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CMS Finalizes Changes to Advance Innovation, Restore Focus on Patients

Changes to the Medicare Physician Fee Schedule and Quality Payment Program will shift clinicians' time from completing unnecessary paperwork to providing innovative, high-quality patient care

Today, the Centers for Medicare & Medicaid Services (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bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices.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 released today 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. Today's rule also updates some policies under Medicare's accountable care organization (ACO) program that streamline quality measures to reduce burden and encourage better health outcomes, although broader reforms to Medicare's ACO program were proposed in a separate rule. 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 healthcare system that delivers better care for Americans at lower cost," said Health and Human Services (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 healthcare 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 CMS's 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. Today's rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the Quality Payment Program, part of the agency's implementation of MACRA, will advance CMS's 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 (MIPS) program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a healthcare facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

To view the CY 2019 Physician Fee Schedule and Quality Payment Program final rule, please visit: https://www.federalregister.gov/public-inspection/

For a fact sheet on the CY 2019 Physician Fee Schedule final rule, please visit: https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

For a fact sheet on the CY 2019 Quality Payment Program final rule, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

For a chart on E&M payment amounts, please visit: https://www.cms.gov/sites/drupal/files/2018-11/11-1-2018%20EM%20Payment%20Chart-Updated.pdf

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