Digital medicine, QPP pushed ahead in 2019 Medicare final rules

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The Centers for Medicare & Medicaid Services (CMS) released combined final rules establishing 2019 Medicare physician fee schedule and Quality Payment Program (QPP) policies.

CMS set the 2019 physician fee schedule conversion factor at $36.0391, and the anesthesia conversion factor is $22.2730. Read the AMA summary of the 2019 fee schedule and QPP final rules.

Digital medicine payment

Due to AMA advocacy efforts, CMS embraced digital medicine in the fee schedule. The agency expanded access to medical care using telecommunications technology, including virtual check-ins, and established separate payment for interprofessional internet consultations.

CMS also lifted restrictions for certain telehealth services, such as home dialysis treatment, and added the patient's home as a permissible originating site for telehealth services furnished to treat substance-use disorders or co-occurring mental health disorders, effective July 1.

CMS finalized its proposal to reduce add-on payments for new part B drugs from 6 percent to 3 percent (before sequestration) until the drug has sufficient data to move to reimbursement based on average sales price. That price can typically be determined after the first quarter the drug is on the market.

Pursuant to extensive AMA Advocacy, CMS moved forward on policies to reduce documentation requirements, such as allowing physicians to verify the history of present illness already recorded by ancillary staff. In addition, the agency postponed payment changes to E/M services until 2021, giving the AMA-convened E/M workgroup time to recommend a better solution. Read more about the E/M changes.

APM risk model stable

The agency maintained reduced reporting requirements for small practices in the Merit-based Incentive Payment System (MIPS). CMS overhauled the Promoting Interoperability category—formerly called Advancing Care Information—to move away from the pass/fail scoring system and eliminated many measures.

That includes measures that were outside the physician's control, such as whether a patient viewed their records. The agency also created an opt-in choice for physicians who fall below the low-volume threshold to participate in MIPS and earn an incentive or receive a penalty.

CMS agreed not to increase the financial risk requirement for alternative payment models (APMs), currently set at 8 percent of revenues, for at least the next six years. In response to AMA advocacy aimed at helping physicians who practice in areas with an above-average proportion of patients in Medicare Advantage plans, CMS waived MIPS reporting and payment adjustments for physicians participating in Medicare Advantage APMs, effective in 2018.

QPP leads to bonuses

CMS has released new information showing that 93 percent of clinicians eligible for MIPS in its first year, 2017, will receive positive incentive payments in 2019, with about three quarters of them qualifying for an "exceptional" performance bonus. In addition, nearly 100,000 clinicians who participated in advanced APMs in 2017 will receive a 5 percent lump-sum bonus payment in 2019.

Physicians in small and rural practices also scored well in the first year of MIPS. Although the mean MIPS score in 2017 for small and rural practices was about 45, compared with 74 for large practices, ninety-three percent of rural and 74 percent of small practices earned a positive incentive payment.