Top Takeaways for Medicare Physician Payments in 2018

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One rule makes changes to the Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which dictates how physicians are paid for Medicare services. The other rule, the Physician Fee Schedule, sets Medicare physician payment rates and policies. Highlights from the two rules are discussed below.

MACRA Quality Payment Program

Under the MACRA Quality Payment Program, starting in 2019, physicians who provide Medicare services will be paid under one of two tracks. Most physicians participate in the Merit-based Incentive Payment System (MIPS), under which CMS adjusts physicians' Medicare payments based on their performance on specified metrics. On the other hand, physicians who demonstrate significant participation in certain advanced alternative payment models (APMs) are exempt from the MIPS requirements and potential payment adjustments, and instead may receive a lump-sum bonus payment. The first measurement year for the new program was 2017, and CMS provided significant flexibility to allow physicians to get used to its requirements while avoiding a payment cut.

CMS has now set its policies for the 2018 measurement year, which will impact physician payment in 2020. Key takeaways include:

- **CMS is continuing its gradual implementation of MIPS in 2018.** The MACRA statute requires CMS to measure physician performance in four categories – quality, cost, practice improvement, and advancing care information (i.e. use of a certified electronic health record (EHR)) – that each contribute to an overall performance score. However, in 2017, CMS did not measure cost performance. In 2018, CMS will begin to measure cost performance, but it will have a low impact on physicians' overall performance score. CMS also is allocating bonus points that will increase physicians'

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performance scores for things like demonstrating year-to-year improvement in quality or cost performance, treating complex patients, and reporting data as a solo practitioner or part of a small practice. Physicians will need to earn 15 points in 2018 to avoid a 2020 payment cut (up from 3 points in 2017). Potential 2020 payment adjustments under MIPS will be on a sliding scale from ±5 percent, based on 2018 performance.

- **More physicians will be excluded from MIPS in 2018.** MACRA exempts from MIPS physicians who provide a low volume of Medicare services. In 2017, physicians were exempt if they billed $30,000 or less in Part B allowed charges, or provided care to 100 or fewer Part B patients. For 2018, CMS has increased the low-volume threshold, to exclude physicians who bill $90,000 or less in Part B allowed charges or provide care to 200 or fewer Part B patients.
- **Solo practitioners and small physician groups have a new option to band together in "virtual groups."** Under this option, individual physicians and those practicing in groups of 10 or fewer physicians may voluntarily form a virtual group, regardless of specialty or practice location. This means that their combined performance will be assessed on quality and cost metrics, and the virtual group will be scored together in those categories. The benefits for those electing to participate in a virtual group include working together to improve cost and quality performance, while decreasing the likelihood that an outlier case has a serious negative impact on performance. CMS has put together a toolkit for those interested in virtual groups, available at its Quality Payment Program resource library. Physicians in a virtual group must elect participation by December 31, and must also execute a formal written agreement that includes rights and obligations of group participation.
- **Physicians can continue to use 2014 Edition certified EHR technology.** CMS will not require physicians to migrate to 2015 Edition certified EHRs, but instead will allow them to use the 2014 Edition or a combination of the 2014 and 2015 Editions to satisfy the advancing care information category

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requirements. Those who do use the 2015 edition exclusively in 2018 can earn a bonus 10 percentage points toward their performance score.

- **While options for Medicare advanced APM participation remain limited, CMS is gearing up for the "All-Payer Combination Option."** CMS did not make any changes under this year's rule that will significantly increase physician participation in advanced APMs. However, the agency has laid the groundwork for the all-payer option, which begins in performance year 2019 and will allow providers to receive credit for certain payment arrangements with non-Medicare payers (e.g. Medicaid and commercial payers) that are similar to Medicare advanced APMs.

Physician Fee Schedule

While most of the CMS action in Medicare physician payment has been through the Quality Payment Program, the agency did finalize some significant policies in the Physician Fee Schedule rule as well. These policies, which generally are effective beginning in 2018, include:

- **Appropriate Use Criteria for Advanced Diagnostic Imaging:** Section 218(b) of the Protecting Access to Medicare Act of 2014 requires CMS to establish a program to promote the use of appropriate use criteria among physicians and other professionals who order advanced diagnostic imaging services by requiring them to consult clinical decision support mechanisms (CDSM). The statute states that, beginning January 1, 2017, professionals who furnish advanced diagnostic imaging may only be paid for those services if they report on the Medicare claim information about the clinical decision support system consulted by the ordering professional. Because of the complexity of the new program, CMS did not meet the statutory deadline, instead implementing its requirements over the past couple of years. However, CMS has now finalized a start date for the program. Physicians may begin consulting available CDSMs during a voluntary participation period beginning in mid-2018 and running through 2019. In 2020, CMS will operate an

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"educational and operations testing year," during which the agency will make payment for advanced diagnostic imaging services regardless of whether the furnishing professional provides information regarding the CDSM consulted. Full implementation of the appropriate use criteria program is slated to begin in 2021.

- **Payment for telehealth services:** CMS finalized the addition of several new codes to the list of services that are payable when provided via telehealth, including:
- Counseling visit for lung cancer screening (HCPCS code G0296)
- Interactive complexity (CPT code 90785)
- Patient-focused and caregiver-focused health risk assessment (CPT codes 96160 and 96161)
- Chronic care management services including assessment and care planning (HCPCS code G0506)
- Psychotherapy for crisis (CPT codes 90839 and 90840)

CMS also finalized separate payment for CPT code 99091, which will allow providers to be reimbursed for time spent collecting and interpreting health data that are is generated by a patient remotely, digitally stored, and transmitted to the provider. Physicians must spend at least 30 minutes on these activities to bill the code, in addition to other requirements. This is significant because it is a first step by CMS to establish separate payment for remote payment monitoring services.

- **Medicare Diabetes Prevention Program:** This program began as a limited demonstration program under the Center for Medicare & Medicaid Innovation, but has been expanded to a permanent, nationwide program that begins in 2018. Its purpose is to provide a structured behavior change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. CMS finalized a number of policies related to this new program, including policies related to the services provided as part of the program, beneficiary eligibility criteria, the payment structure, and supplier enrollment requirements

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and compliance standards.

CMS also finalized a 20 percent payment cut to certain off-campus hospital outpatient provider-based departments, which are now paid under the Physician Fee Schedule under the site-neutral policy enacted in Section 603 of the Bipartisan Budget Act of 2015. More information on policies that will impact hospitals in 2018 and beyond are discussed in this blog post.

Frost Brown Todd's health care team is well positioned to advise you on how these federal policy changes may impact your practice. For more information, please contact Melissa Myers.

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