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News

News

Physician Fee Schedule and QPP: Changes to Advance Innovation, Restore Focus on Patients

On November 1, CMS finalized bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. The final 2019 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) rule also modernizes 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. It makes changes to ease health information exchange through improved interoperability and updates QPP measures to focus on those that are most meaningful to positive outcomes. The rule also updates some policies under Medicare's Accountable Care Organization program that streamline quality measures to reduce burden and encourage better health outcomes. This rule is projected to save clinicians $87 million in reduced administrative costs in 2019 and $843 million over the next decade.

"The historic reforms CMS finalized today move us closer to a health care system that delivers better care for Americans at lower cost," said HHS Secretary Alex Azar. "Among other advances, improving how CMS pays for drugs and for physician visits will help deliver on two HHS priorities: bringing down the cost of prescription drugs and creating a value-based health care system that empowers patients and providers."

"Today's rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community," said CMS Administrator Seema Verma. "Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America's seniors. Today's rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort."

Coding requirements for physician services known as "Evaluation and Management" (E/M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019), where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E/M coding reforms until 2021.

For the first time this rule will also provide access to "virtual" care. Medicare will pay providers for new communication technology-based services, such as brief check-ins between patients and practitioners and pay separately for evaluation of remote pre-recorded images and/or video. CMS is also expanding the list of Medicare-covered telehealth services. This will give seniors more choice and improved access to care.

In addition, the rule continues our work to deliver on President Trump's commitment to lowering prescription drug costs. Effective January 1, 2019, payment amounts for new drugs under Part B will be reduced, decreasing the amount seniors have to pay out-of-pocket, especially for drugs with high launch prices.

CMS is also finalizing an overhaul of Electronic Health Record (EHR) requirements in order to focus on promoting interoperability. The rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the QPP, part of the agency's implementation of MACRA, will advance the Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a health care facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

For More Information:

- Final Rule
- PFS Fact Sheet
- QPP Fact Sheet
- E/M Payment Amounts Chart

See the full text of this excerpted CMS Press Release (November 1).

DME and ESRD Programs: Policies to Modernize and Drive Innovation

On November 1, CMS finalized innovative changes to the Medicare payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) programs. The policies aim to increase access to items and services for patients, drive competition and increase affordability.

"The rule finalized today makes innovative changes to the Medicare payment rules for the durable medical equipment and end-stage renal disease programs. It also helps to ensure continued access to durable medical equipment and makes significant improvements to our competitive bidding system." said CMS Administrator Seema Verma. "Based on many comments we received on our DME proposal from suppliers, manufacturers and their associations -- all of whom supported our proposals -- we are implementing market-oriented reforms to Medicare's DMEPOS Competitive Bidding Program that also reduce burden on suppliers by simplifying the bidding process."

Improved Access to Durable Medical Equipment (DME)

The rule finalizes market-oriented reforms to the Medicare's DMEPOS Competitive Bidding Program (CBP). The final rule will increase beneficiary access to items and services, leverage opportunities to increase the program's effectiveness and better ensure the long-term sustainability of the DMEPOS CBP by streamlining the program and strengthening the bidding rules. Changes to the DMEPOS CBP that we finalized also will reduce burden on suppliers by simplifying the bidding process. This rule establishes lead item bidding, which means suppliers will only need to submit one bid per product category. In addition, the single payment amounts for items in each product category under the DMEPOS CBP would apply to the lead item in the product category. These changes streamline the program, enhance quality and access to innovative products, and help ensure the long term sustainability of the program and the savings it generates. Also, the rule finalizes increases in DMEPOS fee schedule rates, using a blend of adjusted and unadjusted fee amounts, in order to protect access to needed durable medical equipment in rural areas that are not subject to the DMEPOS CBP.

The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated and the current contracts for the DMEPOS CBP will expire on December 31, 2018. As a result,

starting January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, there will be a temporary gap period in the entire DMEPOS CBP and National Mail Order CBP that CMS expects will last two years until December 31, 2020. During that time, Medicare beneficiaries will continue to receive DMEPOS items from any Medicare-enrolled DMEPOS supplier and in most cases, they won't need to switch suppliers.

As required by the 21st Century Cures Act, this rule also finalizes Medicare fee schedule payments for DME furnished on or after January 1, 2019 in areas of the country where competitive bidding is not in effect. For more information, see the Temporary Gap Period fact sheet.

End-Stage Renal Disease Prospective Payment System

CMS is also taking steps to support innovation in Medicare's ESRD Prospective Payment System by expanding the Transitional Drug Add-on Payment Adjustment (TDAPA) for new ESRD drugs and biologicals, effective January 1, 2020. As the largest payer for kidney care, expanding TDAPA to all new renal dialysis drugs and biological products will help incentivize the development and use of transformative and innovative therapies.

Finally, this final rule takes significant steps forward by strengthening quality incentives, improving patient outcomes and reducing administrative burden. These changes advance the Patients Over Paperwork initiative and will allow doctors to spend less time on paperwork and more time with their patients. Based on stakeholder feedback, CMS reduced ESRD facility-related documentation burdens for the comorbidity payment adjustment so that the documentation requirements are more consistent with other payment systems. CMS also reduced the reporting burden for the ESRD Quality Incentive Program by finalizing a more limited measure set that better aligns with the CMS Meaningful Measures Initiative.

For More Information:

- Final Rule
- Fact Sheet

See the full text of this excerpted CMS Press Release (issued November 1).