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SPECIAL EDITION

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CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship

Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care

On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation's health care system and help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

"Today's reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost," said HHS Secretary Alex Azar. "Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS's proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork. Further, today's proposed reforms to how CMS pays for medicine demonstrate the commitment of HHS to implementing President Trump's blueprint for lowering drug prices. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based health care system for the 21st century and making prescription drugs more affordable."

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients," said CMS Administrator Seema Verma. "Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would also modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among health care providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the health care system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this clinician program with the proposed new "Promoting Interoperability" program for hospitals.

If these proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately \$2.6 million in reduced administrative costs in CY 2019.

Proposed CY 2019 PFS Key Changes:

The PFS establishes payment for physicians and medical professionals treating Medicare patients. It is updated annually to make changes to payment policies, payment rates and quality-related provisions. Extensive public feedback the agency has received has highlighted a need to streamline documentation requirements for physician services known as Evaluation and Management (E&M) visits, as well as a need to support greater access to care using telecommunications technology. The proposed changes to the PFS would reinforce CMS' [Patients Over Paperwork](#) initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients' ability to make decisions about their own care.

Streamlining E&M Payment and Reducing Clinician Burden:

CMS and the Office of the National Coordinator for Health Information Technology have heard from stakeholders that CMS's extensive documentation requirements for E&M codes have resulted in unintended consequences. To meet these documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes, in many cases reflecting very little about the patients' actual medical care or story.

Responding to stakeholder concerns, several provisions in the proposed CY 2019 PFS would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:

- Simplify, streamline and offer flexibility in documentation requirements for E&M office visits — which make up about 20 percent of allowed charges under the PFS and consume much of clinicians' time
- Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests
- Remove burdensome and overly complex functional status reporting requirements for outpatient therapy

Advancing Virtual Care:

"CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner," said Administrator Verma.

Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly. Provisions in the proposed CY 2019 PFS would support access to care using telecommunications technology by:

- Paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology
- Paying clinicians for evaluation of patient-submitted photos
- Expanding Medicare-covered telehealth services to include prolonged preventive services

Lowering Drug Costs:

President Trump is putting American patients first and lowering prescription drug costs, and CMS is committed to advancing this effort. CMS is proposing changes as part of the continued rollout of the Administration's blueprint to lower drug prices and reduce out-of-pocket costs. The changes would affect payment under Medicare Part B. Part B covers medicines that patients receive in a doctor's office, such as infusions. CMS is

proposing a change in the payment amount for new drugs under Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that CMS is taking to ensure that seniors have access to the drugs they need.

Proposed CY 2019 Quality Payment program Key Changes:

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the QPP, which consists of two participation pathways for doctors and other clinicians – 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 in risk-based payment models. The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of 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
- Overhauling the MIPS “Promoting Interoperability” performance category to support greater EHR interoperability and patient access to their health information, as well as to 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 clinicians and stakeholders, and we will continue to offer free and customized support from CMS’s technical assistance networks.

Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration:

Aligning with the agency’s goals of improving quality of care and responding to the feedback we have received from clinicians, 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 requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.

Some MA plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage. 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.

Price transparency: Request for information:

Finally, as part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for health care services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower health care consumers.

Public comments on the proposed rules are due by September 10.

For More Information:

- [Proposed Rule](#)
 - [Proposed Policy, Payment, and Quality Provisions Changes to the Medicare PFS for CY 2019](#) Fact Sheet
 - [Proposed Rule for the QPP Year 3](#) Fact Sheet
 - [MA Qualifying Payment Arrangement Incentive Demonstration](#) Fact Sheet
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