

Initial Summary of the 2019 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule

On July 12, 2018, the Centers for Medicare and Medicaid Services (CMS) released the [Revisions to Payment Policies under Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements](#) proposed rule with comment period. This is the first year that CMS is combining the Medicare PFS and the Quality Payment Program proposed rules. CMS is requesting comments on the proposed rule by September 10, 2018, and a final rule is expected to be released in November. CMS has published several fact sheets on the rule including a [fact sheet on the QPP changes](#), and a [fact sheet on the PFS proposals for 2019](#). AMA is continuing to review the rule and will work with our colleagues in the federation to further analyze and draft responses to these proposals in the coming weeks. Below is a summary of some of the proposals included in the draft regulation.

I. Physician Fee Schedule Proposals

Physician Payment Update

The 2019 Medicare Physician Payment Schedule Conversion Factor is \$36.0463. The Anesthesia conversion factor is \$22.2986. The 2019 conversion factors reflect a statutory update of .25%, offset by a budget neutrality adjustment of -0.12 percent, resulting in a 0.13 percent update.

Practice Expense Relative Values

Market-Based Supply and Equipment Pricing Update

As part of their authority under Section 220(a) of the Protecting Access to Medicare Act of 2014 (PAMA), CMS initiated a market research contract with a consulting firm, StrategyGen, to update the direct practice expense inputs for supply and equipment pricing for CY 2019.

Based on the report from StrategyGen, CMS is proposing updated pricing recommendations for 2017 supply and equipment items currently used as direct practice expense (PE) inputs. Market research resources and methodologies included field surveys, aggregate databases, vendor resources, market scans, market analysis, physician substantiation, and statistical analysis. CMS is proposing to update supply and equipment pricing over a 4 year phase-in.

Proposed Additional PE/HR Calculation for Evaluation and Management Services

CMS determines the proportion of indirect PE allocated to a service by calculating a PE/Hour based upon the mix of specialties that bill for a service. Because such a broad range of specialties bill E/M services, CMS' proposal to change the structure of E/M visit into one single visit level and payment rate would have a large effect on the PE/Hour for many specialties. To address this issue CMS is proposing to create a single PE/Hour value for E/M visits of \$136.34, based on an average of the PE/HR across all specialties that bill E/M codes, weighted by the volume of those specialties' allowed charges for E/M services.

Professional Liability Insurance (PLI) Relative Values

CMS seeks specific comment on ways to improve how specialties in the state-level raw rate filings data are crosswalked for categorization into CMS specialty codes in order to develop the specialty-level risk factors and the PLI RVUs. In a March 30, 2018, letter to CMS, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) clearly offers to assist CMS with the categorizations of the rate filings and applying the specialty

descriptions from the rate filings to the appropriate specialty codes.

CMS proposes to add 28 codes identified as low volume services to the list of codes for anticipated specialty assignment. These codes are reported with the -26 modifier and were submitted by the RUC as part of the February recommendations to CMS.

In the Addendum for the CY 2019 Malpractice Risk Factors and Premium Amounts by Specialty, CMS continues to crosswalk non-MD/DO specialties to the lowest MD/DO risk factor specialty, Allergy Immunology. The RUC has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician health care professions.

For 2019, cardiothoracic surgery and neurosurgery, specialties with high professional liability costs, are proposed to receive positive impacts to payments related to their insurance costs.

Global Surgery Data Collection

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on postoperative visits and use these data to assess the accuracy of global surgical package valuation. Beginning July 1, 2017, CMS required groups with 10 or more practitioners in nine states to use the no-pay CPT code 99024 to report postoperative visits for specified procedures. Of practitioners that met the criteria for reporting, only 45 percent participated — this varied substantially by specialty. Among procedures performed by “robust reporters” of 99024, only 16 percent of 010-day global services and 87 percent of 090-day global services had one or more matched visits reported (volume-weighted). The Agency is soliciting comments pertaining to increased compliance and also whether visits are typically being performed in the 010-day global period. Also, they are soliciting comment on whether they should mandate the usage of modifiers -54 “for surgical care only” and -55 “post-operative management only”, regardless of whether the transfer of care is formalized.

2019 Potentially Misvalued Codes List

Each year, CMS proposes a list of potentially misvalued codes for review by the RUC and possible adjustment. Since 2006, the RUC and CMS have identified 2,386 services through 20 different screening criteria for further review by the RUC. The RUC’s efforts for 2009-2018 have resulted in \$5 billion for redistribution within the Medicare Physician Payment Schedule. CMS received

public nominations identifying nine codes as potentially misvalued for review in future rulemaking.

RUC Recommendations

CMS announced proposed work relative values for nearly 200 CPT codes reviewed by the AMA/Specialty Society RVS Update Committee. CMS proposed to accept 71 percent of the RUC recommendations and 81 percent of the RUC’s Health Care Professional Advisory Committee recommendations for CPT 2019. The AMA will advocate that CMS adopt the RUC recommendations. For example, the RUC recommendation for new CPT code 994X7 for chronic care management personally delivered by a physician was based on survey data from more than 150 physicians and CMS has instead proposed to value the service using a flawed formulaic approach. CMS did not consider the RUC recommendation for 20 x-ray services as formal surveys were not conducted by radiology and other specialties. Instead, CMS proposes to value these x-ray services the same, regardless of anatomical area imaged or the number of views. The RUC will work with national medical specialty societies to comment on the CMS proposals.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS seeks to expand access to medical care using telecommunications technology by proposing to cover a number of new services. CMS asks for comment on the description, coverage and valuation of three new CMS created HCPCS codes including: brief, non-face-to-face appointments via communications technology (virtual check-ins); evaluation of patient submitted photos; and the foregoing codes bundled together for use by federally qualified health centers and rural health clinics. In addition, CMS proposes to value new CPT codes for Interprofessional Internet Consultation (CPT codes 994X6, 994X0) consistent with AMA ongoing recommendations while also proposing to unbundle and cover existing CPT codes (99446, 99447, 99448, and 99449). CMS also proposes to cover and value new CPT codes for Chronic Care Remote Physiologic Monitoring (990X0, 990X1, and 994X9) also consistent with AMA ongoing advocacy.

Also, CMS proposes modifications to existing regulations required by the recent passage of the Bipartisan Budget Act of 2018 mandating expanded coverage of telehealth (two-way audio, visual real time communication between physician and patient). CMS proposes to expand coverage of telehealth services and modify or remove limitations relating to geography and patient setting for certain telehealth services, including for end-stage renal disease home dialysis evaluation; diagnosis, evaluation,

and treatment of an acute stroke; and, services furnished by certain practitioners in certain accountable care organizations. CMS also proposes to expand telehealth coverage for prolonged preventive services (but coverage would still be subject to statutory geographic and originating site restrictions). The AMA is very supportive of proposals to expand telehealth coverage.

Evaluation and Management (E/M) Proposals for 2019

Removing Restrictions on E/M Coding

CMS’ proposal eliminates the requirement to document medical necessity of furnishing visits in the home rather than office. Home visits (CPT codes 99341-99350) are paid significantly higher than office visits. The proposal also eliminates the prohibition on same-day E/M visits billed by physicians in the same group or medical specialty.

Documentation Changes for Office/Other Outpatient/Home Visits

CMS is considering eliminating CPT codes for office visits and creating a single G code. However, logistical considerations related to secondary payers led CMS to propose to continue to use existing CPT structure.

Physicians will be allowed to choose method of documentation, among the following options:

1. 1995 or 1997 Evaluation and Management Guidelines for history, physical exam and medical decision making (current framework for documentation)
2. Medical decision making only
3. Physician time spent face-to-face with patients

CMS assumes that some physicians will continue to document and report among the five levels of codes. CMS will only require documentation to support the medical necessity of the visit and to support a level 2 CPT visit code.

In order to report an established office visit to Medicare, physicians need to document medical necessity and then one of the following:

- (1) Two of the three components: (1) problem-focused history that does not include a review of systems or a past, family or social history; (2) a limited examination of the affected body area or organ system; and (3) straightforward medical decision making measured by minimal problems, data review and risk; or
 - (2) Straightforward medical decision making measured by minimal problems, data review and risk;
- or

- (3) Time personally spent by billing practitioner face-to-face with the patient. CMS is soliciting comment on what time should be required if this is the documentation selection (two options mentioned, 10 minutes (CPT defined typical time) or 16 minutes (weighted average of all established office visits).

CMS is seeking comment on other documentation systems (eg, Marshfield clinic). Comments are also sought on the impact of these proposals on clinical workflows and EHR systems. In addition, physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated. CMS is seeking comment if this should be expanded to medical decision-making. CMS will eliminate re-entry of information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner must only document that they reviewed and verified the information.

Condensing Visit Payment Amounts

CMS calls the system of 10 visits for new and established office visits “outdated” and proposes to retain the codes but simplify the payment for applying a single payment rate for level 2 through 5 office visits.

CPT Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99201	\$45	\$43
99202	\$76	\$134
99203	\$110	
99204	\$167	
99205	\$211	

CPT Code Est. Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99211	\$22	\$24
99212	\$45	\$92
99213	\$74	
99214	\$109	
99215	\$148	

Other Coding/Payment Proposals Related to E/M

CMS proposes to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes

on the same day as a separately identifiable E/M visit. The policy is not consistent with current valuation of procedures commonly performed with office visits, as duplicative resources have already been removed from the underlying procedure. It appears that CMS proposes this policy to offset payment increases to dermatology and other specialties that often report lower level office visit codes in conjunction with minor procedures.

CMS will add \$5 to each office visit performed for primary care purposes (definition to be determined via comment process) via a new code GPC1X. *Visit complexity inherent to evaluation and management associated with primary medical care services.*

CMS identified several specialties that often report higher level office visits and noted the potential reduction in payment. To offset this loss, CMS proposes to add \$14 to each office visits performed by the specialties listed below via a new code GCG0X. *Visit complexity inherent to evaluation and management associated with:*

*Allergy/Immunology
Cardiology
Endocrinology
Hematology/Oncology
Interventional Pain Management-Centered Care
Neurology
Obstetrics/Gynecology
Otolaryngology
Rheumatology
Urology*

Podiatry would no longer report office visit codes 99201-99215 and would be directed to report GPD0X *Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient* (\$102) and GPD1X *Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient.* (\$67)

CMS modifies the practice expense methodology to compute a PE RVU for the new blended E/M payment rate by blending the PE/Hour across all specialties that bill E/M codes, weighted by the volume of those specialties' allowed E/M services.

A new prolonged service code will be implemented to add-on to any office visit lasting more than 30 minutes beyond the office visit (ie, hour long visits in total). The code GPRO1 *Prolonged evaluation and management or psychotherapy services(s) (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)* will have a payment rate of \$67.

A neurologist currently reporting a 99205 and spending more than 60 minutes with a patient would be paid \$211. Under the proposed new method, the neurologist would report 99202-99205, depending on their documentation selection, \$134 + GCG0X, \$14 + GPRO1, \$67, for a combined payment of \$215. AMA staff will work to simulate the CMS impact analyses.

Implementation Date and Future Proposals

The proposed implementation date is January 1, 2019. CMS is seeking comment on whether the implementation should be delayed to January 1, 2020. CMS will consider changes to Emergency Department Visits (CPT codes 99281-99285) and other E/M code sets in the future and seeks additional comment on these code families. In addition to implementation of a number of digital medicine/telehealth new payment opportunities, CMS calls for comments on additional codes and payment related to care coordination services.

Appropriate Use Criteria (AUC)

The AUC program requires ordering providers to consult with applicable AUC through a qualified clinical decision support mechanism for applicable imaging services. CMS previously delayed implementation of this program by including a voluntary reporting period, which started in July 2018 and runs through December 2019. In 2020, the AUC program period will begin with an educational and operations testing period, during which CMS will continue to pay claims whether or not they correctly include AUC information. Additionally, in this proposed rule, CMS proposes to:

- Expand the definition of an applicable setting to include independent diagnostic testing facilities;
- Create significant hardship exceptions from the AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- Establish the coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims; and
- Allow non-physicians, under the direction of an ordering professional, to consult with AUC when the consultation is not performed personally by the ordering professional.

CMS clarified that the AUC consultation information must be reported on all claims for an applicable imaging service (e.g., if separate, both the technical and professional claim must include the AUC information). CMS also invites comments on how to identify potential outliers that will be subject to prior authorization.

Bundled Episode Payment for Substance Use Disorder (SUD) Treatment

CMS seeks comment on a bundled episode-based payment for SUD treatment, including: codes, payments, components of a medication-assisted treatment (MAT) program, regulatory changes to help prevent opioid use disorder and improve access to treatment, identification of non-opioid alternatives for pain management and barriers to coverage of these alternatives. AMA has worked with the American Society of Addiction Medicine (ASAM) on an APM for managing treatment of opioid use disorder, but has some concern about implications of such an episode as part of the Physician Fee Schedule, particularly if subject to budget neutrality requirements.

Teaching Physician Documentation Requirements for E/M Services

CMS proposes revising federal regulations by allowing the presence of the teaching physician during evaluation and management services to be demonstrated by the notes in the medical records made by a physician, resident, or nurse. CMS also proposes revising federal regulations to provide that the medical record must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary, and that the extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

The proposed rule may be contrary to CMS guidance dated May 31, 2018, regarding [E/M Documentation Provided by Students](#). The May 2018 CMS guidance document allows teaching physicians to use medical student documentation, including history, physical exam and/or medical student decision making provided that he/she personally performs or re-performs the physical exam and medical decision making of the evaluation and management service and verifies the student's documentation. CMS' proposed rule does not incorporate the policy outlined in the May 2018 CMS guidance document related to E/M documentation provided by students.

Solicitation of Public Comments on the Low Expenditure Threshold Component of the Applicable Laboratory Definition under the Medicare Clinical Laboratory Fee Schedule (CLFS)

The proposed rule contains a significant discussion regarding the laboratories required to report payment data to CMS under the PAMA. CMS notes that laboratory stakeholders have expressed concerns that CY2018 payment

rates for laboratory testing services paid on the CLFS are based on data that is not representative of the laboratory community, meaning that too few physician office laboratories, small independent laboratories, and hospital outreach laboratories are reporting pricing data to CMS. CMS is examining ways to ensure adequate reporting from all sectors of the laboratory community, proposing some changes to the Medicare revenue thresholds that trigger reporting requirements. The agency does state concern about the ability of physician-office based laboratories to accurately report the required information and the administrative burden that reporting places on physician practices, requesting more information about these issues from commenters. The AMA continues to work with physician specialty organizations and other laboratory community stakeholders to ensure adequate reimbursement for clinical testing services performed in office-based laboratories and plans to submit detailed comments on the impact on physician practices and patients.

Part B Drugs: Application of an Add-on Percentage for Certain Wholesale Acquisition Cost (WAC)-based Payments

As called for in the President's 2019 budget proposal, the rule would reduce Medicare reimbursement rates for new drugs just coming onto the market. Generally, Medicare payment is tied to the Average Sales Price (ASP) for drugs, including discounts and rebates. Because there is no ASP data for new drugs, however, reimbursement during the first quarter they are available is tied to the Wholesale Acquisition Cost (WAC), which is based on the manufacturer's list price and does not include discounts and rebates. The ASP or WAC is then increased by 6 percent to reflect overhead costs (but after a 2 percent sequester cut is applied to Medicare's share of the payment, the add-on is actually 4.3 percent). Following a recommendation from the Medicare Payment Advisory Commission (MedPAC), the Administration is proposing to reduce the new drug add-on to 3 percent (which would then be subject to the sequester cut) for a period of three months.

Medicare Shared Savings Program (MSSP) Updates to Quality Measures

In an effort to reduce administrative burden, eliminate redundant measures, and focus the MSSP quality measure set on more outcomes and patient experience measures, CMS proposes to eliminate ten measures and add one measure to the MSSP quality measure set beginning in performance year 2019. The changes would result in 24 measures for which ACOs would be held accountable. Two of the measures proposed for removal are related to admissions and the AMA has continually advocated

that the measures be removed because they disincentive physicians in ACOs from appropriately admitting patients and providing high quality care.

II. Quality Payment Program Proposals

General Issues

MIPS Expanded to New Clinician Types

CMS uses statutory authority to expand MIPS eligible clinicians to new clinician types including physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

Low-Volume Threshold

CMS is proposing to add a third criterion for physicians to qualify for the low-volume threshold--providing fewer than 200 covered professional services to Part B patients. CMS is also proposing a new opt-in policy that allows practices to opt-in to participate in the MIPS program or create virtual groups if they meet or exceed one or two but not all of the low-volume threshold elements (have less than or equal to \$90,000 in Part B allowed charges for covered professional services, provide care to 200 or fewer beneficiaries, or provide 200 or fewer covered professional services under the PFS).

Performance Threshold

CMS proposes to set the overall performance threshold for determining bonuses or penalties at 30 points and the additional exceptional performance threshold at 40 points for performance year 2019.

Medicare Part B Drugs

As Congress required in the Bipartisan Budget Act of 2018, CMS proposes to remove Part B drugs from the low-volume threshold determinations and from physicians' payment adjustments.

Special Status Determination Periods

CMS proposes to consolidate the determination periods to establish whether a practice qualifies for special statuses including the low-volume threshold, non-patient facing physician, small practice, and hospital-based physician. The new consolidated determination periods will run from October 1, 2017 to September 30, 2018 and from October 1, 2018 to September 30, 2019.

Virtual Groups

CMS made very minor changes to its virtual group policies for the 2019 performance year. Physicians can now inquire about their groups' TIN size through the QPP Service Center, and can make an election to participate in a Virtual Group via a web-based system beginning in 2022.

Facility-Based Scoring Option

2019 is the first year physicians can choose to use a facility-based scoring option for the MIPS quality and cost performance categories. Specifically, in order to use facility-based scoring, physicians must perform 75 percent of their services in inpatient, on-campus outpatient or emergency room settings, and must have at least one service billed with the place of service (POS) code used for inpatient (21) or emergency room (23). For groups, 75 percent or more of the National Provider Identifiers (NPIs) billing under the group's Tax Identification Number (TIN) must be eligible for facility-based measurement as individuals.

Facility-based scoring will automatically be applied to MIPS eligible clinicians and groups who qualify and would benefit by having the facility-based score for their quality performance, as long as they submit data under the Improvement Activity (IA) or Promoting Interoperability (PI) categories. CMS maintains the 30 percent floor, so any physician who scores below 30 percent via the facility-based reporting option would have their score reset to 30 percent in the quality performance category. CMS is also seeking comment on possibly expanding the facility-based scoring option to other settings in future years, specifically to post-acute care and end-stage renal disease settings.

Accounting for Social Risk Factors

CMS proposes to maintain the complex patient bonus. CMS proposes to change the eligibility determination period for this bonus to October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the performance period occurs, similar to the proposed changes to the special status determination period.

Quality: Now 45 percent of a physician's final score

Meaningful Measures Initiative

CMS is continuing its Meaningful Measures initiative and notes it believes this will streamline reporting for physicians. Quality measure changes include adding ten new quality measures, removing 36 measures immediately, and removing 52 measures using a more gradual process for measure removal provided in the CY 2018 final rule. As part of this effort, CMS proposes to revise the definition of a high-priority measure to include quality measures that relate to opioids and to further clarify the types of outcome measures that are considered high priority. CMS proposes a high-priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related

quality measure. We have concerns with the large number of measures being removed absent a reduction in quality reporting requirements and will further analyze how this will affect physicians in different specialties.

New Reporting Option

CMS proposes to allow for a combination of data collection types for the quality performance category. CMS will score the measure based on the most successful collection type. The multiple-submission type option does not apply to web-interface reporters.

CMS proposes to limit the claims based reporting option to individuals who are in small practices. However, CMS also expands the claims-based reporting option to allow small group practices (15 or fewer eligible clinicians) to report via claims.

Small Practices

CMS maintains the three point floor for quality measures that do not meet the data completeness requirement. In addition, CMS proposes to move the small practice bonus points to a physician's quality category score. The small practice bonus points would be capped at 3 points for 2019.

Reporting Period

CMS maintains a full-year reporting period for the quality performance category in 2019, despite the AMA's advocacy to allow physicians and groups the option to submit a minimum of 90-days of data.

Score Re-weighting

CMS proposes to re-weight a physicians' score in the quality performance category if the score cannot be calculated due to lack of available measures, due to extreme and uncontrollable circumstances, or if an eligible clinician joined a practice in the last 90-days of a performance period and the practice does not participate as a group.

Data Completeness Criteria, Threshold and Scoring

CMS maintains that for a physician to be successful in reporting on a measure, they must meet the data completeness criteria of 60 percent of all denominator eligible patients, and must report a minimum of 20 cases. Physicians reporting via claims must report on 60 percent of Medicare Part B patients only and on a minimum of 20 cases.

If a measure has a benchmark and a physician meets the data completeness criteria, they are eligible to receive three to ten points based on performance compared

to the benchmark. If a physician fails to meet the data completeness criteria, they would only be eligible to receive three points. CMS proposes to reduce the point floor to one point in the 2020 performance period, except for small practices who would continue to receive three points if they do not meet the data completeness criteria.

Topped Out Measures

For the 2020 payment year, six measures will receive a maximum of seven measure achievement points, provided that the applicable measure benchmarks are identified as topped out again in the benchmarks published for the 2018 performance period. Beginning with the 2021 MIPS payment year, measure benchmarks (except for Web Interface) that are identified as topped out for two or more consecutive years will receive a maximum of seven measure achievement points beginning in the second year the measure is identified as topped out.

Measures Impacted by Clinical Guideline Changes

Measures impacted by clinical guideline changes will be given a score of zero, and the physician who reports the measure will have his or her quality performance category denominator score reduced by 10.

Bonus Points

- **High-Priority Measures:** For the 2019 performance year, CMS proposes to discontinue awarding bonus points to CMS Web Interface reporters for reporting high-priority measures, but would continue the high priority bonus (as long as a physician reports on a minimum of one high-priority measure) for all other reporting types.
- **End-to-end Reporting:** CMS proposes to continue to assign bonus points for end-to-end reporting for the 2021 payment year as a way to incentivize reporting through electronic means.

Future Approaches to Scoring the Quality Performance Category

CMS is seeking comment on several approaches to scoring quality in the future as an effort to move physicians toward reporting high-value measures and more accurate performance measurement. The AMA has some initial concerns with the proposals because they appear to add complexity to the program as opposed to simplifying scoring and reducing physician burden.

Cost: Now 15 percent of a physician's final score

Cost Category Weight

Currently, 10 percent of physicians MIPS score is tied to

costs. This was originally scheduled to rise to 30 percent in the 2019 performance year; however, legislation pushed by the AMA and adopted earlier this year authorized CMS to weight costs at any level from 10 percent to 30 percent through the next three years. CMS is proposing to increase the cost weight to 15 percent in 2019 and then increase it by an additional 5 percent in each of the next two performance years until it reaches the maximum 30 percent in the 2022 performance year.

Cost Measures

The proposed rule would retain the two existing cost measures (Medicare Spending Per Beneficiary and Total Per Capita Cost of Care) with no changes and add eight new episode-based measures in 2019. All of the measures include both Part A and Part B costs and are calculated from administrative claims. CMS intends to continue setting a relatively low 0.4 percent reliability threshold for all of the cost measures in order to “measure as many clinicians as possible in the cost performance category.” The agency is also considering increasing the length of the cost category measurement period to two years in the future so more physicians would meet minimum case thresholds to be counted in at least one cost measure.

Unlike the current measures, which had no real clinical input, the new episode measures were developed with significant input from clinicians. They have undergone a limited pilot test in which most, but not all, exceeded the 0.4 percent reliability threshold. Five of the new measures are tied to costs associated with a particular procedure (elective percutaneous coronary intervention, knee arthroplasty, revascularization for lower limb ischemia, routine cataract removal with IOL, and screening colonoscopy). Three (intracranial hemorrhage or cerebral infarction, simple pneumonia with hospitalization and ST-Elevation Myocardial Infarction with PCI) involve costs associated with an acute inpatient medical condition. Reliability was generally higher for the procedural than the medical measures.

Procedural episodes would be attributed to any physician who billed one of the trigger procedure codes, and any physician with at least 10 episodes in a given measure would be scored on it. For medical condition measures, CMS proposes to attribute episodes to each physician who bills for inpatient E/M services and is affiliated with a group (TIN) that provides at least 30 percent of inpatient E/M codes during a hospitalization for the condition in question. To have the measure counted in the cost score, the TIN would need a minimum of 20 cases. Earlier versions of the measure were attributed at

the individual level rather than the TIN level unless the physicians participated as a group. The modification is intended to make more physicians subject to the cost category.

Promoting Interoperability (PI) (previously Advancing Care Information): 25 percent of a physician’s score

2015 Certified Electronic Health Record Technology (CEHRT)
CMS proposes to require all physicians to use 2015 CEHRT in 2019.

Program Requirements

CMS proposes to allow physicians to report fewer measures, and adopts a new performance-based scoring methodology, rather than the previous threshold approach. Proposals also include the elimination of the base, performance and bonus scoring. Instead, CMS would score physicians on a 100 point scale at the individual measure level. CMS also maintains the hardship exemption for this performance category.

New Measures

CMS proposes to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement. It also consolidates two former measures into one new measure: Receive and Incorporate Health Information.

Reporting Period

CMS proposes to allow physicians to report for any consecutive 90-day reporting period in 2019.

Improvement Activities (IA): 15 percent of a physician’s score

IA Reporting

CMS proposes to maintain an attestation reporting option and a 90-day reporting period for the IA performance category. CMS also proposes to maintain reduced reporting requirements for small practices. CMS is proposing six new IAs, modifications to five existing IAs, and removal of one existing IA.

Bonuses in PI Category

The previous bonus that physicians could receive in the ACI / PI category for completing certain IA activities has been removed. As such, proposed IAs must meet one of CMS’ other enumerated criteria to be considered for inclusion in the program (in previous years, an IA that could result in a PI bonus would be sufficient to be considered for inclusion by CMS).

New IA Criterion

CMS is proposing to adopt an additional criterion entitled “Include a public health emergency as determined by the Secretary” to the criteria for nominating new IAs to promote clinician adoption of best practices to combat public health emergencies such as the opioid epidemic. New IAs are not required to meet this criterion; rather, it is an additional option for stakeholders to utilize when submitting nominations for new IAs.

Alternative Payment Models (APMs)*Advanced APMs*

Consistent with AMA recommendations not to require APM participants to take increased financial risk in order to qualify as Advanced APMs, CMS proposes to maintain the revenue-based financial risk requirement for Advanced APMs at 8% of revenues for an additional 4 years, from 2021 through 2024.

Beginning in 2019 for Medicare APMs and 2020 for Other Payer APMs, CMS proposes to increase from 50% to 75% the percentage of an APM’s participating physicians required to use CEHRT in order for APMs to qualify as Advanced APMs. AMA previously opposed such an increase and is considering recommending alternative approaches to meeting requirements for use of health IT in Advanced APMs.

All-Payer Combination Option

Consistent with AMA advocacy, CMS proposes to allow participants in Other Payer APMs to describe their compliance with requirements that 50% of APM physicians use CEHRT, instead of mandating that APM payment contracts explicitly require use of CEHRT. As AMA recommended, CMS proposes to certify Other Payer APMs as meeting CMS requirements for APMs for up to 5 years instead of having to annually re-apply.

CMS proposes to add a third option to assess whether physicians have met the All-Payer threshold for Qualified APM Participants at the practice level (Taxpayer ID Number), in addition to the individual level and the APM Entity level. CMS also clarifies that APM participants can meet Medicare and Other Payer participation thresholds using patient counts for one threshold and payment counts the other threshold, whatever is most advantageous to the physician.

MAQI Demonstration

In response to AMA advocacy aimed at helping physicians who practice in areas with an above-average proportion of Medicare patients in Medicare Advantage (MA) plans, the proposed rule waives requirements

for MIPS reporting and MIPS payment adjustments for physicians participating in MA APMs, effective in 2018, whether or not the physician also participates in APMs for Medicare fee-for-service patients.

Physician Compare

CMS proposes not to publicly report first year quality and cost measures for the first two years a measure is in use to help clinicians and groups first gain feedback in program. CMS also proposes to only use an indicator for “successful” performance in the PI performance category starting with year two data. CMS also proposes to determine measure benchmarks based on historical data beginning with year three, and add star ratings for Qualified Clinical Data Registry (QCDRs) measures beginning with performance year two.

Notes on Estimated Impacts of the 2019 QPP Proposals

Although CMS recently provided physicians with performance feedback and scores for their 2017 MIPS reporting, the estimated impacts in the 2019 proposed rule are still based on reporting under the legacy programs that predated MIPS. Last year’s final rule projected that 90 percent of MIPS-eligible clinicians would participate in MIPS reporting, and 97.1 percent of these clinicians in practices of all sizes would receive a positive or neutral payment adjustment in 2020 based on their 2018 MIPS reporting. The current proposed rule forecasts that 96.1 percent of clinicians in practices of all sizes will receive a positive or neutral payment adjustment in 2021 based on 2019 MIPS reporting.

For clinicians in practices of 15 or fewer, last year’s rule projected 90 percent of MIPS participants would get a neutral or positive payment adjustment. The current proposed rule projects that 92.5 percent of MIPS participants in practices of 15 or fewer will get a neutral or positive payment adjustment in 2021. The percentage of clinicians in small practices that are projected to get an “exceptional” payment adjustment is 46.4 percent. CMS estimates that clinicians in small practices participating in MIPS will perform as well or better than mid-size practices and will receive an average 1.9 percent incentive payment. CMS also notes that 28,096 of the 31,921 clinicians who are projected to be MIPS-eligible but not to submit any MIPS data are in practices of less than 15.

The 2018 final rule contained two different estimates of the number of APM participants excluded from MIPS on that basis, listed in one impact table as 70,732 and elsewhere in the rule as between 185,000 and 250,000. The 2019 proposed rule projects that between 160,000 and 215,000 clinicians will be Qualified APM Participants in the 2021 payment year.

III. Requests for Information (RFIs)

RFI on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to CMS Patient Health and Safety Requirements for Hospitals and Other Medicare/Medicaid Participating Providers and Suppliers

CMS issued a request for information on promoting interoperability and the electronic exchange of health care information. The AMA plans on commenting on this section and has previously commented on a similar RFI in the Hospital Inpatient Prospective Payment System (IPPS) proposed rule.

RFI on Price Transparency: Improving Beneficiary Access to Providers and Supplier Charge Information

The proposed rule includes a RFI on price transparency initiatives under consideration by CMS. In the RFI, CMS encourages all providers to undertake efforts to engage in “consumer-friendly communication of their charges and potential financial liability for the patient.” The RFI is seeking input from responders regarding issues such as the definition of “standard charges,” types of information beneficial to patients, potential requirements for providers and suppliers to provide out-of-pocket cost information to patients prior to services, and Medigap coverage and its impact of patient understand of out of pocket costs. The AMA is generally supportive of efforts to provide patients with better information regarding the costs of physician services and plans to respond to this RFI. The AMA recently submitted comments to Congress on a similar RFI.