Nov. 15, 2018: National Advocacy Update

2019 Medicare final rules include QPP changes and advance digital medicine

CMS released combined final rules establishing 2019 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) policies. CMS set the 2019 PFS conversion factor at $36.0391 and the anesthesia conversion factor is $22.2730. Read the AMA's summary (PDF).

Due to AMA advocacy efforts, CMS embraced digital medicine in the PFS. 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 (ASP). ASP can typically be determined after the first quarter the drug is on the market.

Pursuant to extensive AMA Advocacy, CMS 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 in the issue spotlight feature of this week's *Advocacy Update*.

The agency maintained reduced reporting requirements for small practices in the Merit-based Incentive Payment System (MIPS). CMS overhauled the Promoting Interoperability (formerly, Advancing Care Information) category to move away from the pass/fail scoring system and eliminated many measures, including ones that were outside the physician's control, such as whether a patient viewed their records. The agency also created an opt-in option 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.

Quality Payment Program leads to positive incentive payments

CMS has released new information (PDF) 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 five 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 to 74 for large practices, 28 percent of rural and 30 percent of small practices earned a positive incentive payment in 2017. An additional 65 percent of small practices and 44 percent of rural practices qualified for an exceptional performance bonus.

Highlights from the 2018 AMA Interim Meeting

This year's AMA Interim Meeting addressed a wide range of clinical practice, payment, public health topics and more, including:

- Physicians again forcefully spoke out on gun-violence policy
- Sex ed should include age-appropriate content on bullying, consent
- AMA moves to protect income-based loan repayment programs
- Vaping is an epidemic and the FDA must act
- Front-of-package labels on food products need transparency
- Eight ways to promote affordable access to high-value care

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