



ACEP's Highlights of the Calendar Year (CY) 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Final Rule

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released a Medicare annual payment rule for the calendar year (CY) 2019 that finalizes changes to Medicare payments for physicians and other health care practitioners. This year, the rule combines policies for the Medicare Part B physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). CMS had issued a proposed rule in July, which ACEP responded to with a robust set of comments. Highlights of ACEP's response to the proposed rule are found [here](#).

Found below is a summary of key policies. The rule becomes effective starting on January 1, 2019.

Physician Fee Schedule (PFS)

The PFS sections of the rule include the following major policies. Emergency physician payments are expected to remain relatively flat, as these policies, along with other proposed refinements to physician codes, will cause the PFS conversion factor (which converts the relative value units for each code to dollars) to just slightly increase in 2019 by 0.14% from \$35.99 in 2018 to \$36.04.

1. Restructuring Evaluation and Management (E/M) Codes and Streamlining Documentation Requirements

- CMS is DELAYING their proposal to create a new, single blended payment rate for new and established patients for office/outpatient E/M level 2 through 5 visits, and a series of add-on codes (called "G" codes) to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services.
 - For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits.
 - Starting in CY 2021, CMS will pay a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5. CMS will also allow physicians to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current E/M documentation guidelines. Physicians could also continue using the current framework.
 - During the two-year delay, CMS will continue to get feedback on appropriate payment for E/M services from the AMA, the RUC, and other stakeholders.
 - **None of these changes impact the emergency department (ED) E/M code set. This code set is currently under evaluation by the American Medical Association (AMA) Relative Value Scale Update Committee (RUC), and new values for these codes may be proposed in the next annual PFS rule.**
- CMS is finalizing a few policies effective starting on January 1, 2019 that aim to reduce documentation burden for clinicians. One of these policies aims to eliminate potentially

duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

2. Payment for the Use of Remote Communications Technology

- In an effort to expand the use of telehealth in Medicare, CMS will pay separately for two newly defined physicians' services furnished using communication technology:
 - Brief Communication Technology-based Service: This service will cover a “virtual check-in” by a patient via telephone or other telecommunications device to decide whether an office visit or other service is needed.
 - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient: This service will allow practitioners to be separately paid for reviewing a patient-transmitted photo or video information (such as by text message) to assess whether a visit is needed.
- New chronic care remote physiologic monitoring and interprofessional internet consultation codes will also be eligible for separate payment.
- Beginning in July 2019, a patient's home will be eligible to be the originating site for telehealth services for opioid and substance abuse disorder treatment or co-occurring mental health disorders.

3. Appropriate Use Criteria (AUC) Program

- CMS is finalizing minor changes to the Appropriate Use Criteria (AUC) Program, including revising the hardship criteria include 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues, or 3) extreme and uncontrollable circumstances.
- In the proposed rule, CMS did not address ACEP's concerns about the lack of clarity around the exemption for emergency medical conditions. ACEP continues to believe that, due to a drafting error in the legislation, CMS is only exempting imaging services for emergency services when provided to individuals with emergency medical conditions—and is NOT exempting all services delivered in the emergency department.
 - **In the final rule, CMS clarifies that exceptions granted for an individual with an emergency medical condition include instances where an emergency medical condition is suspected, but not yet confirmed. This may include, for example, instances of severe pain or severe allergic reactions. In these instances, the exception is applicable even if it is determined later that the patient did not, in fact, have an emergency medical condition. In other words, if physicians think their patients are having a medical emergency (even if they wind up not having one), they are excluded from the AUC requirements.**

4. Request for Information on Price Transparency

- In the proposed rule, CMS included a request for information (RFI) on what role clinicians play in making health care prices transparent to their patients. In the RFI, CMS discussed current hospital requirements around making standard charges available to the public and stated that CMS remains concerned that patients are “being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits.” ACEP responded to the RFI by stating that we believe it is the responsibility of insurers to clearly provide information to consumers prior to the emergency about the potential costs of seeking emergency care under their particular coverage. In the final rule, CMS thanked the public for their comments.

5. Bundled Episode Payment for Substance Use Disorder (SUD) Treatment

- As part of CMS’ effort to combat the opioid epidemic, CMS sought comment in the proposed rule on creating a bundled payment for components of Medication Assisted Treatment (MAT) such as management and counseling services to help expand access to treatment for SUDs. CMS will consider comments they received from this solicitation to help inform future rulemaking.

6. Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)

- CMS finalizes a subset of changes to the Medicare Shared Savings Program for ACOs proposed in the August 2018 proposed rule “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations Pathways to Success.” These policies included:
 - Creating a voluntary 6-month extension for existing ACOs whose participation agreements expire on December 31, 2018.
 - Allowing beneficiaries who voluntarily align to a Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, or a specialist (like an emergency physician) to be prospectively assigned to an ACO, as permitted under the Bipartisan Budget Act of 2018.
 - Providing relief for ACOs impacted by extreme and uncontrollable circumstances in 2018 and future years.
- CMS plans to release another rule to address the other proposals included in the August 2018 proposed rule.

The Quality Payment Program

CMS finalizes policies that impact the third performance year (2019) of the Quality Payment Program (QPP). The QPP includes two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

MIPS Policies

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly EHR Meaningful Use). Performance on these four categories (which are weighted) rolls up into an overall score that translates to an upward, downward or neutral payment adjustment that clinicians receive two years after the performance period (for example, performance in 2019 will impact Medicare payments in 2021).

The first two years of MIPS included some flexibilities that allowed for a transition into the Program. Congress recently intervened with the Bipartisan Budget Act of 2018 and extended some of these flexibilities available in the first two years through the fifth year of MIPS. In this final rule, CMS implements the changes included in the Bipartisan Budget Act and also finalizes a number of other policies described below.

1. Length of Performance Period

- CMS is maintaining the 12-month reporting period for the Quality and Cost categories. The length of the performance period for the Improvement Activities and Promoting Interoperability categories will continue to be 90-days.

2. Low-Volume Threshold

- The low volume threshold in 2018 is set at $\leq \$90,000$ in Medicare Part B allowed charges for covered professional services OR ≤ 200 Medicare beneficiaries. This means that if a provider has less than \$90,000 in covered charges or treats fewer than 200 Medicare beneficiaries, he/or is exempt from MIPS. In the final rule, CMS adds a third option for being excluded from MIPS: the number of professional services provided.
- Therefore, for 2019, clinicians and groups must meet at least one of the following criterion to be exempted from MIPS:
 - Have $\leq \$90K$ in Part B allowed charges for covered professional services,
 - Provide care to ≤ 200 beneficiaries, or
 - Provide ≤ 200 covered professional services under the PFS
- Clinicians or groups will be able to **opt-in** to MIPS starting in 2019 **if they meet or exceed one or two, but not all, of the low-volume threshold criterion.**

3. Performance Category Weighting in Final Score

- As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. CMS is reducing the Quality category weight from 50 to 45% and increasing the Cost category from 10 to 15%.
- The Cost category increase is still much less than the original 30% it was statutorily mandated to be increased to in 2019 under the original MACRA legislation. Through the Balanced Budget Act, Congress gave CMS flexibility for the next few years to keep the percentage at less than 30%.

- General Performance Category Weights Finalized for 2019:
 - Quality: 45% (down from 50% in 2018)
 - Cost: 15% (up from 10% in 2018)
 - Promoting Interoperability (EHR): 25% (same as 2018)
 - Improvement Activities: 15% (same as 2018)

4. The Performance Threshold

- The Balanced Budget Act also gave CMS flexibility to set the performance threshold in 2019. In the original MACRA legislation, CMS was required to use the mean or median of the performance scores to set the performance threshold starting in 2019. The performance threshold is the score that clinicians must at least meet to avoid a downward payment adjustment (penalty).
- CMS is increasing the performance threshold from 15 points in 2018 to **30 points** in 2019, as proposed.
- There is also an additional performance threshold which if surpassed by clinicians provides an additional bonus on top of their upward payment adjustment. CMS increased this threshold from 70 to **75 points**. In the proposed rule, CMS had proposed increasing it to 80 points.
- As required by law, the maximum negative payment adjustment is -7%, and the positive payment adjustment can be up to 7% (before any exceptional performance bonus). Since MIPS is a budget neutral program, the size of the positive payment adjustments is ultimately controlled by the amount of money available through the pool of negative payment adjustments.

In the rule, CMS provides an example of what the positive adjustments could be in 2021 (based on performance in 2019). CMS estimates that the 7% payment update would be scaled down to 1.11% and that the maximum bonus for exceptional performance would be 3.58%. Therefore, the total maximum payment adjustment a provider could receive in 2021 if they received a perfect MIPS score in 2019 would be 4.69% (1.11% + 3.58%).

5. Facility Scoring Option

- Starting in 2019, CMS is creating a new option for facility-based clinicians to receive credit for the Quality and Cost categories of MIPS.
- To qualify for the facility-based reporting option, clinicians must furnish 75 percent or more of their services in an inpatient hospital, on-campus outpatient hospital, or an emergency room, based on claims for a period prior to the performance period.
- Clinicians must also have billed at least a single service in an inpatient hospital or emergency room. In other words, clinicians who bill every single one of their services in an on-campus outpatient hospital department (which is “Place of Service” 22) would not be eligible. Facility-based reporting is based on the Hospital Value-based Purchasing Program (HVBP) measure set for the provider’s hospital.

- Clinicians eligible for the facility-based reporting option can still report to MIPS under a traditional mechanism (such as through a qualified clinical data registry). If an eligible clinician or group continues to report traditionally, CMS will automatically take the higher of the hospital’s HVBP score and the traditional MIPS score to determine the eligible clinician or group’s Quality and Cost scores. If an eligible clinician chooses not to report any data under the Quality and Cost categories traditionally, then the eligible clinician will simply receive the hospital’s HVBP score. CMS intends to provide as much information as possible as early as possible to clinicians about their eligibility and the hospital performance upon which a clinician’s score would be based. This will help clinicians understand their reporting options and make important financial and operational decisions about how to best participate in MIPS.

6. Quality Performance Category

- To report under the Quality performance category, CMS will allow individuals or groups to submit data using multiple collection types (for example, electronic clinical quality measures (eCQMs), and Qualified Clinical Data Registry (QCDR) measures.) Medicare Part B claims measures can only be submitted by clinicians in a small practice (15 or fewer eligible clinicians), whether participating individually or as a group.
- Clinicians must report data on 60 percent of patients. This requirement remains unchanged from 2018.
- Small practices (defined as 15 or fewer clinicians) will receive a 5-point bonus that will be added to their total Quality performance score.
- CMS is designating quality measures that relate to opioids as a high priority measures, with 2019 performance impacting payments in 2021.

7. Cost Category

- CMS is keeping the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and will add 8 episode-based cost measures.
- The Cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

8. Improvement Activities

- CMS is finalizing some modifications, which include:
 - The addition of one new criterion for nominating new improvement activities called “Include a public health emergency as determined by the Secretary,” and the removal one called “Activities that may be considered for a Promoting Interoperability bonus;”
 - The addition of 6 new Improvement Activities;
 - The modification of 5 existing Improvement Activities; and
 - The removal of 1 existing Improvement Activity.

9. Promoting Interoperability

- The “Advancing Care Information” category has been changed to “Promoting Interoperability.”
- CMS is requiring that clinicians use 2015 Edition certified EHR technology (CEHRT) starting in 2019. CMS is also eliminating the base, performance and bonus scores, and finalizing a new simplified scoring methodology.
- CMS is creating create four overall objectives: e-Prescribing; Health Information Exchange; Provider to Patient Exchange; and Public Health and Clinical Data Exchange
- CMS is also adding two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement.

10. Other Policies of Interest

- **CMS is NOT finalizing the proposal to force QCDR measures that are approved for MIPS reporting to be generally available for other QCDRs’ use without a fee.**
- CMS is not changing the definition of “hospital-based” clinician.
- CMS is finalizing a few proposals related to its public reporting website, Physician Compare. CMS had previously established that Physician Compare would report all measures under the MIPS Quality performance category, but exclude new measures for a year. CMS is now going to exclude new measures for two years.

Alternative Payment Model (APM) Policies

1. Use of Certified EHR Technology (CEHRT)

- In order to currently qualify as an Advanced APM, an APM must require that at least **50%** of the clinicians in each participating entity use CEHRT. CMS is bumping this requirement up to 75%.

2. Definition of Nominal Financial Risk

- An Advanced APM also must have some (a nominal amount) of downside financial risk. CMS is proposing to continue to keep a “revenue-based” standard for determining financial risk, which helps smaller organizations, like physician groups, feel comfortable participating. CMS is maintaining the revenue-based standard at **8%** of estimated Parts A and B revenue of clinicians in participating APM Entities.