SATINSKY CONSULTING

LATE FALL 2018 NEWSLETTER

The healthcare environment continues to change at a rapid pace. Looking ahead to 2019, we can expect major changes in both the public and private sectors. In this newsletter we preview anticipated, but not final, changes at both the federal and state levels. Keep your eyes and ears open for final decisions so you are prepared to make necessary modifications in practice operations. If you would like background information on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and on changes since the passage of the legislation, see our Winter 2018 Newsletter.

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FEDERAL AND STATE CHANGES THAT MAY IMPACT YOU IN 2019

Potential Changes at the Federal Level
Medicare Physician Payment and Quality Reporting

Potential Changes to Physician Payment

The Centers for Medicare & Medicaid Services (CMS) has proposed changes to physician payment, evaluation and management (E/M) coding, Part B drugs and appropriate use criteria (AUC) for advanced diagnostic imaging services. The proposed implementation date is January 1, 2019. There is a possibility that the E/M changes may be delayed until January 1, 2020.

1. The 2019 **Medicare PFS conversion factor** would increase to $36.0463, including the 0.25% update required by the Bipartisan Budget Act of 2018. There is a budget-neutrality adjustment of -0.12%. For anesthesiologists, the estimated conversion factor is $22.2986.

2. In recognition of the trend toward increased physician-patient communication through technology, CMS proposes to pay for two **new services**: (a) brief non-face-to-face appointment (i.e. virtual check-ins) using HCPCS code GVCI1; and (b) evaluation of patient-submitted images or video (i.e. store and forward technology) using HCPCS code GRAS1. CMS also proposes to pay separately for new codes that describe internet consultation between or among professionals. With respect to remote patient monitoring (RPM), CMS already provides payment under CPT code 99091 and would add new codes (CPT codes 990X0, 990X1 and 994X9) to be used when qualified health professionals remotely monitor measures such as weight, blood pressure, pulse oximetry and respiratory rate. With these proposals, CMS is shifting its

interpretation of the scope of "Medicare telehealth services." Section 1834 (m) of the Social Security Act defines "Medicare telehealth services" but also restricts coverage to those beneficiaries who are located at specific and limited site categories. The new proposal puts RPM into a new category, thus avoiding the restrictions and expanding coverage for beneficiaries.

3. CMS is proposing a new approach to **E & M visit payment amounts**. The current system includes reimbursement for five categories of new patient office visits and five categories of established patient office visits. The proposed new system would pay specific amounts for 99201 and 99211. It would group the codes 99202-99205 and 99212-99215 into two categories and pay a blended rate for each.

   Many physicians are fearful about the potential impact on patient revenue of this proposed change in payment. Physicians would be able to bill only $93 at Level 2, the highest level—down from the $148 maximum under the current five category coding system. The lowest level charge would rise slightly from $22 to $24.

4. When a physician or a physician in the same group provides a **procedure or additional visit on the same day** as an initial and separate E/M visit, CMS proposes to reduce payment by 50% for the least expensive of the two.

5. In recognition of the fact that both primary care physicians and physicians in some specialties (Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Ob/Gyn, Otolaryngology, Rheumatology or Urology) may at times encounter **complex situations during evaluation and management visits**, CMS is proposing two new codes that would add additional payments: GPC1X ($5) for primary care physicians and GCG0X ($12) for specialists.

6. CMS proposes to recognize instances when office visits last more than 30 minutes beyond the visit itself. A new code, GPRO1, would apply to **prolonged evaluation and management or psychotherapy services** and would be listed separately from the code for the office visit itself.

7. In an ongoing effort to **simplify physician documentation** for office and outpatient E/M visits, CMS proposes to offer physicians three options for documentation. The minimum documentation standard would support the strategy of shrinking the E & M code categories for levels 2-5. Still another proposed change in documentation would eliminate the requirement that physicians re-record elements of the history and physical exam when there is evidence that ancillary staff has already reviewed and updated the information. The physician documentation would be reduced to review and verification rather than replication. Although reduced documentation appears to be a time saver for physicians, it may conflict with quality incentive programs (e.g. MIPS) that depend on documentation in the medical record to demonstrate that physicians have done their quality reporting.

8. CMS proposes to **reduce Medicare reimbursement for new drugs** that are coming onto the market. Medicare payment for existing drugs is generally tied to the Average Sales Price (ASP) for drugs. The ASP includes both discounts and rebates. Because new drugs have no ASP, CMS determines Medicare reimbursement according to the Wholesale Acquisition Cost (WAC) – i.e. the manufacturer's list price, excluding discounts and rebates. Right now, Medicare adds 6% of the ASP or WAC to cover overhead, then deducts 2% for Medicare's share of the payment. The proposed change would reduce the new drug add-on to 3%, subject to the sequester cut, for 3 months.

9. **The appropriate use criteria (AUC) program** for advanced diagnostic imaging services requires ordering providers to consult a qualified decision support mechanism. The voluntary reporting period began in July 2018 and runs through December 2019. The program will begin in 2020 with an operations testing period. CMS is proposing hardship exceptions, establishment of coding mechanisms and allowing nonphysicians, under the direction of the ordering professional, to consult with the AUC when the ordering physician is not personally performing the consultation.

Potential Changes to Quality Reporting

1. When MACRA passed in 2015, Eligible Clinician (EC) included physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse anesthetists. Using its statutory authority to add new clinician types, CMS is proposing **additional EC categories in 2019**, including physical and occupational therapists, clinical social workers and clinical psychologists. The proposed expansion of EC would add approximately 650,000 clinicians.

2. CMS already has three criteria that **exclude low-volume clinicians** from the MIPS program. The 2019 proposal continues to exclude ECs and groups that bill $90,000 or less in Medicare Part B charges or that see 200 (up from 100 in 2018) or fewer Medicare beneficiaries or provide 200 or fewer covered professional services. It removes the current criteria for low-volume determination that is related to Part B drugs and offers a **new opt-in opportunity** for ECs and group practices that exceed one of the three low-volume threshold criteria and would like to participate in MIPS.

3. **MIPS scoring** would continue to be done on a scale from 0-100 based on data in four performance categories: quality (45 points); promoting interoperability (previously called advancing care information) (25 points); cost (15 points) and improvement activities (15 points). ECs and group practices would need to earn 30 out of the possible 100 points to avoid a reduction in Medicare reimbursement of up to 7% in 2021. The current threshold is 15 points. ECs and groups that earn more than 30 points would be eligible for a positive payment adjustment in 2021. The Bipartisan Budget Act of 2018 changes the application of the MIPS payment adjustments, applying them only to professional services and not to Part B drugs.

- Promoting Interoperability: moving away from base, performance and bonus scoring, CMS is proposing **performance-based scoring for each measure**, excluding those that require a yes/no response. ECs and groups would report on measures from four objectives and the scores would be combined to calculate an overall category score. CMS also proposes to remove the bonus for reporting certain improvement activities using CEHRT.

- The **cost category** would be worth 15 rather than 10% of the total MIPS score. CMS would continue to measure ECs and group practices on the total per capita cost and Medicare spending/beneficiary. There would be eight new episode measures that include only items and services related to the episode of care for a clinical condition or procedure rather than all services provided to a patient over time.

4. With respect to **technology**, CMS proposes to require use of **2015 CEHRT** beginning in 2019. This proposed changes may impact many ECs that currently use technology certified to the 2014 edition or to a combination of the 2014 and 2015 editions. The estimate of MIPS ECs that currently meet the 2015 CEHRT requirement is only 66%.

5. In response to advocacy by MGMA and other advocacy groups, CMS proposes to **expand the options for quality reporting**. It also proposes to allow third-party intermediaries to submit data on behalf of groups to the CMS Web Interface. Right now the CMS Web Interface is available to groups of 25 or more ECs, and CMS is considering lowering that requirement to groups of 16 or more. With respect to small practices, CMS proposes to limit the claims-based reporting to small practices with 15 or fewer ECs, allowing submission at the practice level.

6. A new **facility-based measurement for ECs** who perform at least 75% of their services in the hospital inpatient, on-campus outpatient or emergency department setting. With respect to groups, 75% or more of the ECs in the group would need to meet this standard.

Potential Changes at the State Level
Moving North Carolina's Medicaid Program to Managed Care

In 2015, the North Carolina General Assembly made the commitment (House Bill 372) to move away from the state's traditional fee-for-service Medicaid and Health Choice programs to Medicaid managed care. The goal is to shift the insurance risk of the program to multiple statewide and regional prepaid health plans (PHPs), embracing the concept of value-based care.

In October 2018, organizations submitted proposals to the NC Department of Health and Human Services (DHHS). Among them are many managed care plans and the Carolina Complete Health partnership between the North Carolina Medical Society (NCMS) and the NC Community Health Canter

Association and Centene Corporation. The evaluation committee, consisting of state employees with expertise in managed care, will award four statewide contracts for pre-paid health plans (PHP) in February 2019. The new system will be phased in on a regional basis. The target start date is November 2019, provided that CMS approves the required amended 1115 Waiver Application submitted in November 2017.

Organizations that are competing for the new contracts are already in the process of building their provider networks. Physicians and PAs will have the option of participating in multiple networks. Because credentialing will be centralized, they will not need to go through a separate credentialing process for each network. The pharmacy formula, like credentialing, will be centralized. With respect to the amount of the capitation payments, DHHS has contracted with Mercer Government Human Services Consulting (Mercer) to develop PHP capitation rates. The draft rate book for Year 1 is already available. The rates ensure 100% of the current Medicaid fee-for-service reimbursement rates.

More Information About Medical Practice Management

For more information on medical practice management, contact us at **Margie@satinskyconsulting.com** or **919.383.5998** or visit our website at **www.satinskyconsulting.com**.

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