CHANGES PROPOSED FOR 2019, SUMMER 2018 "SURPRISES," AND APM UPDATES

In this installment, I will briefly review the proposed revisions to the 2019 Physician Fee Schedule (PFS) that will be finalized in November, APM updates, a couple of emerging options for proceduralists, and some "summer surprises." The conversion factor will be $36.0463 for RBRVS codes and $22.2986 for anesthesia, which is a 0.25% update but offset by a budget neutrality adjustment of -0.12% resulting in an actual 0.13% update. What a windfall! CMS is proposing to update supply and equipment pricing gradually over four years, create a single indirect practice expense per hour of $136.34 for E/M services, and seeking ways to better reflect specialty and state-level professional liability insurance (PLI) relative values into the PLI RVU component. There are also proposal requests to recognize and integrate telecommunication between both patients and physicians, removal of the requirement to document medical necessity of providing a home visit rather than in the office, and eliminating the prohibition on same day E/M visits by physicians with the same group or medical specialty.

However, the proposal that has drawn the most attention and concern is the proposal to condense payment amounts for Level 2 through 5 office visits for both new and established patients while retaining the codes. There are concerns over still having to determine, and document, the proper code albeit removing the financial risk for miscoding since there would be no financial impact, which may have the effect of reducing incentives to do RAC audits. The proposed payment for the 99201 and 99211 payments would go from $45 to $43 and $22 to $24 respectively. The 99202 to 99205 codes would go from $76, $110, $167, and $211 to a single rate of $134. The 99212 to 99215 codes would go from $45, $74, $109, and $148 to a single rate of $92. Ten specialties that more often report higher level office visits will be paid an extra $14 if they use the new ode GCG0X. Podiatry will have a new unique code and no longer report the 99201-99215 codes. The financial impact for condensing the codes is estimated from +4% to -4%. However, when coupled with the multiple procedure payment reduction (MPPR) policy, the actual changes for office visits range from -20% to +18%. As a general observation that while not justified is not surprising, this will disproportionately impact higher acuity practices and those who tend to perform multiple services during the visit. For instance, podiatry decreases 4% with the collapsed codes and another 8% with MPPR for a total decrease of 12%. Some high acuity specialties such as endocrinology that don't tend to provide multiple services remain materially unchanged.

For Low-Volume Threshold practices, CMS proposes to add a third criterion of providing fewer than 200 covered professional services to Part B non-Medicare Advantage patients. I must admit I don't understand how this moves the needle since I am assuming there is at least one service per patient visit and the number is the same to qualify under either the service or beneficiary threshold. This is in addition to < $90,00 in allowable Part B charges or < 200 beneficiaries. They are also proposing a new opt-in policy for MIPS as long as one does not meet all three exclusionary criteria.

While those of you in primary care have the statutory option of a Patient Centered Medical Home (PCMH), most of you in small to medium size practices are not able to participate due to the regulatory hurdles and expense to get and maintain the official designation despite doing most, if not all, the various steps. A Rand study found that the PCMH transformation cost varied widely but the median was ~$65,000 per clinician. As in earlier years, most of the 2019 changes are still in the MIPS bucket, but there are some that apply to the APM realm. The earlier requirement that practices bear "more than nominal risk" for monetary losses, which was defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures will be in the second year of its two-year extension. There had been earlier discussion of increasing this to 15% so this was good news, and I am unaware of any current proposed changes. On June 13, 2018, HHS Secretary Azar announced none of the twelve APMs put forth by PTAC will be implemented as proposed. PTAC's comments and recommendations are the first step in the process and then provided to the Secretary for consideration and approval so this announcement was a disappointment to many and places those plans in limbo.

The ACS-Brandeis Advanced APM was submitted by the American College of Surgeons and accepted in May 2017 for limited-scale testing and is very applicable to those involved in procedural specialties. The link to their website for a deeper dive is: https://aspe.hhs.gov/system/files/pdf/253406/TheACSBrandeisAdvancedAPM-ACS.pdf. One of the four stipulations by PTAC at the time of approval was that "the algorithms and construct of the episode grouper, which is the lynchpin of the model, should be made publicly available; and a mechanism should be in place for continuous update of the grouper so that it remains current with advances in healthcare." It is my understanding that they are working to create aspects of the model as a public utility for all to use. In May one of the prominent State Surgical Quality Collaboratives met with CMMI to promote a multi-state pilot based on PSH and ERAS principles. The meeting reportedly went well and is still in the process of evaluation. Hopefully, we will have further updates later this fall …. But then again, I expected updates last year!

Two summer "surprises" may impact or predict trends in the development of APMs. On July 26, CMS proposed "site neutral payments" whereby payments for clinic visits by hospital and ambulatory physicians would be paid at the Physician Fee Schedule (PFS) rate beginning in 2019. This is the most common code group paid by Medicare and will result in a 2/3 cut to hospital and ambulatory-employed practices that will gut the primary foundation for facility-owned medical practices. The bottom line impact is a reduction from an average of ~$116 with a $23 co-pay to $46 with a $9 co-pay per visit. For example, if a facility-employed physician PCP saw 5,250 patients with a 45% Medicare market share, the revenue impact is ($165,375) per physician. This saves Medicare about $760M and patients due to lower copays for the same service $150M. While you might think this will never pass, there is an election in less than two months where out of pocket medical costs are an issue. While our AMA advocates for site of service neutrality, we are advocating for increases and updates to office-based physician services; we are opposed to decreasing everyone to the lowest common denominator. Unfortunately, some physician groups will hail this as a step forward from the perspective of decreasing the incentive for facilities to acquire physician practices. It is better for all to experience a rising tide rather than celebrating everyone at a low and unsustainable tide. This would be a tremendous opportunity for physicians to speak with one voice for a common goal. Comments by one hospital-friendly consulting giant noted that this might be a mixed blessing because it would force physicians to come to the table to quit resisting ACO and bundled payment initiatives in order to stabilize the system. This comes on top of the loss of 340B pharmaceutical income of $320M and potential impact of compensation changes secondary to the condensing of the E/M codes and MPPR discussed above that will probably disproportionately impact facility-based practices. These developments total well over $1B and will place extreme financial pressure on facilities thereby highlighting and placing pressure on compensation for service agreements as they try to rebalance their portfolio of services to achieve budgetary stability in a very narrow time frame.

On August 9, the other game-changer was announced by CMS Administrator Seema Verma, which was "Pathways to Success" for Medicare Shared Savings Program (MSSP) ACOs. She noted that it was time for the program to evolve. The evolution is the number of tracks would be consolidated from the current four to two: one "basic," the other "enhanced." The structure of the "basic" path is two years of "upside-only" shared risk followed by three years of gradually increasing two-sided risk. The fifth year in the basic track would meet the standard to qualify as an advanced alternative payment model. The current Track One option with upside-only risk in multiple three-year cycles is gone. The key factoid is that 82% of MSSP participants are Track One and wrote a letter in February 2018 to Administrator Verma that they are not ready to assume risk albeit in the sixth year (second cycle) for many of them. This will call the question for many and may result in an accelerated and disruptive transition to risk products and maturation of existing ACOs since they will want to qualify as an "advanced" APM. These two developments will certainly qualify as disruptive innovation! However, now is the time to evaluate your options for the future – be the leader as you offer constructive solutions to their crisis and a pathway to success.

Hopefully, the comment period will still be open when this is published. These represent substantial changes to your practice environment and likely to either directly or indirectly influence your personal practice as well as stability within your community and referral base. These changes will come into play either in total, or in part if revised, well after capital budgets and professional service contracts have been formulated for both the current and near-term cycles. I feel the potential for severe disruption is not an unlikely scenario since the amounts are so great and tactically coming from so many different directions where the chances of collective unintended consequences increase dramatically. As the flight attendants tell you, "Place your tray table in the full upright position, fasten your seat belts, and prepare for takeoff."

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