

AAWC ALERT – Call for Action from Physicians

The 2019 CMS Proposed Rule for the Physician Fee Schedule has multiple changes to payment & documentation requirements.

 See Attachment A for summary of major changes and how to send comments to CMS.

Letter to Doctors from CMS Administrator Seema Verma, Tuesday, July 17, 2018

Dear Doctor,

Thank you for the difference you make in your patients' lives. Many of our nation's best and brightest students go into medicine – the competition is intense for every spot. To become a practicing physician, you had to put in years of training, hours of studying, and long days and nights on the wards.

Your dedication and commitment have enabled you to join the profession that makes up the core of our health care system. But after years of education, training, and hard work, our system is not fully leveraging your expertise. **Instead, doctors today spend far too much of their time on burdensome and often mindless administrative tasks.**

From reporting on measures that demand that you follow complicated and redundant processes, to documenting lines of text that add no value to a patient's medical record, to hunting down records and faxes from other physicians and sifting through them, wasteful tasks are draining energy and taking time away from patients. Our system has taken our most brilliant students and put them to work clicking through screens and copying and pasting. **We have arrived at the point where today's physicians are burning out, retiring early, or even second-guessing their decision to go into medicine.**

In a recent Medscape survey of over 15,000 physicians, 42 percent reported burnout. Enough is enough. CMS's focus is on putting patients first, and that means **protecting the doctor-patient relationship.**

- ✓ **We believe that you should be able to focus on delivering care to patients, not sitting in front of at a computer screen.**

Washington is to blame for many of the frustrations with the current system, as policies that have been put forth as solutions either have not worked or have moved us in the opposite direction.

- **Electronic Health Records were supposed to make it easier for you to record notes, and the government spent \$30 billion to encourage their uptake.**
- **But the inability to exchange records between systems – and the increasing requirements for information that must be documented – has turned this tool into a serious distraction from patient care.**

CMS is committed to turning the tide.

President Trump has made it clear that he wants **all agencies to cut the red tape**, and CMS is no exception.

- Last year, we launched our **“Patients Over Paperwork” initiative**, under which we have been working to reduce the burden of unnecessary rules and requirements.
- **As part of this effort, we have proposed an overhaul of the Evaluation & Management (E&M) documentation and coding system to dramatically reduce the amount of time you have to spend inputting unnecessary information into your patients’ records.**
- E&M visits make up 40 percent of all charges for Medicare physician payment, so changes to the documentation requirements for these codes would have wide-reaching impact.

The current system of codes includes 5 levels for office visits – level 1 is primarily used by nonphysician practitioners, while physicians and other practitioners use levels 2-5. The differences between levels 2-5 can be difficult to discern, as each level has unique documentation requirements that are time-consuming and confusing.

We’ve proposed to move from a system with separate documentation requirements for each of the 4 levels that physicians use to a system with just one set of requirements, and one payment level each for new and established patients.

- Most specialties would see changes in their overall Medicare payments in the range of **1-2% up or down from this policy**
- **But we believe that any small negative payment adjustments would be**

outweighed by the significant reduction in documentation burden. If you add up the amount of time saved for clinicians across America in one year from our proposal, it would come to more than 500 years of additional time available for patient care.

- In addition to streamlining documentation, under the leadership of the White House's Office of American Innovation, **we are advancing the MyHealthEData Initiative which promotes the interoperability of electronic medical records.**
- Patients must have control of their medical information; and **physicians need visibility into a patient's complete medical record.**
- Having all of a patient's information available to inform clinical decision-making saves time, improves quality, and reduces unnecessary and duplicative tests and procedures.
- **CMS is taking action to make this vision a reality, including recently proposing a redesign of the incentives in the Merit-Based Incentive Payment System or "MIPS" to focus on rewarding the sharing of health care data securely with patients and their providers.**

We welcome your thoughts on our proposals, and we look forward to partnering with you to make them successful.

Patients and their families put their trust in your hands, and you should be able to focus on keeping them healthy. And to secure the future strength of our system, we must make sure that the nation's best students continue to choose to go into medicine.

We need your input to improve the health care system. Once again, thank you for your service to your patients.

Sincerely,

Seema Verma

ATTACHMENT A
Key Changes Proposed by the CMS for the Medicare
2019 Physician Fee Schedule Rules

- + Public comments due no later than 5 p.m. on September 10, 2018.
 - + (See instructions at conclusion of summary.)
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CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Proposed CY 2019 PFS Key Changes:

Several provisions in the proposed CY 2019 Physician Fee Schedule (PFS) Rule 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.

1. Streamlining E&M Payment and Reducing Clinician Burden:

Currently, to meet documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes. 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. Proposal would:

- Simplify and **offer flexibility in documentation requirements for E&M office visits.**
- **Reduce unnecessary physician supervision of radiologist assistants** for diagnostic tests.
- Remove **functional status reporting requirements for outpatient therapy.**

CMS has proposed:

- To **collapse payment** for office and outpatient **E&M visits Level 2-5.**
 - Payments would be blended for new patient office visit (99202-99205) to **\$135.**
 - Payments would be blended for established patient office visits (99212-99215) to **\$93.**
 - New codes would be **created** to provide add-on payments to office visits for specific specialties (**NOT specified which specialties**) to **(\$9)** and for **primary care physicians (\$5).**

- When physicians **report an E/M service and a procedure on the same date**, CMS proposes to implement a **50% multiple procedure reduction** to the lower paid of the

two services

- Documentation for history and exam will focus on **interval history since last visit**.
 - Physicians will be allowed to **review and verify** certain information in the medical record entered by ancillary staff or the beneficiary, rather than re-entering the information.
 - Implement new CPT codes and payment for **remote monitoring and interprofessional consultations** 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**.
- To replace existing documentation guidelines, CMS proposes to allow use of:
 - (1) 1995 or 1997 documentation guidelines;
 - (2) medical decision-making or
 - (3) time.

2. Advancing Virtual Care:

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**.

3. Lowering Drug 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.

- 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**.
- **Effective January 1, 2019**

4. Proposed CY 2019 Quality Payment program Key Changes:

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required 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 reported are low-value or low-priority, in order to **focus on meaningful measures that have a greater impact on health outcomes.**
- Overhaul MIPS “**Promoting Interoperability**” performance category to support **greater EHR interoperability and patient access to their health information.**
- Align this performance category for clinicians with the proposed **new Promoting Interoperability Program for hospitals.**
- CMS is continuing the gradual implementation of certain MIPS requirements to **ease administrative burden on clinicians.**

5. Proposals for Changes in the Merit-based Incentive Payment System (MIPS):

- Retain the low-volume threshold but **add a third criteria** of providing fewer than 200 covered professional services to Part B patients.
- Retaining bonus points for:
 - Care of complex patients
 - End-to-end reporting
 - Small practices
- Allowing eligible clinicians to opt-in if they meet one or two, but not all, of the low volume threshold criterion.
- Consolidating the low-volume threshold determination periods with the determination period for identifying a small practice.
- Eliminate the base and performance categories and reduced the number of measures in the Promoting Interoperability category.
- Require Eligible clinicians to move to 2015 CEHRT.
- Providing the **option to use facility-based scoring for facility-based clinicians.**

Proposed weights for 2019 performance year:

- **Quality** - 45% [*currently 50%*]
- **Cost** - 15% [*currently 10%*]
- **Promoting Interoperability** – 25% [*currently 25%*]
- **Clinical practice Improvement activities**- 15% [*currently 15%*]

Bipartisan Budget Act of 2018 provided additional flexibility for CMS on several MIPS issues including:

- Excluding Medicare Part B drug costs from MIPS payment adjustments and from the low-volume threshold determination;
- Allowing CMS to reweight the cost performance category to not less than 10% and

- not more than 30% for 2019-2021 performance years;
- Allowing CMS flexibility in setting the performance threshold for performance years 2019-2021 to provide a **gradual and incremental transition for physicians**.

6. Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration:

CMS **proposes waivers of MIPS requirements** as part of testing a demonstration called the **Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration**.

- Test waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs. 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.

7. Price transparency: Request for information:

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 Rule due by September 10.
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 **Submit electronic comments:** Attention: CMS-1693-P @ <http://www.regulations.gov>.

 **Submit mail written comments:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P, P.O. Box 8016, Baltimore, MD 21244-8016.