

Health Policy Update – November 1, 2018

Stay up to date on public policy initiatives and legislation impacting your community specialty clinic. The Health Policy Update is a bi-weekly newsletter for McKesson Specialty Health customers with curated content, and resources to help you advocate for your practice and patients.

CMS Releases Final Medicare Payment Rules for 2019

The Centers for Medicare and Medicaid Services (CMS) issued a final rule to update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP). CMS will be accepting comments on the rule until December 31, 2018. These policies are set to go into effect on January 1, 2019. Here are the highlights:

Payment Policy Changes

The CY 2019 PFS conversion factor is estimated to be \$36.04 a slight increase above the 2018 PFS conversion factor of \$35.99. Changes in payment policy outlined in the final rule result in the overall average impact for the following specialties:

- Hematology/Oncology: -1%
- Radiation Oncology: -1%
- Radiation Therapy Centers: -1%
- Urology: +1%
- Rheumatology: 0%
- Gastroenterology: 0%
- Diagnostic Testing Facility: -5%
- Independent Lab: -2%
- Ophthalmology: -1%

Streamlining Evaluation and Management Payment and Reducing Clinical Burden

CMS is delaying payment and coding changes for office evaluation and management (E/M) visits until CY 2021. Acknowledging concerns from stakeholders, CMS is not finalizing a separate PE/HR for office/outpatient E/M visits which would have had significant consequences for the allocation of indirect PE across the PFS. For CYs 2019 and 2020, CMS is implementing several documentation policies to provide immediate burden reduction.

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- For E/M office/outpatient visits, for new and established patients, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and
- Removal of 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 for E/M visits furnished by teaching physicians.

Beginning in CY 2021, CMS will implement payment and coding changes for E/M office/outpatient visits. Specifically, for CY 2021, CMS is finalizing the following policies:

- \$130 payment rate for new patient E/M office visit levels 2 through 4; \$211 payment rate for new patient E/M office visit level 5
- \$90 payment rate for established patient E/M office visit levels 2 through 4; \$148 payment rate for established patient E/M office visit level 5
- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time, or alternatively practitioners could continue using the current framework;
- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time;
- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care – not restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits; and
- Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS is not finalizing aspects of the proposal that would have: (1) reduced payment when E/M office/outpatient visits are furnished on the same day as procedures, or (2) standardized the allocation of practice expense RVUs for the codes that describe these services.

Reduction to Add-on Amount for WAC-Based Payment for Part B Drugs

CMS is finalizing a policy 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. CMS will also update manual provisions 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.

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

CMS is finalizing the proposal to adopt updated direct PE input prices for supplies and equipment. While CMS is adopting most of the prices for supplies and equipment as recommended by the contractor and included in the proposed rule, in the case of particular items, CMS is finalizing refinements to the proposed prices based on feedback from commenters. CMS is also finalizing the proposal to phase-in use of these new prices over a 4-year period beginning in CY 2019.

Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS is finalizing the proposal 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 GVCI1)
- Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code GRAS1)

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

CMS is finalizing the proposal to maintain the current PFS relativity adjuster of 40 percent for non-excepted off-campus provider-based departments.

Clinical Laboratory Fee Schedule

CMS is finalizing the proposal to change the way Medicare Advantage payments are treated in the definition of “applicable laboratory”, which may result in additional laboratories of all types that serve a significant population of beneficiaries enrolled in Medicare Part C in meeting the majority of Medicare revenues threshold and potentially qualifying as an applicable laboratory and report data to CMS.

CMS is amending the applicable laboratory definition to include hospital laboratories that bill for their non-patient laboratory services.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

For CY 2019, CMS is finalizing the revision of the significant hardship criteria in the AUC program to include:

- insufficient internet access;
- electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or
- extreme and uncontrollable circumstances.

CMS is also finalizing allowing ordering professionals experiencing a significant hardship to self-attest their hardship status. In addition, CMS is adding independent diagnostic testing facilities (IDTFs) to the definition of applicable setting under this program. CMS is also allowing AUC consultations, when not personally performed by the ordering professional, to be performed by clinical staff under the direction of ordering professional.

Final Changes to the Quality Payment Program Year 3

CMS is finalizing policies to reduce burden and offer flexibilities by:

- Overhauling the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record interoperability and patient access while aligning with the Medicare Promoting Interoperability Program requirements for hospitals.
- Moving clinicians to a single, smaller set of objectives and measures with scoring based on measure performance for the Promoting Interoperability performance category.
- Allowing the use of a combination of collection types for the Quality performance category.
- Retaining and increasing some bonus points
- For the Cost or Quality performance categories, providing the option to use facility-based scoring for facility-based clinicians, who are planning to participate in MIPS as a group. This option does not require data submission. CMS expects to release a facility-based scoring preview in Q1 of 2019.

CMS is also finalizing the following changes to MIPS Performance Category Weights:

- Quality: from 50% in Year 2 to 45% in Year 3
- Cost: from 10% in Year 2 to 15% in Year 3
- Improvement Activities (IA) and Promoting Interoperability (PI) remain the same at 15% and 25% respectively.

Key Changes to QPP under the Bipartisan Budget Act of 2018

- Providing flexibility in the weighting of the Cost performance category in the final score for three additional years. Instead of requiring this performance category to have a weight of 30% in Year 3 of the program (performance period 2019) the weight is required to be not less than 10 percent and not more than 30 percent for the third, fourth and fifth years of the Quality Payment Program.

- Allowing flexibility in establishing the performance threshold 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.

CMS is finalizing the following changes and updates to APMs:

- Updating the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75 percent of eligible clinicians in each APM Entity use CEHRT.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs and Other Payer Advanced APMs through performance year 2024.
- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.
- Streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM criteria to reduce confusion and burden among payers and eligible clinicians submitting payment arrangement information to CMS.
- Clarifying the requirement for MIPS APMs to assess performance on quality measures and cost/utilization.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.

To view the CMS fact sheet on the PFS final rule, [CLICK HERE](#).

To view the CMS fact sheet on the QPP final rule, [CLICK HERE](#).

To view the final rule in its entirety, [CLICK HERE](#).