

# Summary of 2019 changes to the Medicare Physician Fee Schedule, Quality Payment Program, and other federal programs

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## Introduction

On November 23, 2018, the Centers for Medicare & Medicaid Services (CMS) published Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Part B for Calendar Year (CY) 2019, including Revisions to the Quality Payment Program (QPP). The [final rule](#) updates payment rates and policies for services supplied under the PFS on or after Jan. 1, 2019. Access the [CMS press release](#) for more information and links to relevant fact sheets.

## I. Updates to the Physician Fee Schedule (PFS)

### Regulatory Impact Analysis

For this final rule to maintain budget neutrality, the finalized 2019 conversion factor is **\$36.0391**. Internal medicine will remain neutral without a negative or positive impact. According to Table A below (based on Table 94 in the final rule), the overall estimated impact on total allowed charges for internal medicine and its subspecialties will be:

**Table A: Overall estimated impact on total allowed charges for internal medicine and subspecialties**

| Specialty           | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact** |
|---------------------|-----------------------|----------------------------|--------------------------|--------------------------|-------------------|
| ALLERGY/IMMUNOLOGY  | \$239                 | 0%                         | -1%                      | 0%                       | -1%               |
| CARDIOLOGY          | \$6,616               | 0%                         | 0%                       | 0%                       | 0%                |
| CRITICAL CARE       | \$342                 | 0%                         | -1%                      | 0%                       | -1%               |
| ENDOCRINOLOGY       | \$482                 | 0%                         | 0%                       | 0%                       | 0%                |
| GASTROENTEROLOGY    | \$1,754               | 0%                         | 0%                       | 0%                       | 0%                |
| GERIATRICS          | \$197                 | 0%                         | 0%                       | 0%                       | 0%                |
| HEMATOLOGY/ONCOLOGY | \$1,741               | 0%                         | -1%                      | 0%                       | -1%               |
| INFECTIOUS DISEASE  | \$649                 | 0%                         | 0%                       | 0%                       | -1%               |
| INTERNAL MEDICINE   | \$10,766              | 0%                         | 0%                       | 0%                       | 0%                |
| NEPHROLOGY          | \$2,188               | 0%                         | 0%                       | 0%                       | 0%                |
| NEUROLOGY           | \$1,529               | 0%                         | 0%                       | 0%                       | 0%                |
| PEDIATRICS          | \$61                  | 0%                         | 0%                       | 0%                       | 0%                |
| PULMONARY DISEASE   | \$1,714               | 0%                         | 0%                       | 0%                       | 0%                |
| RHEUMATOLOGY        | \$541                 | 0%                         | 0%                       | 0%                       | 0%                |

## Impact by Specialty

According to Table B below (based on Table 103 of the final rule), the total estimated impact on internal medicine and its subspecialties of finalizing single PFS rates for office/outpatient Evaluation and Management (E/M) Levels 2-4 and other finalized policies with the exception of the PE per hour adjustment and the G-codes for podiatric visits would be:

**Table B: Total estimated impact on internal medicine and related subspecialties of finalized E/M policies excepting the PE per hour adjustment and G-codes for podiatric visits**

| Specialty           | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact** |
|---------------------|-----------------------|----------------------------|--------------------------|--------------------------|-------------------|
| ALLERGY/IMMUNOLOGY  | \$239                 | 1%                         | 1%                       | 0%                       | 1%                |
| CARDIOLOGY          | \$6,618               | 0%                         | -1%                      | 0%                       | -1%               |
| CRITICAL CARE       | \$342                 | -1%                        | -1%                      | 0%                       | -2%               |
| ENDOCRINOLOGY       | \$482                 | 0%                         | -1%                      | 0%                       | -1%               |
| GASTROENTEROLOGY    | \$1,757               | -1%                        | 0%                       | 0%                       | -2%               |
| GERIATRICS          | \$197                 | 0%                         | 0%                       | 0%                       | -1%               |
| HEMATOLOGY/ONCOLOGY | \$1,741               | 1%                         | 0%                       | 0%                       | 1%                |
| INFECTIOUS DISEASE  | \$649                 | -1%                        | -1%                      | 0%                       | -2%               |
| INTERNAL MEDICINE   | \$10,767              | 0%                         | 0%                       | 0%                       | 1%                |
| NEPHROLOGY          | \$2,190               | -2%                        | -1%                      | 0%                       | -2%               |
| NEUROLOGY           | \$1,529               | 0%                         | 0%                       | 0%                       | 0%                |
| PEDIATRICS          | \$61                  | 1%                         | 0%                       | 0%                       | 1%                |
| PULMONARY DISEASE   | \$1,715               | -2%                        | -1%                      | 0%                       | -3%               |
| RHEUMATOLOGY        | \$541                 | -1%                        | -1%                      | 0%                       | -2%               |

## Evaluation and Management (E/M) Visits

### Documentation Changes

Effective starting in 2019, CMS finalized reducing redundant documentation and eliminating extra documentation for home visits, which ACP recommended for immediate implementation. CMS will continue the current coding and payment structure for E/M office/outpatient visits. Physicians should continue to use either the 1995 or 1997 versions of the E/M guidelines to document E/M

office/outpatient visits. Starting Jan. 1, 2019, when relevant information is already contained in the medical record, clinicians will only be required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. Clinicians must still review prior data, update as necessary, and indicate this in the medical record.

Beginning in 2021, for E/M office/outpatient Levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented, specifically a choice to use the current framework (1995 or 1997 documentation guidelines), medical decision making (MDM), or time.

### Payment Changes

The table summarizing finalized 2019 relative value units (RVUs) can be found in Appendix 1 on page 21 of this document.

Following strong pushback from ACP and other stakeholders, CMS imposed a two-year delay in implementing E/M code proposals to pay a single rate for office/outpatient visits (they will be implemented in 2021). During this delay, the Agency is willing to consider additional feedback from stakeholders and further refine the policies before they are implemented. As explained in greater detail below, CMS finalized several changes to payment, coding, and associated documentation rules for E/M office/outpatient visits **set to become effective in 2021**, including:

- Changes to office/outpatient E/M visit codes including a single rate for E/M office/outpatient visit levels 2, 3, and 4 (one for established and another for new patients). CMS will also apply a minimum supporting documentation standard associated with Level 2 visits when clinicians use the current framework or MDM to document the visit.
- New add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of specialized medical care. These add-on codes will only be reportable with E/M office/outpatient Levels 2-4 visits, and their use generally will not impose new per-visit documentation requirements.
- A new “extended visit” add-on code for use only with E/M office/outpatient Levels 2-4 visits to account for the additional resources required when physicians need to spend extended time with the patient.

Rather than establish single payment rates for visit Levels 2-5, as originally proposed, the final rule establishes single blended payment rates for Levels 2-4 (one for new patients and one for established patients) with Level 5 visits remaining separate. The Level 5 visits will remain at current payment amounts and require documentation that meets Level 5 visit guidelines, though they will be able to choose from any of the three new documentation options (current 1995 or 1997 guidelines, medical decision making, or time). This change came in response to concerns raised by ACP and others.

CMS finalized a new “extended visit” add-on for prolonged services that can be billed in addition to the primary care or specialty add-on code. The new extended visit add-on is not eligible to be used on Level 5 visits, but the existing prolonged services codes may continue to be used.

CMS also finalized several add-on codes for primary care, certain specialties, and prolonged services that may be billed with Levels 2-4 visits. The primary care and specialty add-ons can be billed with Levels 2-4 visits for new or established patients and recognize additional relative resources for primary care visits

and inherent visit complexity that require additional work. The new primary care code **GPC1X** is used for established patient visits is intended to reflect visit complexity inherent to primary medical care services that serve as the continuing focal point for all needed health care services. GPC1X can also be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions that are not already accounted for by other coding. The new specialty code **GCG0X** is intended to reflect visit complexity for specialties that apply predominantly non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic diseases.

The Agency accepted ACP's recommendation that the primary care and specialty codes be valued the same, valuing both codes at approximately \$13. In the proposed rule, the primary care add-on was approximately \$5 and the specialty add-on was \$14. CMS also made positive changes to the code descriptions in response to ACP comments, including that the primary care code can now be billed with new patient visits in addition to established patient visits and the specialty code description includes additional specialties and can be used during non-procedural specialty care visits. ACP called attention to the fact that the add-on codes do not alone adequately account for the intense cognitive nature of visits provided by internal medicine physicians and subspecialists and will continue to advocate for additional changes to the E/M payment structure to value cognitive services more appropriately.

Following concerns raised by ACP and others, CMS did not finalize its proposal to move forward with a multiple procedure payment reduction (MPPR) to fund E/M payment policy changes and new add-ons.

#### **Indirect Practice Expense (PE) per Hour Data**

While no changes were finalized in this rule, CMS is considering updating the data source used to calculate indirect PE in response to concerns raised by ACP and others that the Physician Practice Information Survey (PPIS) that is currently used is outdated and distorts PE RVUs. Specifically, ACP recommended that CMS proceed with another physician PE survey utilizing available funds dedicated to improving the relativity and allocation within the Resource-based Relative Value Scale (RBRVS).

#### **New separately reimbursable codes for communication technology-based services**

CMS finalized several new, separately reimbursable codes for interprofessional telecommunication consultations and communication-technology based services. The table of finalized 2019 RVUs including these new service codes can be found in Appendix 1 starting on page 21 of this document. Cost sharing will apply so prior to billing for these communication technology-based codes, the treating physician must document patient consent in the medical record.

CMS finalized six codes pertaining to interprofessional telecommunications consultations (99446, 99447, 99448, 99449, 99451, and 99452). Codes 99446-99449 are time-based and entail interprofessional telephone or internet assessment and management services provided by a consulting physician, including verbal and written report to the patient's treating/requesting physician or other qualified health care professional. Code 99451 entails a brief (5 min.) interprofessional assessment and management via telephone, internet or (new in 2019) EHR by the consulting physician to a patient's treating physician. Code 99452 entails interprofessional referral services via telephone, internet, or EHR by a requesting/treating physician or other qualified health professional.

CMS also established two G-codes for communication technology-based services. These services must be rendered to established patients and did not original from a related E/M service provided within the

previous seven days or leading to an E/M service or procedure within the following 24 hours or soonest available appointment and include:

- **G2012:** “Virtual” office visit e.g. when a physician or other qualified health care professional has a brief (e.g. 5-10 minute) non-face-to-face check-in with a patient via communication technology to assess whether the patient’s condition necessitates an office visit.
- **G2010:** Remote evaluation of pre-recorded video and/or images submitted by a patient including interpretation with follow-up with the patient within 24 business hours. Services under this Current Procedural Terminology (CPT) code would be exempt from existing 1834(m) Medicare telehealth restrictions.

### **Recognizing Communication Technology-Based and Remote Evaluation Services for RHCs and FQHCs**

CMS finalized payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit. These services will be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous 7 days or within the next 24 hours or at the soonest available appointment. RHCs and FQHCs will be able to bill for these services using a newly created RHC/FQHC Virtual Communication Service Healthcare Common Procedure Coding System (HCPCS) code **G0071** with payment set at the average of the PFS national non-facility payment rates for communication technology-based services and remote evaluation services.

### **Expanding telehealth services for treatment of Substance Use Disorders (SUDs)**

CMS is implementing a provision from the SUD Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of an SUD or a co-occurring mental health disorder for services furnished on or after July 1, 2019. Additionally, the SUPPORT Act establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs under Medicare Part B, beginning on or after Jan. 1, 2020.

### **Payment rates for non-excepted off-campus Provider-Based Hospital Departments (PBD)**

CMS will continue to pay for items and services furnished in non-excepted off-campus PBDs under the PFS at 40% of OPPS rates. In the separate [2019 Hospital Outpatient Prospective Payment System and ASC final rule](#), CMS also finalized several site neutral policies including reimbursing clinic visit services provided at off-campus PBDs at PFS rates, which is expected to save beneficiaries an estimated \$380 million in reduced copays in 2019 and was supported by ACP. CMS also added several services that will now be covered by Medicare when performed in ASCs.

### **Therapy services**

CMS established two new modifier codes for outpatient physical therapy (PT) and occupational therapy (OT) services that are furnished wholly or in-part by a therapy assistant. CMS defines “in-part” as when more than 10% of the service is provided by the PT assistant or OT assistant. The new codes are payment modifiers, rather than therapy modifiers so that they may be used alongside existing service modifiers to prevent coding disruptions. The codes are “CQ” and “CO” for PT and OT services

respectively and will be reimbursed at 85% of the Part B allowed payment amounts. The modifier codes will be required starting in 2020 but the payment reduction will not take effect until 2022. CMS also discontinued functional reporting requirements for outpatient therapy services effective 2019. However, the Agency will retain the HCPCS G-codes until 2020 to allow time to update billing systems.

The Bipartisan Budget Act of 2018 (BBA) repealed Medicare outpatient therapy caps but requires use of an appropriate modifier (such as KX) after a beneficiary's outpatient therapy services have exceeded one of the previous annual cap amounts to ensure therapy services are being furnished appropriately. In 2019, the KX modifier threshold amount for OT services and combined PT and speech language pathology (SLP) services will be increased to \$2,040, up from \$2,010. Targeted medical reviews will continue to be triggered at \$3,000 for OT services and for combined PT and SLP services.

### **Application of an add-on percentage for Wholesale Acquisition Cost (WAC)-based payments**

Drugs and biologics paid for under the Medicare Part B benefit include a 6% add-on which is typically applied to the average-sales price (ASP), but in certain limited circumstances such as when a drug is new to the market, this 6% add-on is applied to the wholesale acquisition cost (WAC) which is not inclusive of rebates, discounts, or reductions in price and is consequently typically higher than the ASP. Effective starting in 2019, WAC-based payments will utilize a 3% add-on in place of the current 6% add-on with a limited exception for single-source drugs under section 1847A(b) of the Social Security Act.

### **Clinical Laboratory Fee Schedule (CLFS)**

CMS will expand the number of laboratories that meet the definition of an applicable laboratory and must report data by removing Medicare Advantage (MA) plan revenues from the calculation of the majority of Medicare revenues threshold which increases the likelihood that a laboratory's CLFS and PFS revenues constitute a majority of its Medicare revenues for laboratories that have a significant amount of MA patients. To capture more hospital outreach laboratories, CMS will also include revenue listed on Form CMS-1450 for the 2019 and 2020 data collection periods. Hospital outreach laboratories will still be able to obtain a separate billing National Provider Identifier (NPI) and use that to qualify as an applicable laboratory. CMS declined to finalize any changes to the low expenditure threshold but will continue to evaluate this policy in the future given stakeholder concerns that most physician office and small independent laboratories are excluded under this threshold, possibly skewing the data.

### **Appropriate Use Criteria (AUC) for advanced diagnostic imaging services**

CMS maintained the previously established 2020 implementation date for AUC for certain advanced diagnostic imaging but finalized a number of changes to previously established policies. Independent diagnostic testing facilities (IDTFs) will now be included in the definition of applicable settings for furnishing advanced diagnostic imaging services. CMS will allow consultation with AUC to be performed by clinical staff working under the direction of the ordering clinician when not performed personally by the ordering clinician, provided they have sufficient clinical knowledge to interact with the CDSM and communicate with the ordering professional. To facilitate implementation by Jan. 1, 2020, CMS will use a combination of G-codes and modifiers to report the AUC information on claims but will consider creating a unique consultation identifier in the future. CMS also clarifies that AUC consultation information must be reported on all claims for an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system, including claims from the furnishing professionals and from facilities for the professional and technical components.

CMS finalized hardship exceptions unique to the AUC program. Clinicians are not required to include AUC information if they have insufficient internet access, EHR or CDSM vendor issues, or extreme and uncontrollable circumstances. To claim hardship exceptions, ordering physicians must attest that they are experiencing a significant hardship at the time that they place an order for imaging services and provide information on the hardship to the furnishing physician, along with the AUC consultation information. The furnishing clinician would then add a modifier to the claim indicating that the ordering physician experienced a hardship exception. Information on the AUC consultation is not required on the claim in these instances.

### **Medicaid Promoting Interoperability Program Requirements**

CMS finalized for the 2019 Medicaid Promoting Interoperability (PI) Program the same framework, objectives, and measures as Stage 3 Meaningful Use. The Agency made modifications to some of the Stage 3 measure thresholds but did not address the difference in requirements for clinicians participating in the Medicaid versus Medicare PI Programs. CMS did align the electronic Clinical Quality Measures (eCQMs) and quality measure requirements for the Medicaid PI program with the PI and Quality Categories within MIPS.

### **Physician Self-Referral (“Stark”) Law**

Pursuant to changes under the BBA, CMS codified changes to the writing and signature requirements for specific billing and referral exceptions to allow compensation arrangement writing requirements to be satisfied by a collection of documents evidencing the course of conduct between the parties. CMS will allow for temporary noncompliance in compensation arrangement exceptions with signature requirements. The signature requirement will be satisfied if (1) the signatures are obtained within 90 calendar days of noncompliance; and (2) the compensation arrangement otherwise complies with requirements of the exception. These changes will be effective starting Jan. 1, 2019. The restriction on invoking the special rule only once every three years has also been lifted effective Feb. 9, 2018.

## **II. Updates to the Quality Payment Program (QPP)**

### **Participation Estimates**

CMS estimates that in 2019, between 165,000 and 220,000 clinicians will become Qualifying Advanced Alternative Payment Model (APM) Participants (QP), which exempts them from MIPS and qualifies them for a 5% incentive payment. CMS estimates that approximately 798,000 clinicians will be MIPS eligible clinicians (ECs) in 2019, representing an increase due in part to the new opt-in option for ECs previously excluded under the low-volume threshold and new clinician types added to the list of MIPS ECs. Approximately \$390 million is expected to be collected in penalties and redistributed in bonuses under standard MIPS payment adjustments in addition to an additional \$500 million that will be allocated to exceptional performers.

### ***Merit-Based Incentive Payment System (MIPS)***

#### **MIPS Eligible Clinicians (ECs)**

In addition to the existing EC types which includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, CMS added physical therapists,



occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals to the list of MIPS ECs. CMS did not finalize adding clinical social workers and certified nurse midwives.

### **MIPS Determination Period**

CMS streamlined the various eligibility determination periods for the low-volume threshold, non-patient facing, small practice, hospital-based, and ASC-based status into a single MIPS determination period. It features two 1-year sequential segments that align with the fiscal year. The first begins Oct. 1 of the calendar year two years prior to the applicable performance period and ends Sept. 30 of the calendar year directly preceding the performance period. The second begins Oct. 1 of the calendar year directly preceding the applicable performance period and end Sept. 30 of the performance period. The first segment features a 30-day claims run-out, the second does not. The facility-based and virtual group eligibility determinations will utilize only the first segment. ECs or groups that qualify under the first segment will qualify regardless of their status during the second segment. If a new TIN/NPI combination did not exist in the first segment but does in the second, the EC could be eligible for MIPS participation.

### **Low-Volume Threshold**

CMS added one additional criterion to the low-volume threshold for 2019 and subsequent years: providing 200 or fewer covered professional services to Part B-enrolled individuals. This new third criterion will be in addition to the two existing criteria of delivering services to 200 or fewer Part B-enrolled individuals and billing \$90,000 or less in allowed charges.

Following ACP advocacy, clinicians, groups and APM Entities can “opt-in” to MIPS starting in 2019 if they qualify under one or two of the low-volume threshold criteria (but not all three). Those wishing to opt-in may indicate this through the QPP portal. This decision would be considered final and they would be subject to MIPS payment adjustments. Designations by APM Entities can occur only at the APM Entity level. Electing to participate as a virtual group will automatically count as electing to opt-in to MIPS. Clinicians who wish to remain excluded and do not report data would not have to take any further action. CMS predicts a modest impact on the payment adjustment as a result of this new opt-in policy.

### **Virtual groups**

Official designated virtual group representatives must submit an election by Dec. 31 of the calendar year prior to the applicable performance period. For the 2019 performance year, virtual group elections may be submitted via email to [MIPSVirtualGroups@cms.hhs.gov](mailto:MIPSVirtualGroups@cms.hhs.gov). CMS will explore facilitating elections through the QPP portal in future years. The virtual group eligibility determination period will start Oct. 1, 2017 and end Sept. 30, 2018 for the 2019 performance period. In August - December prior to every performance year, practices may request preliminary estimates of Tax Identification Number (TIN) sizes. These estimates are intended to be for informational purposes only and are not considered final. For performance year 2019, requests should be made through designated technical assistance representatives. For 2020 and subsequent performance years, these requests can be made directly through the QPP Service Center. Electing to participate as part of a virtual group prior to the start of the performance period will no longer constitute an automatic election to participate in MIPS if Partial QP status is later achieved. Clinicians or APM Entities who subsequently achieve Partial QP status would be considered excluded from MIPS if they do not elect to participate nor report any data.

## MIPS performance period

CMS made no changes to performance periods. The Quality and Cost Categories remain a full calendar year and the Promoting Interoperability (PI) and Improvement Activities Categories remain a minimum of 90 consecutive days up to and including a full calendar year two years prior to the MIPS payment year. The Agency indicates that it will work to shorten this two-year lag between performance and payment years in response to concerns raised by ACP and other stakeholders.

## Data submission

CMS finalized the following terminology changes:

- ***MIPS Clinical Quality Measures (CQMs)***: formerly registry measures
- ***Collection type***: a set of quality measures with comparable specifications and data completeness criteria including: electronic CQMs (eCQMs), MIPS CQMs, Qualified Clinical Data Registry (QCDR) measures, Medicare Part B claims measures, CMS Web Interface measures, CAHPS for MIPS survey measures, and administrative claims measures
- ***Submitter type***: the EC, group, or third party intermediary that submits data on measures and activities under MIPS
- ***Submission type***: the mechanism by which data is submitted to CMS including direct, log in and upload, log in and attest, Medicare Part B claims and the CMS Web Interface
- ***Third party intermediaries***: entities that have been approved to submit data on behalf of an EC, group, or virtual group including QCDRs, qualified registries, health IT vendors, or CMS-approved survey vendors

Tables 32 and 33 in the final rule summarize data submission types available for ECs reporting as individuals and as part of a group, respectively. Claims-based reporting is now only available to small practices, but it is an option regardless of whether they report as individual ECs or as a group. The CMS Web Interface can no longer be used to submit data for the Improvement Activities and PI Categories. Third party intermediaries may submit CMS Web Interface data directly to CMS on behalf of groups. The MIPS Web Interface data submission deadline will now align with deadlines for the other submission types, which is March 31 following the performance year.

## Third party Intermediaries

CMS strengthened vendor and measure criteria, including requiring that all QCDRs have clinical expertise in medicine and quality measure development starting in 2020. In addition, all QCDR measure owners must now enter into license agreements permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS, or risk having their measure rejected. CMS also strengthened its oversight authority to implement remedial actions and terminate privileges to submit MIPS data for third party intermediaries if they fail to meet criteria or submit data that is inaccurate, unusable, or otherwise compromised. The Agency also extended notification requirements for data deficiencies and errors, including publicly disclosing data error rates above 3% online.

## Quality Category

CMS finalized the weight of the Quality Category at 45% of the overall MIPS composite performance score, representing a 5% reduction from 2018. The performance period for the Quality Category will remain a full year. CMS retained the basic quality reporting requirements from 2018; for most data collection types, ECs and groups must report six quality measures including one outcome measure. If no applicable outcome measures are available, ECs and groups will report on a high priority measure.

In line with its Meaningful Measures Initiative, CMS removed a total of 26 measures, summarized in Appendix 1, Table C of the final rule. The complete final set of MIPS quality measures for 2019 can be found in Appendix 1, Table A and the list of new and modified measures is in Appendix 1, Table B.

CMS added opioid-related quality measures to the list of high priority measures and will consider developing public health priority measure sets. CMS clarified that subspecialty measure sets constitute separate measure sets and may not be combined. New quality measures with benchmarks based on the performance period (rather than a baseline period) will continue to have a “floor” of three points.

CMS did not change data completeness requirements for 2019, which entails 60% of eligible Part B patients for claims measures and 60% of all patients regardless of payer for eQMs, MIPS CQMs, and QCDR measures. CMS Web interface and CAHPS for MIPS survey measures will continue to have their own unique data completeness requirements. CMS will remove the one-point floor for measures that fail to meet data completeness requirements for most practices in 2020, but extended indefinitely the three-point floor for measures that do not meet data completeness requirements for small practices. Table 50 summarizes the scoring rules based on data completeness requirements. CMS will maintain for 2019 the three-point floor for quality measures that do satisfy data completeness criteria and the 20-case minimum. For practices that intend to submit the CAHPS for MIPS survey but fail to meet sampling requirements, CMS will reduce the denominator for the quality performance category by 10 points. Tables 34-35 in the rule summarize data completeness and data submission criteria for the 2019 performance period. Moving forward, CMS will only apply the validation process to MIPS CQMs and claims collection types. ECQMs will no longer be subject to validation, even if submitted via registry.

Moving forward, CMS will limit reporting quality measures via Medicare Part B claims to small practices (those with 15 or fewer eligible clinicians), but they may submit Part B claims data as a group. Previously it was only available to individual reporters. CMS removed a number of Web Interface measures (see Table D). For Web Interface reporters, CMS is discontinuing bonus points for reporting additional high-priority measures, though bonus points for reporting CAHPS for MIPS survey measures will continue.

CMS moved the small practice bonus from the MIPS composite score to the Quality Category in 2019 and future performance years and will award a total of six points to the Quality Category score if the EC submits data on at least one quality measure. This will increase the Quality score by 10% but diminishes the overall value of the small practice bonus in terms of the MIPS composite score, unless reweighting occurs. CMS will continue awarding one bonus point for each quality measure reported using end-to-end electronic reporting for the 2019 performance period. CMS clarifies that this bonus would only apply to data submitted by direct log in and upload or the CMS Web interface. The Agency will not accept outdated versions of eQMs and ECs will not receive the end-to-end electronic reporting bonus if they submit outdated versions of the eQMs. The three-point complex patient bonus will continue for the 2019 performance year while CMS develops a long-term policy.

CMS will apply benchmarks based on collection type rather than by submission mechanism. Benchmarks will be based on data from all available sources, including individual eligible clinicians, groups, APM Entities, and third party intermediaries.

CMS will maintain its 4-year cycle for removing measures considered “topped out.” Beginning in 2019, measure benchmarks identified as “topped out” for two consecutive years will receive a maximum of 7 points in the second year. All measures subject to the 7-point cap for 2019 will be available in late 2018 when 2019 benchmarks are published. For measures considered “extremely topped out” (e.g., average performance in 98<sup>th</sup>-100<sup>th</sup> percentile), the Agency may propose removal in future rulemaking regardless of where they are in the four-year cycle for topped out measures. CMS also reserves the right “suppress” measures without rulemaking if they are significantly impacted by clinical guidelines changes or other changes that may pose patient safety concerns. CMS will give those measures a score of zero and adjust the denominator of the Quality Category to 50 points (instead of 60) so a clinician’s score would not be adversely impacted. Measure stewards are expected to notify CMS of guidelines changes. CMS will post such measures to the CMS website prior to the start of the data submission period.

### **Cost Category**

CMS will continue to calculate cost measures from claims data; the Cost Category will continue to not require active reporting by clinicians. The BBA granted CMS additional flexibility in weighting the Cost Category through the 2021 performance year. CMS will increase the weight of the Cost Category from 10% to 15% next year and intends to increase its weight by 5% each year until it reaches the required 30% for the 2022 performance year. In accordance with the BBA, CMS will not factor improvement into the Cost Category score until 2022. Cost benchmarks will continue to be based on performance during the current performance period. Each cost measure will continue to have a case minimum of 20 ECs or groups to establish a benchmark. Measures without a benchmark will not be scored.

Despite concerns expressed by the College and others regarding the low average reliability rating of certain measures, CMS finalized eight new episode-based measures (summarized in Table C below which appears as Table 37 in the final rule), which include items and services related to the episode of care for a specific clinical condition or procedure, including those that occur after the initial treatment period but within the episode window. Detailed measure specifications can be found on the CMS QPP website. Episode-based measures will be payment standardized to ensure consistency across setting types and geographic areas, as well as risk adjusted based on the HCC model and additional recommended measure-specific risk adjustors that adjust for severity and account for comorbidities. They will be calculated using Medicare Parts A and B claims data based on the allowed amount, including both Medicare and beneficiary payments.

**Table C: Average reliability for new episode-based measures at finalized case minimums**

| Measure name   | Percentage TINs with 0.4 or higher reliability | Mean Reliability for TINs | Percentage TIN/NPIs with 0.4 or higher reliability | Mean Reliability for TIN/NPIs |
|--|--|---------------------------|--|-------------------------------|
| Elective Outpatient Percutaneous Coronary Intervention (PCI)         | 100.0%   | 0.73                      | 84.1%  | 0.53                          |
| Knee Arthroplasty  | 100.0%   | 0.87                      | 100.0%   | 0.81                          |
| Revascularization for Lower Extremity Chronic Critical Limb Ischemia | 100.0%   | 0.74                      | 100.0%   | 0.64                          |
| Routine Cataract Removal with Intraocular Lens (IOL) Implantation    | 100.0%   | 0.95                      | 100.0%   | 0.94                          |
| Screening/Surveillance Colonoscopy                                   | 100.0%   | 0.96                      | 100.0%   | 0.93                          |
| Intracranial Hemorrhage or Cerebral Infarction                       | 100.0%   | 0.70                      | 74.9%  | 0.48                          |
| Simple Pneumonia with Hospitalization                                | 100.0%   | 0.64                      | 31.8%  | 0.40                          |
| ST-Elevation Myocardial Infarction (STEMI) with PCI                  | 100.0%   | 0.59                      | 100.0%   | 0.59                          |

CMS finalized a case minimum of 10 episodes for all procedural episode-based measures and 20 episodes for acute inpatient medical condition episode-based measures. The Agency also codified previously finalized case minimums of 35 for the MSPB measure, 20 for the total per capita cost measure, and 20 for the episode-based measures for the 2017 MIPS performance period.

CMS proposes separate patient attribution methodologies for the two types of finalized episode-based measures. For acute inpatient medical condition episode groups, CMS will attribute episodes to each EC who bills inpatient E/M claim lines during a trigger inpatient hospitalization (identified by a particular Medicare Severity Diagnosis Related Groups (MS-DRG)) under a TIN that renders at least 30% of the inpatient E/M claim lines in that hospitalization. This differs from previously finalized policy, which excludes all episodes where no TIN/NPI exceeds the 30% threshold. For procedural episode groups, CMS will attribute episodes to each EC who renders a trigger service as identified by HCPCS/CPT procedure codes. In both cases, if a single episode is attributed to multiple TIN/NPIs in a single TIN, the episode would only be counted once in the TIN's measure score.

CMS will annually review cost and quality measure specifications to ensure continued accuracy. Every three years, all measures will be comprehensively reevaluated to ensure they meet reliability and validity standards, as well as strategic priorities. Substantive measure changes will be proposed through the formal rulemaking process. The Agency intends to continue developing additional episode-based cost measures for future performance years that encompass additional specialties. CMS will also post on the CMS website any cost measures under development, as required under the BBA.

### Improvement Activities Category

CMS added six, modified five, and deleted one improvement activity. These changes are summarized in Exhibit 2, Tables A and B. CMS Web Interface will no longer be able to submit data for the Improvement Activities Category. CMS made several technical changes to the *CMS Study on Burdens Associated with Reporting Quality Measures*, including renaming it the *CMS Study on Factors Associated with Reporting Quality Measures*.

Patient-Centered Medical Homes (PCMHs) and comparable specialty practices will continue to receive full credit for the improvement activities performance category provided at least 50% of practice sites within the TIN are recognized. However, CMS clarified that they must attest to belonging to a PCMH or comparable specialty practice in order to receive this credit. Non-patient facing ECs and groups, small practices, and practices located in rural areas and geographic health professional shortage areas (HPSAs)

will continue to have their activities double weighted so that submitting one high-weighted activity will earn full credit. CMS intends to “thoroughly revisit” Improvement Activity weighting policies in next year’s rulemaking and will specifically look to apply high-weighting to any activity that employs Certified EHR Technology (CEHRT).

The Annual Call for Activities will run from Feb. 1<sup>st</sup> through June 30<sup>th</sup>, which provides an additional four months. CMS also lengthened the new activity approval process. Activities under consideration will now be included in the following year’s proposed rulemaking process for possible implementation the following calendar year. For example, submissions received in the 2019 Annual Call for Activities would be proposed during the CY 2020 rulemaking cycle for possible implementation in 2021. Submission forms can be found at the CMS QPP website. To help address the opioid crisis, CMS added “addressing a public health emergency” as criteria for considering new activities. The Agency also noted that it takes into consideration whether a nominated activity “uses publically available products or techniques.”

### **Promoting Interoperability (PI) Category**

CMS renamed the Advancing Care Information Performance Category the Promoting Interoperability (PI) Performance Category and finalized a number of scoring and measurement changes to better reflect the Agency’s focus on interoperability and improving patient access to health information. The Agency maintained minimum 90 consecutive day reporting period for PI in 2019 and will now require the use of 2015 CEHRT. In 2018, CMS allowed ECs to use either the 2014 or 2015 Edition of CEHRT. One of the specific functionalities required in the 2015 Edition is Application Programming Interfaces (APIs), intended to promote interoperability and improve the flow of information between physicians and patients and clinical workflows.

The final 2019 PI objective and measure set reflected in Table D below is comprised of four objectives (e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange) and six required measures (e-Prescribing, Support Electronic Referral Loops by Sending Health Information, Support Electronic Referral Loops by Receiving and Incorporating Health Information, Provide Patients Electronic Access to Their Health Information, Public Health Registry Reporting, and Clinical Data Registry Reporting), unless a measure exclusion is claimed. CMS finalized two new opioid-related measures that will count as bonus points for the 2019 performance year.

**Table D: Final measures for Promoting Interoperability Category in 2019 and onward**

| <b>Measure Status</b>                | <b>Measure</b>  |
|--------------------------------------|---|
| Measures retained - no modifications | 1. e-Prescribing  |
| Measures retained with modifications | 1. Send Summary of Care (New Name: Supporting Electronic Referral Loops by Sending Health Info)<br>2. Provide Patient Access (New Name: Provide Patients Electronic Access to Their Health Info)<br>3. Immunization Registry Reporting<br>4. Syndromic Surveillance Reporting<br>5. Electronic Case Reporting<br>6. Public Health Registry Reporting<br>7. Clinical Data Registry Reporting |
| Removed measures                     | 1. Request/Accept Summary of Care<br>2. Clinical Info Reconciliation<br>3. Patient-Specific Education<br>4. Secure Messaging  |

|              |   |
|--------------|---|
|              | 5. View, Download or Transmit<br>6. PGHD  |
| New measures | 1. Query of PDMP<br>2. Verify Opioid Treatment Agreement<br>3. Support Electronic Referral Loops by Receiving and Incorporating Health Info |

**\*Security Risk Analysis is retained, it is a required measure without points.**

CMS streamlined the PI scoring methodology by replacing the separate base, performance, and bonus categories with a performance-based point system in which each measure translates to a performance rate that is applied to the total category score. The new scoring methodology still does not remove the “all-or-nothing” aspect as there are still required measures and failure to adequately report any of the required measures would automatically result in a score of zero for the entire PI Category.

**Table E: Final scoring methodology for Promoting Interoperability Category in 2019 and onward**

| Objective                                | Measure   | Maximum Points |
|--|---|----------------|
| e-Prescribing                            | e-Prescribing   | 10 points      |
|  | Optional with Bonus: Query of PDMP  | 5 points bonus |
|  | Optional with Bonus: Verify Opioid Treatment Agreement  | 5 points bonus |
| Health Information Exchange              | Support Electronic Referral Loops by Sending Health Information   | 20 points      |
|  | Support Electronic Referral Loops by Receiving and Incorporating Health Information   | 20 points      |
| Provider to Patient Exchange             | Provide Patients Electronic Access to Their Health Information  | 40 points      |
| Public Health and Clinical Data Exchange | <u>Choose two of the following:</u><br>Immunization Registry Reporting<br>Electronic Case Reporting<br>Public Health Registry Reporting<br>Clinical Data Registry Reporting<br>Syndromic Surveillance Reporting | 10 points      |

#### **APM scoring standard for ECs participating in MIPS APMs**

The MIPS performance category weights will remain consistent for MIPS APM participants in 2019 at 50% for Quality, 0% for Cost, 30% for Improvement Activities, and 20% for PI. CMS clarifies that each distinct track of an APM will be considered separately for meeting criteria to be considered a MIPS APM. In addition, an APM’s first performance year begins when participants must report on quality measures. CMS expects the following APMs will qualify as MIPS APMs in 2019: the Comprehensive ESRD Care Model (all Tracks), Comprehensive Primary Care Plus Model (all Tracks), Next Generation ACO Model, Oncology Care Model (all Tracks), MSSP (all Tracks), Bundled Payments for Care Improvement Advanced Model, Independence at Home Demonstration, Maryland Primary Care Program, and the Vermont Medicaid ACO Initiative. Final determinations will be announced through the QPP website. Measure lists for each model can be found in Tables 44-49 of the final rule.

#### **Facility-based measure scoring option**

Starting next year, ECs and groups may use utilize quality data from the Hospital Value-Based Purchasing (VBP) Program toward the Quality and Cost Categories of MIPS. CMS will determine the percentile

performance of the facility in the Hospital VBP Program for the specified year, then award a score associated with that same percentile performance in the MIPS Quality and Cost Categories. Clinicians scored under facility-based measurement will not be scored on other cost measures. CMS will not count improvement for ECs who are scored by facility-based measurement one year but not the next. The measures, performance period, and benchmarks for facility-based measurement will be those adopted under the VBP Program for the same performance period. The 12 measures for the 2019 performance year for the facility-based measurement option are summarized in Table 52 of the rule.

CMS will automatically apply facility-based measurement to ECs and groups who are eligible, unless it receives another submission of quality data and the combined Quality and Cost Category scores of that submission results in a higher score. There are no submission requirements for individual clinicians in facility-based measurement but groups would have to submit data for the Improvement Activities or PI Categories to indicate they wish to be measured as a group. If a group does not submit this data, CMS will apply facility-based measurement to the individual clinicians and score them individually.

The agency limits facility-based reporting to the inpatient hospital setting for the first year, but is open to expanding it to additional facility types in future rulemaking, particularly for post-acute care and end-stage renal disease (ESRD) settings. The facility-based standard applies to ECs who furnish 75% or more of covered professional services in sites of service identified by place of service (POS) codes 21 (inpatient), 22 (outpatient), or 23 (emergency department) based on claims during the first segment of the MIPS Determination Period. The clinician must bill at least one service under POS codes 21 or 23 to qualify. A facility-based is a group in which 75% or more of its ECs qualify for facility-based measurement as individuals. If CMS is unable to identify a facility with a VBP Program score to attribute to an EC's performance (such as hospitals in Maryland), then that EC is ineligible for facility-based measurement.

Clinicians will receive scores derived from the VBP score for the facility at which the clinician provided services to the most Medicare beneficiaries during the determination period. A facility-based group will receive a score under the facility-based standard derived from the VBP score for the facility at which the plurality of clinicians would have their scores determined under facility-based measurement as individuals. In both cases, if an equal number of Medicare beneficiaries are treated at more than one facility, CMS will use the score for the highest-scoring facility.

CMS intends to provide additional information regarding facility-based measurement eligibility status, facility attribution, and preview scores based on data from the previous performance period. The Agency will do so during the first quarter of the performance period if technically feasible.

### **MIPS final score methodology and payment adjustments**

CMS will increase the weight of the cost category from 10% to 15% and will decrease the weight of the Quality Category from 50% to 45%. The weights of the PI and Improvement Activities Categories will remain consistent with 2018 levels, at 25% and 15% respectively.

**Table F: 2019 MIPS performance category weights**

|             | Quality | Cost | Promoting Interoperability | Improvement Activities |
|-------------|---------|------|----------------------------|------------------------|
| <b>2018</b> | 50%     | 10%  | 25%                        | 15%                    |
| <b>2019</b> | 45%     | 15%  | 25%                        | 15%                    |



Under additional flexibilities granted by the BBA, CMS set the MIPS Performance Threshold at 30 points, doubling it from 2018. The Agency also increased the MIPS Exceptional Performance Threshold from 70 to 75 points, half of what was originally proposed. The 2017 mean MIPS score ranged between 63.5 and just under 69 points, and the median score ranged between approximately 78 and 82.5 points, depending on various participation assumptions. All ECs with a final score at or below 7.5 points will receive the maximum penalty of -7%. The scaling factor for the positive MIPS payment adjustment factor will depend on total penalties but cannot exceed three. CMS anticipates more clinicians will receive bonuses than penalties, and therefore the positive adjustment would likely not exceed the maximum penalty. Exceptional performance bonuses are separately funded and will be paid in addition to the standard MIPS payment adjustments to those who meet or exceed the exceptional performance threshold.

Under the BBA, MIPS payment adjustments will only apply to “covered professional services” under Medicare Part B, not to part B for other items and services, including Part B drugs. Beginning with 2019 MIPS payment adjustments (based on 2017 performance), MIPS payment adjustments will apply only to claims billed and paid on an assignment-related basis, not to non-assigned claims. In addition, MIPS payment adjustment factors will not apply to section 115A model specific payments including Monthly Enhanced Oncology Services (MEOS) payments under the Oncology Care Model. CMS will list all of the models subject to this new policy on the QPP website and in the Federal Register.

The small practice bonus will be moved to the Quality Category in lieu of adding it to the final total MIPS composite score. Following ACP advocacy, CMS will increase the bonus to six points. For small practices that do not apply to have their PI Category reweighted to zero and thus have their Quality score weighted as 45% of their total MIPS score, the bonus will be worth 4.5 final score points, a 0.5 decrease. However, for small practices that do apply to have their PI score re-weighted to the Quality Category, the bonus would effectively be worth more. CMS will monitor to determine if the amount of the small practice bonus needs to be adjusted in the future and noted that this is intended to be temporary. Small practices must report at least one quality measure to qualify for the bonus.

### **MIPS exceptions and weighting flexibilities**

Beginning next year, ECs who join an existing TIN during the final three months of the calendar year that is not participating in MIPS as a group or was newly formed during those final three months will not be subject to a MIPS payment adjustment. For groups submitting data at the TIN-level, CMS will apply the final group score to all of the TIN/NPI combinations that bill under that TIN during a 15-month window from Oct. 1 prior to the MIPS performance period - Dec. 31 of the performance period year.

CMS extended the automatic extreme and uncontrollable circumstances policy under which ECs affected by extreme and uncontrollable circumstances affecting entire regions or locales can be held harmless from MIPS payment adjustments. ECs and now groups may also submit applications for MIPS exceptions. Exempted ECs that submit data for a given performance category will be scored as any other clinician would. For clinicians that may have already submitted some quality data via Part B claims prior to submitting a hardship exemption for extreme and uncontrollable events, they will only be scored if they subsequently submit data for at least one other performance category. CMS would reweight the Cost Category to zero even if it receives claims data that would enable it to calculate a Cost score unless data for at least two other performance categories are submitted.

In general, CMS will redistribute the weight of other performance categories to the Quality Category and will redistribute the weight of the Quality Category to the PI and Improvement Activities Categories. Specific weighting scenarios are summarized in Table 54 of the rule. CMS will consider redistributing more weight to the Cost Category in future performance years.

### Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

CMS finalized MAQI Demonstration, which allows ECs to be excluded from QPP reporting requirements and payment adjustments if they participate to a sufficient degree in a combination of Qualifying Payment Arrangements with Medicare Advantage Organizations (MAOs) and Medicare Advanced APMs, but fall short of qualifying as QPs or Partial QPs and are not otherwise excluded from MIPS. The thresholds will be based on the percentage of payments received or patients seen through qualifying models and align with QP thresholds (25% of payments or 20% of patients in 2018; 50% of payments or 35% of patients in 2019-2020). ECs who elect to participate in the Demonstration and meet the thresholds are prohibited from reporting MIPS data. The demonstration started with the 2018 performance year and will run for five years. CMS plans to collect 2018 participation information in the fall and make determinations available in December 2018, or January 2019 “at the latest.”

### Physician Compare

Quality and cost measures will not be considered for public reporting for the first two years they are in use to encourage adoption and allow for sufficient feedback and experience using the measures. CMS eliminated plans to indicate “high” performance for the PI Category and will instead simply denote “successful” performance, e.g. any score above zero. CMS will proceed with utilizing the ABC™ methodology with historical data to create measure benchmarks and 5-star ratings for QCDR measures.

### Advanced APMs

#### Qualified Advanced APM Participant (QP) Determinations

CMS will maintain the current revenue-based nominal amount (i.e. risk) standard of 8% of average estimated total revenue of all providers and suppliers for both Medicare Advanced APMs and Other Payer APMs through the 2024 performance period, but is interested in increasing this threshold in the future. Beginning next year, ECs may become QPs in APMs through a combination of participation in Medicare Advanced APMs and Other Payer Advanced APMs through the All-Payer Combination Option. Participation thresholds would be based on the proportion of payments or patients that flow through APMs, reflected in Tables G and H below (which appear as Tables 57-58 in the final rule). CMS will calculate both and use the most advantageous score.

**Table G: QP payment amount thresholds for All-Payer Combination Option**

| Payment Year                        | 2019 | 2020 | 2021 | 2022 | 2023 and later |
|-------------------------------------|------|------|------|------|----------------|
| QP Payment Amount Threshold         |      |      |      |      |                |
| Medicare Minimum                    | N/A  | N/A  | 25%  | 25%  | 25%            |
| Total                               |      |      | 50%  | 50%  | 75%            |
| Partial QP Payment Amount Threshold |      |      |      |      |                |
| Medicare Minimum                    | N/A  | N/A  | 20%  | 20%  | 20%            |
| Total                               |      |      | 40%  | 40%  | 50%            |

**Table H: QP patient count thresholds for All-Payer Combination Option**

| Payment Year                       | 2019 | 2020 | 2021 | 2022 | 2023 and later |
|------------------------------------|------|------|------|------|----------------|
| QP Patient Count Threshold         |      |      |      |      |                |
| Medicare Minimum                   | N/A  | N/A  | 20%  | 20%  | 20%            |
| Total                              |      |      | 35%  | 35%  | 50%            |
| Partial QP Patient Count Threshold |      |      |      |      |                |
| Medicare Minimum                   | N/A  | N/A  | 10%  | 10%  | 10%            |
| Total                              |      |      | 25%  | 25%  | 35%            |

In addition to making QP determinations at the EC and APM Entity levels, CMS will now also make QP determinations at the TIN level in cases where entire TINs participate in a single APM Entity. CMS will assess QP status based on the most advantageous result for each clinician. CMS will apply a special weighting methodology to ensure that an individual clinician does not receive a lower QP calculation based on their participation in Medicare APMs than they would have received at the APM Entity level. CMS will calculate a TIN's QP threshold scores both on its own and using this weighted methodology and will use the most advantageous score.

All QP determination “snapshots” for both Other Payer and Medicare APMs will align with existing snapshots for Medicare Advanced APMs, with the QP performance period running from Jan. 1 through Aug. 31 with three snapshot dates of March 31, June 30 and August 31. All necessary patient count and/or payment information must be submitted by Dec. 1 of the applicable performance period. To notify ECs about their QP status earlier, CMS shortened the claims runout for each snapshot period from 90 to 60 days, which they expect will result in a 0.5% difference in claims processing completeness. For ECs determined to be Partial QPs at the individual level, ECs must make an affirmative election to report in order to be considered MIPS ECs and be subject to MIPS reporting requirements and payment adjustments. In cases where the APM Entity is responsible for making this decision on behalf of all ECs in the group, those clinicians will not be considered MIPS ECs unless the APM Entity opts the group into MIPS participation, regardless of the actions of individual clinicians.

### **Advanced APM Criteria**

In previous years, CMS required that in order to qualify as an Advanced APM, a model must require at least 50% of ECs within an APM entity to use CEHRT. Starting next year, in order to qualify as a Medicare Advanced APM, APM Entities must provide documentation to CMS that at least 75% of ECs used CEHRT to document and communicate clinical care with patients and other health care professionals. For Other Payer Advanced APMs, 50% of ECs in each APM Entity must do so in 2019, and 75% must do so in 2020 and beyond. Effective in 2020, in order to qualify as an Advanced APM, at least one quality measure and at least one outcome measure upon which an APM bases payment would have to be a MIPS measure, endorsed by a consensus-based entity, or otherwise be determined to be evidence-based, reliable, and valid. Other Payer APMs submitted prior to 2020 will be exempted from this requirement for five years, or until the end of the payment arrangement, whichever comes first.

### **Other Payer Advanced APM Determination Process**

Payers can request to have their payment arrangements designated as Other Payer Advanced APMs through an annual Payer-Initiated Other Payer Advanced APM Determination Process. Medicaid, MA, and CMS multi-payer models can start making these requests in 2018 to qualify for the 2019 performance year. Commercial and private payers can start to make requests in 2019 for the 2020 performance year. Following the payer-initiated process, APM Entities and ECs will have an opportunity

to request that any additional payer arrangements in which they participate be designated as Other Payer Advanced APMs. Table 59 in the rule summarizes the timeline for Other Payer Advanced APM Determinations for the 2020 QP Performance Period for both the payer- and EC-initiated processes.

Other Payer Advanced APM determination submission forms available prior to the first payer-initiated submission period, which would begin Jan. 1 and end June 1 prior to the relevant performance year. Should incomplete or inadequate information be submitted, the Agency will inform the submitter and allow 15 days to submit additional information. All determinations will be final and not subject to reconsideration. CMS intends to notify payers of determination decisions “as soon as practicable” after the submission deadline and post a list of all Other Payer Advanced APMs to the CMS website prior to the start of the relevant QP Performance Period, which would later be updated with any additions based on the APM Entity- and EC-Initiated Process. The list of qualifying Medicaid, MA, and CMS multi-payer models for 2019 is expected to be posted by CMS to the QPP website prior to Jan. 1.

CMS reversed its earlier policy to require annual resubmissions of all Other Payer APM Determinations. Beginning with determinations for the 2020 performance year, requesters will only need to submit information if there are any material changes relevant to it meeting Other Payer Advanced APM criteria. Otherwise, existing determinations would remain in effect for either the duration of the payment arrangement, or five years, whichever comes first.

### **Medicare Shared Savings Program (MSSP)**

MSSP participants may now report Promoting Interoperability data at either the NPI- or TIN-level. MSSP participants will be able to access performance feedback at the TIN-level starting next year. As part of its Meaningful Measures Initiative, CMS removed ten and added two new measures to the 2019 MSSP quality measure set, resulting in 23 total measures, down from 31 in 2018. Table 26 in the final rule summarizes the final 2019 quality measure set and Table 27 displays how these measure changes will impact Accountable Care Organizations’ (ACOs’) final quality scores. CMS will also score two CAHPS for ACO survey measures that were previously reported for informational purposes only: ACO-45: courteous and helpful office staff and ACO-46: care coordination, which entails provider access to beneficiary information and follow-up. Both will be scored on a pay-for-reporting basis for performance years 2019-2020 then gradually phase into pay-for-performance starting in 2021.

In the event an MSSP ACO fails to satisfactorily meet MIPS quality reporting requirements, an exclusion is triggered that allows participants to submit quality data. Solely submitting CAHPS for MIPS data will not count as satisfying MIPS quality reporting requirements, and ACO participating TINs will be allowed to submit their own quality data. Starting next year, that data may now be reported at the individual clinician level in addition to the TIN-level.

CMS finalized a voluntary six-month extension for existing ACOs whose participation agreements expire Dec. 31, 2018 that would span Jan. 1 – June 30, 2019 to allow ACOs flexibility to more rapidly transition “as early as July 1, 2019” to the proposed new participation options “should they be finalized.” ACOs electing to extend their participation agreements must certify with CMS that they updated participant agreements and, if applicable, skilled nursing facility (SNF) affiliate agreements prior to Jan. 1, 2019 and must extend the term of their repayment mechanism agreements by six months. After 2019, the annual application cycle featuring a Jan. 1 agreement start date will resume.

For the Jan. 1 – June 30, 2019 performance period, financial and quality data will be reported and calculated based on the entire year under current policies and any resulted shared losses or savings will be prorated by half to account for the six-month performance year. CMS intends to provide further education and outreach on how this would work. Those that terminate either voluntarily or involuntarily prior to June 30 will not owe shared losses or be eligible for shared savings.

CMS lifted certain requirements related to voluntary beneficiary assignment. Beneficiaries may select any ACO professional, regardless of specialty, as their primary clinician. Beneficiaries who select any clinician outside of an ACO will not be assigned to that ACO, even if they otherwise would have based on claims. Additionally, it is no longer a requirement that beneficiaries receive at least one primary care service from a qualifying ACO professional during the performance year in order to be assigned to an ACO. If a beneficiary does not change their primary clinician designation, the beneficiary will remain assigned to that ACO for any subsequent agreement periods, even if the beneficiary no longer seeks care from ACO professionals, except in limited circumstances when the beneficiary is also eligible for assignment to certain other APMs. CMS clarifies that these changes will not alter current exclusivity requirements and specialists may continue participating in multiple ACOs. In cases where a beneficiary is assigned to an ACO professional who is participating in one or more ACOs, they will be assigned to an ACO based on the plurality of primary care services received.

CMS finalized new additional codes to the definition of primary care services including advance care planning services (CPT codes 99497 and 99498), administration of health risk assessment services (CPT codes 96160 and 96161), prolonged E&M or psychotherapy services (CPT codes 99354 and 99355), annual depression screenings (HCPCS code G0444), alcohol misuse screenings (HCPCS code G0442), and alcohol misuse counseling services (HCPCS code G0443). The Agency also altered its methodology for excluding SNF claims. Rather than exclude all claims including POS code 31, CMS will instead exclude services billed under CPT codes 99304 through 99318 when furnished in a SNF.

CMS extended its extreme and uncontrollable circumstances policies for MSSP ACOs indefinitely, and will apply it to ACOs affected by the recent hurricanes in North Carolina and Florida and other disasters in 2018. The Agency also made several small revisions to this policy, including that CMS will use the list of assigned beneficiaries used to generate the Web Interface quality reporting sample to calculate whether 20% of beneficiaries reside in an area affected by a disaster so that they may notify affected ACOs sooner. CMS clarifies that if any ACO participant TINs do report data for the PI Category, it will not be reweighted to zero and that data will be used to score the ACO under the APM Scoring Standard in MIPS. These policies apply to ACOs with a six-month performance year from Jan. 1 – June 30, 2019, regardless of when during the calendar year the disaster occurred.

Starting next year, 2015 CEHRT will be required by all MSSP ACOs, including those not considered Advanced APMs. All MSSP ACOs will also be required to certify annually that at least 50% of ECs participating in the ACO use CEHRT to document and communicate clinical care. Following pushback from ACP and other stakeholders, CMS did not finalize a proposal that would require ACOs to certify meeting this requirement at the time of application. The Agency removed *ACO-11: Use of CEHRT* from the ACO quality measure set, clarifying this will not affect reporting data on the PI Category for MIPS but that this data would no longer be used to assess the ACO's quality performance under the MSSP.

CMS will address other policies from the *Pathways to Success* proposed rule regarding a July 1 - Dec. 31, 2019 performance period under new program rules in a separate impending final rule expected in early 2019.

**Appendix 1: New HCPCS codes and RVUs finalized for 2019 and future years**

| <b>HCPCS</b> | <b>Descriptor</b>   | <b>CY 2018 Work RVU</b> | <b>Proposed CY 2019 Work RVU</b> | <b>Final CY 2019 Work RVU</b> |
|--------------|---|-------------------------|----------------------------------|-------------------------------|
| 99201        | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.                           | 0.48                    | 0.48                             | 0.48                          |
| 99202        | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. | 0.93                    | 0.90                             | 0.93                          |
| 99203        | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family   | 1.42                    | 1.90                             | 1.42                          |
| 99204        | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of  | 2.43                    | 1.90                             | 2.43                          |

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|       | moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.  |      |      |      |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.   | 3.17 | 1.90 | 3.17 |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.   | 0.18 | 0.18 | 0.18 |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.                          | 0.48 | 1.22 | 0.48 |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. | 0.97 | 1.22 | 0.97 |

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| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.       | 1.50 | 1.22 | 1.50 |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. | 2.11 | 1.22 | 2.11 |
| 99446 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review   | 0.00 | 0.35 | 0.35 |
| 99447 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 11-20 minutes of medical consultative discussion and review  | 0.00 | 0.70 | 0.70 |
| 99448 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 21-30 minutes of medical consultative discussion and review  | 0.00 | 1.05 | 1.05 |
| 99449 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written  | 0.00 | 1.40 | 1.40 |



|       |  |     |      |      |
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|       | report to the patient's treating/requesting physician or other qualified healthcare professional; 31 minutes or more of medical consultative discussion and review   |     |      |      |
| 99451 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time   | New | 0.50 | 0.70 |
| 99452 | Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes  | New | 0.50 | 0.70 |
| 99457 | Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the Patient/caregiver during the month   | New | 0.61 | 0.61 |
| 99491 | CCM provided personally by a physician / QHP   | New | 1.22 | 1.45 |
| G2010 | Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment  | New | 0.18 | 0.18 |
| G2011 | abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes  | New | 0.33 | 0.33 |
| G2012 | Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion | New | 0.25 | 0.25 |

## **Appendix 2: Glossary of key terms**

**ACO:** Accountable Care Organization  
**API:** Application Programming Interface  
**APM:** Alternative Payment Model  
**ASC:** Ambulatory Surgical Center  
**ASP:** Average Sales Price  
**AUC:** Appropriate Use Criteria  
**BBA:** Bipartisan Budget Act of 2018  
**CCM:** Chronic Care Management  
**CAHPS Survey:** Consumer Assessment of Healthcare Providers & Systems Survey  
**CEHRT:** Certified Electronic Health Record Technology  
**CLFS:** Clinical Laboratory Fee Schedule  
**CMS:** Centers for Medicare & Medicaid Services  
**CMMI:** Center for Medicare and Medicaid Innovation  
**CPT:** Current Procedural Terminology  
**CQM:** MIPS Clinical Quality Measure  
**EC:** MIPS Eligible Clinician  
**EHR:** Electronic Health Record  
**E/M:** Evaluation and Management  
**ESRD:** End-Stage Renal Disease  
**FQHC:** Federally Qualified Health Center  
**GPCI:** Geographic Practice Cost Indices  
**HCPCS:** Healthcare Common Procedure Coding System  
**Health IT:** Health Information Technology  
**HPSA:** Health Professional Shortage Area  
**MACRA:** Medicare Access and CHIP Reauthorization Act of 2015  
**MAC:** Medicare Administrative Contractor  
**MAO:** Medicare Advantage Organization  
**MAQI:** MA Qualifying Payment Arrangement Incentive  
**MDM:** Medical Decision Making  
**MIPS:** Merit-Based Incentive Payment System  
**MPIP:** Medicaid Promoting Interoperability Program  
**MPPR:** Multiple Procedure Payment Reduction  
**MSSP:** Medicare Shared Savings Program  
**NPI:** National Provider Identifier  
**NPRM:** Notice of Proposed Rulemaking  
**PCMH:** Patient-Centered Medical Home  
**PCP:** Primary Care Physician  
**PE:** Practice Expense  
**PFS:** Physician Fee Schedule  
**QCDR:** Qualified Clinical Data Registry  
**QP:** Qualified Advanced APM Participant  
**QPP:** Quality Payment Program  
**RHC:** Rural Health Center  
**RUC:** Relative Value Scale Update Committee  
**RVU:** Relative Value Unit  
**SNF:** Skilled Nursing Facility  
**TIN:** Taxpayer Identification Number  
**VBP:** Hospital Value-based Purchasing Program  
**WAC:** Wholesale Acquisition Cost