<td>Changes to E/M Payment &amp;</td>
<td>Performance Categories and Scoring</td>
</tr>
<tr>
<td>Documentation</td>
<td>Promoting Interoperability Category</td>
</tr>
<tr>
<td>Collapse Payment for Office/Outpatient E/M Services</td>
<td>Low-Volume Threshold/Op-In</td>
</tr>
<tr>
<td>New Codes for Add-on Payments to Office Visits</td>
<td>Advanced APMs</td>
</tr>
<tr>
<td>New Procedure Payment Reduction</td>
<td>Increases CEHRT Threshold to 75%</td>
</tr>
<tr>
<td>New Codes and Payment for Remote Services</td>
<td>Mandates 5% revenue-based nominal risk standard</td>
</tr>
<tr>
<td></td>
<td>Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration (MAQI)</td>
</tr>
</tbody>
</table>

Key Issues

- Proposed changes to Evaluation & Management codes
- Proposed reduction in documentation
- Modifier – 25 payment reductions
- Sustainability of independent practices
- Impact on Medicare beneficiaries
- Lack of action on Alternative Payment Models
Medicare Physician Fee Schedule

Proposed 2019 Conversion Factor and Total Allowed Charges for Family Physicians

- Conversion Factor:
  - 2018: $35.9996
  - 2019: $36.0463

- Total Allowed Charges: Estimated $6.2 B for family medicine
  - 1% increase relative to 2018

Proposed Restructuring of E/M Payment Levels

- Collapse Payment for Office/Outpatient E/M Services
  - Blended, single payment for new patient office visits levels 2 - 5 (99202 - 99205)
  - Blended, single payment for existing patient office visits level 2 - 5 (99212 - 99215)
Other Proposed E/M Payment Changes

• **New Codes for Add-on Payments to Office Visits**
  - Visit complexity inherent to E/M associated with specific specialties ($13.70)
    - Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management, Critical Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, Urology
  - Visit complexity inherent to primary care E/M ($5.40)
  - 30-minute prolonged E/M visit ($67.40)

• **Multiple Procedure Payment Reduction**
  - 50% reduction on lower paid service when physicians report E/M service and certain procedures on the same date

Proposed Changes to E/M Documentation

• Focus documentation of history and exam on changes since last visit or pertinent issues
• Review and verify rather than re-enter certain information in the medical record that is entered by ancillary staff or beneficiary
• Remove requirement that teaching physicians duplicate notations already included in the medical records by residents or medical team members
• Allow physicians a choice in documentation for E/M visits:
  - 1995 or 1997 E/M documentation guidelines, OR
  - Medical decision-making, OR
  - Time
• Document only to level 2 for office/outpatient E/M

Proposed Payments for Telehealth

• **New Codes and Payment for Remote Services**
  - Time spent with beneficiaries via select telecommunications methods to assess if office visit/service is needed (“virtual check-in”)
  - Time spent evaluating video/image sent by patient
5 Key Takeaways

1. Directionally appropriate – technically flawed
2. The E&M proposal is at best net-neutral for most family physicians
   • Disproportionate impact on smaller practices
3. The MPFR policy is a problem and would result in major cuts
4. The total package is net-negative for many if not most
5. Proposal upends progress towards comprehensive primary care
   • Incentivizes churn
   • Not patient-centered

AAFP Recommendations

We (AAFP) recommend five major changes that would strengthen the proposed policies included in the 2019 MPFS. Those recommendations are:

1. Disconnect documentation and coding. Proceed with the proposed changes in documentation and implement immediately – but without the collapse to a single payment for codes 99202-99205 and 99212-99215. Furthermore, we urge CMS to use its unique position to drive changes in documentation not only in Medicare, but through all public and private health plans.

2. Delay implementation of any changes to E&M policies, codes and descriptors until such time as the AAFP and other medical associations can work with CMS to develop new or revised office visit codes, descriptors, and values that incentivize comprehensive, continuous and coordinated primary care and not fragmentation and churn.

3. Eliminate the proposed primary care add-on code and replace it with a 15% increase in payment for E&M services provided by physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics.
### AAFP Recommendations

4. Eliminate the proposed 50 percent Multiple Procedure Payment Reduction (MPPR) for physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics.

5. Eliminate the co-insurance requirements for the chronic care management codes. Elimination of the co-insurance requirements would facilitate greater utilization of these codes and increase coordination of care for those beneficiaries with the greatest health care needs. If CMS is unable to make this change via rulemaking, we would encourage you to request that Congress make this change via legislation.
Performance Category Weights:

- Cost gradually increases until weighted at 30% in 2022.
- Improvement Activities (15%) and Promoting Interoperability (25%) remain the same.

Quality:
- 2018: 50%
- 2019: 45%

Cost:
- 2018: 10%
- 2019: 15%

*Bipartisan Budget Act of 2018

Performance Period:

- 2018 – Quality/Cost (Full Year) | ACI/IA (90 Days)
- 2019 - proposed to remain the same

ACI/IA Performance Period:

Performance Threshold:

- Exceptional Performance: 70
- Performance Threshold in 2019: 30
- Performance Threshold in 2018: 15

New provision: The Secretary may set the Performance Threshold for program years 2019, 2020 and 2021 (it will gradually increase).
Bonus Points

• Small practices:
  – 15 or fewer
  – Five points added to Quality Score

• Complex Patient
  – Calculated based on HCC Scores and % of dual eligible patients
  – Added to final score (max. 5 pts)

+5

Promoting Interoperability Category

• New Scoring for Promoting Interoperability (PI) Category
  – Formerly Advancing Care Information (ACI)
  – Removes ACI base and performance categories
  – Reduces number of measures in PI category
  – Does not remove “All or Nothing” Scoring Criteria

• Requires MIPS Eligible Clinicians to Adopt 2015 Edition CEHRT

Proposed Updates to Low-Volume Threshold

• Low Volume Threshold (LVT)
  1. Have ≤ $90K in Part B allowed charges for covered prof. services
  2. Provide care to ≤ 200 beneficiaries
  3. NEW! Provide ≤ 200 covered services to Part B patients

• Proposed Opt-In option for MIPS
  – any EC that meets or exceeds one or two of the LVT criteria can opt-in
  – Eligible for both positive and negative payment adjustments.
Low-volume Threshold

The Centers for Medicare and Medicaid Services (CMS) has published a CMS Look-Up Tool for clinicians to verify their MIPS-eligibility status by entering their National Provider Identifier (NPI) number

qpp.cms.gov

Updates to Advanced APMs Track

- CEHRT Changes. Increases CEHRT use threshold to require at least 75% of eligible clinicians in each APM Entity use CEHRT
- Nominal Risk Standards. Maintains 8% revenue-based nominal risk standard for Advanced APMs/Other Payer Advanced APMs through PY2024
- MAQI. Introduces Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
  - Allows clinicians in Medicare Advantage (MA) payment arrangements—similar to Advanced APMs—to be exempt from MIPS requirements
  - The MAQI application period is August 6-September 6

MIPS Playbook

Step-by-Step guide to help:
- Understand MIPS reporting requirements
- Provides checklists and actionable steps
- Prepare for successful performance in the QPP

Available at www.aafp.org/MACRANeeds
Questions?

Type your question into the question log