

## **NAACOS Analysis of the Proposed 2019 Medicare Physician Fee Schedule**

### **Executive Summary**

In mid-July, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2019 Medicare Physician Fee Schedule (MPFS) [rule](#) and related [factsheet](#). This regulation includes proposed policies affecting Medicare physician payment, quality measure changes for Medicare Shared Savings Program (MSSP) ACOs and Quality Payment Program (QPP) requirements for 2019. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included annual 0.5 percent increases to the Medicare conversion factor through 2019. This increase as well as other statutory requirements and CMS's proposals results in a projected conversion factor of \$36.05 for 2019, which is a minor increase from the \$35.99 conversion factor included in the 2018 final MPFS. Some of the key issues affecting ACOs are shown below and further detailed in the analysis. NAACOS is seeking member input on the proposals included in this rule, which will help us shape our comment to CMS. Please share your feedback by emailing us at [advocacy@naacos.com](mailto:advocacy@naacos.com).

### **Medicare Physician Fee Schedule Proposals**

- Allow providers to select from a few options for documentation of office and outpatient Evaluation & Management (E/M) services
- Establish a single PFS rate for new patient office/outpatient E/M visit levels 2 through 5 and create a single rate for established patient office/outpatient E/M visit levels 2 through 5, along with introducing add-on codes for primary and specialty care
- Update the MSSP quality measure set, including proposals that would reduce the total MSSP quality measure set from 31 measures to 24 measures. Specifically, CMS proposes to eliminate 10 measures and add two Consumer Assessment of Healthcare Provider and Systems (CAHPS) for ACOs survey measures as well as a new Web Interface measure focused on screening for falls.
- Add the following codes to the list of telehealth services: Healthcare Common Procedure Coding System (HCPCS) codes G0513 and G0514 (Prolonged preventive service(s))
- Modify writing and signature requirements for the compensation arrangements exception of the Stark law in accordance with the Bipartisan Budget Act of 2018
- Introduce a new chronic care management code (CCM), 994X7, which reflects 30 minutes or more of CCM furnished by a physician or other qualified health care professional
- Change payment policy regarding two newly defined physicians' services furnished using communication technology including 'Brief Communication Technology-based Service' (e.g. Virtual Check-In) and 'Remote Evaluation of Recorded Video and/or Images Submitted by the Patient.' CMS also proposes to pay separately for new coding describing Chronic Care Remote Physiologic Monitoring and Interprofessional Internet Consultation.

- Allow payment for communication technology-based services and remote evaluation services furnished by rural health clinics and federally qualified health centers
- Establish policies for the continued implementation of the Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging services
- Seek comment on the creation of a new bundled episode of care for management and counseling treatment for substance use disorders and methods to identify non-opioid alternatives for pain treatment and management

### **Quality Payment Program (QPP) Proposals**

- Establish a 30-point performance threshold and 80-point exceptional performance threshold for the Merit Based Incentive Payment System (MIPS)
- Make changes to the Promoting Interoperability performance category (formerly Advancing Care Information) including requiring the use of 2015 CEHRT beginning in 2019
- Modify how CMS establishes quality benchmarks to make more fair comparisons in MIPS. This change is a direct result of NAACOS advocacy, and we are pleased to see this proposal.
- Expand the definition of MIPS eligible clinicians (ECs) to include physical therapists, occupational therapists, clinical social workers, and clinical psychologists
- Create a new opt-in policy to allow those who meet some, but not all of the MIPS exclusion criteria to voluntarily opt-in to MIPS
- Maintain the revenue-based standard for Advanced Alternative Payment Model (APM) risk requirements at 8 percent through performance year 2024, for both Medicare APMs and Other Payer APMs
- Increase the CEHRT use requirement for Advanced APMs from 50 to 75 percent, starting in 2019 for Medicare APMs and starting in 2020 for Other Payer APMs
- Refine certain processes for the All-Payer Combination Option, including opportunities to avoid annual submission requirements for details on Other Payer APM arrangements
- Introduce a waiver of MIPS as part of testing the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration

## **Physician Fee Schedule Proposals**

### **Medicare Shared Savings Program Quality Measure Changes**

CMS makes several proposed changes to the MSSP quality measure set for 2019. As a result of these proposals, CMS would reduce the current quality measure set from 31 measures to 24 measures. CMS proposes to delete/retire 10 measures while adding three measures, as outlined in Table 25 in the proposed rule on page 35878. These changes are described in further detail below.

### **Changes to Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures**

CMS proposes to begin scoring ACOs on two new CAHPS measures:

- ACO-45, Courteous and Helpful Office Staff

- ACO-46, Care Coordination

These measures are currently collected in the CAHPS for ACOs survey, but ACOs are not scored on such measures at this time and rather are provided information on the measures for informational purposes only. CMS requests comments on whether the agency should score ACO-7, Health and Functional Status, as a pay-for performance measure in the future (this measure is currently pay-for-reporting in all program years). Additionally, CMS requests comments on possible options for the agency to enhance collection of functional status data in the future, such as collecting data from the same beneficiaries over time.

#### Other Measure Changes

CMS proposes to remove the following quality measures for MSSP ACOs:

- ACO-35, Skilled Nursing Facility (SNF) 30-day Readmissions
- ACO-36, All-cause Unplanned Admissions, Diabetes
- ACO-37, All-cause Unplanned Admissions, Heart Failure
- ACO-44, Use of Imaging Studies for Low Back Pain
- ACO-12, Medication Reconciliation Post-Discharge
- ACO-13, Falls Screening for Future Falls Risk
- ACO-15, Pneumonia Vaccination Status for Older Adults
- ACO-16, BMI Screening and Follow-Up
- ACO-41, Diabetes Eye Exam
- ACO-30, IVD Use of Aspirin or Another Antiplatelet

CMS will continue to provide ACOs with feedback on their imaging use via the quarterly claims-based quality reports. Because CMS proposes to remove ACO-41 from the diabetes composite included in the MSSP measure set, ACO-27, Diabetes HbA1c Poor Control, would now be assessed as an individual measure. As a reminder, beginning in 2019 ACO-11, Use of Certified Electronic Health Record Technology (CEHRT) is a pay-for-performance measure. CMS continues to rely on MIPS Promoting Interoperability specifications for this measure. More information on proposed changes to the PI performance category criteria are outlined in this analysis.

#### Additions to Group Practice Reporting Option (GPRO) Web Interface quality measure set:

- ACO-47, Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls

CMS also discusses the possibility of adding a replacement measure to address SNF readmissions in the future and seeks comment on this proposal. Finally, CMS seeks comments regarding the possibility of expanding the core set of Web Interface measures in the future to include specialty measures, such as surgery measures. Tables 25 and 26 from the proposed rule, found on pages 35878-35879 outline the new measure set and domains, as proposed.

### **Evaluation & Management (E/M) Visits**

CMS has long acknowledged the need to revise payment, guidelines, and documentation requirements for billing E/M services, and the agency takes important steps in this rule. The proposals initially focus on office and outpatient E/M codes (Current Procedural Terminology (CPT) codes 99201 through 99215), though the agency may evaluate other E/M codes in the future. CMS proposes more flexibility related to documentation for office or outpatient E/M visits and home visits by allowing practitioners to continue using the current framework specified under the 1995 or 1997 E/M documentation guidelines, or use Medical Decision Making (MDM) or time as a basis to determine the appropriate E/M level. This would provide choices for providers to document the factors most relevant to their clinical practice.

Regardless of the selected documentation approach, the payment rates for E/M codes would change under CMS's proposed policy. Specifically, the agency proposes to create and pay a single PFS rate for new patient office/outpatient E/M visit levels 2 through 5 and to create and pay a single rate for established patient office/outpatient E/M visit levels 2 through 5. This proposal retains the current CPT coding structure for E/M visits, except for podiatry, and practitioners would report the appropriate level of visit they furnished using the existing CPT codes. Level 1 office/outpatient E/M visits would be paid at lower rates, and Tables 19 and 20 on page 35840 show estimated payment rates of \$135 for the blended level 2 through 5 for new patients and \$93 for established patients.

The agency proposes to apply a minimum documentation standard where for the purposes of PFS payment, practitioners would only need to meet the documentation requirements currently associated with a level 2 visit for history, exam and/or MDM (except when using time to document the service). For practitioners choosing to support their coding and payment for an E/M visit by documenting the amount of time spent with the patient, CMS proposes to require the practitioner to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient. The typical time for the proposed new payment for E/M visit levels 2 through 5 is 31 minutes for an established patient and 38 minutes for a new patient. Overall, these policies do not change the need for practitioners to review and/or update information necessary for medical decision-making, but practitioners would not necessarily need to re-record as much information as is currently required and this would eliminate the need for audits related to visit levels. CMS also proposes to remove the requirement that the medical record must document the medical necessity of furnishing a visit in the home rather than in the office.

In addition to modifying the payment rates, CMS proposes adjustments and G-codes for use along with the broader E/M changes. Specifically, CMS proposes adjustments such as an E/M multiple procedure payment adjustment to account for duplicative resource costs when E/M visits and procedures with global periods are furnished together. CMS also proposes HCPCS G-code add-ons

to recognize additional relative resources for primary care visits and inherent visit complexity that requires additional work beyond that which is accounted for in the new payment rates. If finalized, GPCIX would be billed as an add-on code that CMS expects would be billed with every primary care-focused E/M visit for an established patient. The agency also proposes a G-code, GCG0X, that would be used to describe additional resources for specialty professionals to reflect visit complexity appropriate for certain specialties and would be billed in conjunction with the E/M visit.

CMS reports that most specialties would see overall Medicare payment changes in the range of 1 to 2 percent up or down from this policy, and the agency believes payment reductions would be outweighed by reduced documentation burdens. Table 22 on page 35846 shows rough estimates for projected payment adjustments by specialty based on these E/M proposals. CMS proposes these E/M visit policies would be effective beginning January 1, 2019, and the agency anticipates the need to utilize additional guidance to further refine and detail the policies moving forward.

#### Teaching Physician Documentation Requirements for E/M Services

CMS proposes to streamline teaching physician documentation requirements for E/M services. For example, the agency proposes to revise regulations to eliminate requirements for notations that may have previously been included in the medical records by residents or other members of the medical team. This would prevent requiring teaching physicians to personally document their participation in the medical record in certain instances. CMS also proposes to add language that the medical record must document the extent of the teaching physician's participation in the review and direction of services furnished to a beneficiary, and that the extent of this participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

#### **Determination of Work, Practice Expense (PE), and Malpractice Relative Value Units (RVUs)**

As is typical in the PFS, CMS outlines its proposed 2019 work and PE RVU updates. The agency proposes to add two new specialties to this process, Hospitalists and Advanced Heart Failure and Transplant Cardiology, as these specialties were recognized by Medicare in the past year. CMS also proposes a new direct input methodology for pricing of certain supplies and equipment, which the agency would phase in over four years. CMS notes that, in some cases, changes to PE values could have significant implications for reimbursement of certain CPT codes. Further, while CMS is normally required to phase-in "significant" RVU changes over multiple years, the agency proposes a mechanism to allow certain large PE changes to take effect immediately, if based on actual invoice data. These reimbursement changes could cause unexpected variation between an ACO's costs and its historical benchmark unrelated to its actual performance. ACOs should review the modified reimbursement for updated codes to assess whether the revised values will change their ability to earn savings (or the size of any savings). Table 13 on page 255 and Table 14 on page 275 show proposed work and PE RVU changes, respectively. CMS plans to update the malpractice RVUs in 2020 and is soliciting comment on how to best crosswalk specialty data to make appropriate updates.



### **Potentially Misvalued Services**

As is typical in this rulemaking, CMS proposes review of certain potentially misvalued services. This year seven codes are nominated for review, including anthroplasty, Computerized Tomography (CT), colonoscopy, and electrocardiogram codes. CMS is also evaluating certain global surgery codes. CMS also provides data about its evaluation of global surgery codes (including the specialties most likely to provide follow-up evaluation and management or E/M services).

### **Geographic Practice Cost Indices (GPCIs)**

CMS updates the geographic practice cost indices (GPCIs) every three years and the next update will occur in 2020. CMS solicits comment on these updates and specifically requests data on commercial rent.

### **Chronic Care Management (CCM) Services**

For CY 2019, the CPT Editorial Panel created CPT code 994X7, which describes situations when the billing practitioner is doing the care coordination work that is attributed to clinical staff in CPT code 99490. Beginning in 2019, CMS proposes to add the new 994X7 code to the PFS, which would correspond to 30 minutes or more of CCM furnished by a physician or other qualified health care professional and is similar to CPT codes 99490 and 99487.

### **Payment for Care Management Services and Communication Technology-based Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

As detailed in this NAACOS [resource](#), beginning with 2018 CMS finalized changes related to RHC and FQHC billing of CCM services, including two new HCPCS codes for RHCs/FQHCs. CMS proposes to update the payment for one of these codes, General Care Management code G0511, to reflect the input of the new CCM code 994X7 described above. CMS also propose that RHCs and FQHCs would be eligible to receive payment for communication technology-based services or new remote evaluation services. CMS proposes to create a new Virtual Communications G code for use by RHCs and FQHCs only, with a payment rate set at the average of the PFS national non-facility payment rates for HCPCS code GVC11 for communication technology-based services, and HCPCS code GRAS1 for remote evaluation services. RHCs and FQHCs would be able to bill the Virtual Communications G-code either alone or with other payable services. The agency also proposes to waive the RHC and FQHC face-to-face requirements when these services are furnished to an RHC or FQHC patient.

### **Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments (PBDs) of a Hospital**

CMS is continuing its efforts to equalize payments between provider-based entities and physician practices. Building on policies implemented in the past few years, CMS proposes to continue to allow nonexcepted off-campus PBDs to bill for nonexcepted items and services on an institutional claim using a modifier (PN) and to apply a PFS Relativity Adjustor of 40 percent for CY2019. The

agency recently made adjustments to the PFS Relativity Adjustor based on new data. CMS also proposes to maintain the 40 percent adjustment for future years until new information is available, at which time the agency would formally propose changes through the regulatory process.

### **Communication Technology-based and Telehealth Services**

In recognition of the proliferation of telehealth and other digital health technologies, CMS proposes to reimburse and/or waive certain restrictions for several new services and/or codes: (1) virtual check-in; (2) remote professional evaluation of patient-transmitted information; and (3) inter-professional internet consultations. Specifically, for interprofessional internet consultation codes (994X6, 994X0, 99446, 99447, 99448, and 99449), CMS proposes to change the status to active, making them separately payable under the PFS. The agency also proposes RVUs for Chronic Care Remote Physiologic Monitoring codes 990X0, 990X1, and 994X9.

CMS also proposes to add two prolonged preventative service codes to the Medicare telehealth services list. Lastly in the area of digital health, CMS proposes to implement remote End State Renal Disease (ESRD) assessment and telestroke provisions of the Bipartisan Budget Act of 2018.

### **Physician Self-Referral Law**

CMS proposes to modify certain writing and signature requirements for the compensation arrangements exception of the Stark law in accordance with the Bipartisan Budget Act of 2018.

### **Appropriate Use Criteria (AUC) for Imaging Services**

For 2019, CMS proposes to amend the AUC Program requirements to expand applicable settings and add independent diagnostic testing facilities (IDTFs), specify that AUC consultations may be performed by auxiliary personnel under the direction of an ordering professional and incident to the ordering professional's services, and establish coding methods to be used in the program. CMS also makes modifications to the significant hardship exception requirements under this program. More information on the AUC Program can be found in our 2018 MPFS [analysis](#).

### **Therapy Services**

CMS proposes a number of changes to payment policies related to occupational therapy and physical therapy services as a result of the Bipartisan Budget Act of 2018. Beginning January 1, 2022, CMS proposes to establish new payment modifiers and alter the definition of therapy assistant. CMS also proposes changes to functional reporting requirements for certain outpatient therapy services. Specifically, CMS proposes to discontinue functional reporting requirements for services furnished on or after January 1, 2019.

### **Part B Drugs**

Consistent with the Medicare Payment Advisory Commission (MedPAC) recommendations, CMS proposes to reduce the 6 percent add-on to 3 percent for Wholesale Acquisition Cost (WAC)-based payments for Part B drugs. This policy would apply to drugs and biologic products that are produced or distributed under a New Drug Application (NDA) approved by the Food and Drug Administration (FDA) and that are not included in the Average Sales Price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File. This would not alter Outpatient Prospective Payment System (OPPS) payment limits.

#### **Solicitation of Comments on Creating a New Bundled Payment Episode of Care for Substance Use Disorder Treatment**

CMS is seeking comments on how to create a new bundled episode of care for management and counseling treatment for substance use disorders and methods to identify non-opioid alternatives for pain treatment and management.

#### **Request for Information on Interoperability**

CMS is seeking input on ways to promote interoperability and health information exchange. Specifically, CMS considers revising current CMS Conditions of Participation (CoPs) for hospitals to require hospitals to share admissions, discharge and transfer information electronically.

#### **Request for Information on Price Transparency**

CMS is seeking feedback on barriers preventing providers and suppliers from informing patients of their out-of-pocket costs and ways to increase price transparency for patient out-of-pocket costs.

### **QUALITY PAYMENT PROGRAM (QPP) CHANGES**

#### **Advanced APM Proposals**

##### **Advanced APM Participation**

CMS estimates the number of providers qualifying for Advanced APM bonuses will remain steady in the third year of the program, which includes the PY 2019 and 2021 payment adjustments. The agency estimates that between 160,000 and 215,000 clinicians will become Qualifying Provider (QPs) and earn bonuses. This number is similar to CMS's estimate for the PY 2018, which is between 180,000 and 245,000 QPs. CMS projects the agency will pay aggregate 2021 Advanced APM bonuses between \$600 million and \$800 million.

##### **Financial Risk Requirements**

Current rules require Advanced APMs to have a certain level of financial risk, referred to as the nominal amount standard. This includes a benchmark-based standard requiring a risk level be set at or above 3 percent of the expected expenditures for which an APM Entity is responsible under the



APM, or a revenue-based standard requiring risk levels be set at or above 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in a participating APM Entity. In this rule CMS proposes to maintain the revenue-based standard at 8 percent for PY 2021 through 2024; no changes are proposed to the benchmark-based standard. CMS seeks feedback on whether the agency should raise these levels in 2025 and later.

#### **Use of Certified Electronic Health Record Technology (CEHRT)**

Current policy requires that an Advanced APM must require at least 50 percent of ECs in each APM Entity to use CEHRT to document and communicate clinical care with patients and other health care professionals. CMS proposes to increase the threshold to 75 percent beginning with PY 2019.

#### **Quality Measures Comparable to MIPS**

Advanced APMs must provide for payment for covered professional services based on quality measures comparable to those under the MIPS quality performance category. These measures must include at least one outcome measure and meet criteria related to reliability and validity. In the proposed rule, CMS seeks to clarify its policy by proposing that beginning with PY 2020 at least one of the measures and one outcome measure upon which an Advanced APM bases payment must be on the final list of MIPS quality measures, be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidenced-based, reliable, and valid. CMS notes this clarification does not change the status of any current APMs as qualifying as Advanced, including ACO models.

#### **QP and Partial QP Determinations**

CMS proposes to shorten the claims run-out timeframe for data used to make QP determinations from 90 days to 60 days. This would apply to each of the three QP determination snapshot dates (March 31, June 30, and August 31) allowing QP determinations to be made more quickly, approximately three months after the snapshot date. If finalized, this would alter the timeframe in which claims need to be processed in order for those services to be included in calculating the QP threshold score.

For Advanced APM entities that fail to meet QP thresholds but do meet the lower Partial QP thresholds, current policy requires them to actively elect to report MIPS if they want to report and be subject to MIPS payment adjustments. If an APM Entity does not meet QP thresholds, CMS evaluates ECs individually if they participate in multiple Advanced APMs. CMS proposes to align the MIPS election policy across Partial QP APM Entities and ECs by requiring Partial QP ECs to make an election that they want to report MIPS and be subject to payment adjustments. As with Partial QP APM Entities, no election by the EC means they would be exempt from MIPS.

#### **All-Payer Combination Option**

CEHRT Use Requirements and Quality Measures

Advanced APMs are only initially evaluated based on traditional Medicare APM participation. Beginning with PY 2019, CMS will give credit for qualifying APM participation with payers outside of Medicare, including Medicare Advantage (MA), Medicaid and commercial plans. This All-Payer Combination Option or Other-Payer Option has similar criteria to the Medicare Option, and CMS proposes a number of updates. CMS proposes to increase the Other Payer Advanced APM CEHRT use requirement from 50 percent to 75 percent beginning with PY 2020. Therefore, as of January 1, 2020, the Other Payer APM arrangement must require at least 75 percent of participating ECs in each APM Entity to use CEHRT.

In response to NAACOS advocacy, CMS proposes to modify the nature by which Other Payer APMs demonstrate they meet the CEHRT use requirements. MACRA requires that Other Payer APMs show that CEHRT is used, and CMS previously enforced this by necessitating payers or providers demonstrate that CEHRT is explicitly required in the terms of the payment arrangement. However, given concerns that many contracts do not include such explicit language, CMS proposes that a payer or EC must provide documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement by at least 50 percent of the ECs in PY 2019 and 75 percent of the ECs in PY 2020 and beyond. CMS also proposes updates to the Other Payer quality measure requirements. Specifically, for PY 2020 and beyond at least one of the quality measures and the outcome measure used in the qualifying Other Payer payment arrangement with an APM Entity must be on the MIPS final list of measures, be endorsed by a consensus-based entity, or be otherwise determined by CMS to be evidenced-based, reliable, and valid.

#### *Financial Risk Requirements and Determining Other Payer APMs*

CMS proposes to maintain the 8 percent revenue-based nominal amount standard for Other Payer Advanced APMs through 2024. Despite NAACOS objections, last year CMS finalized a policy requiring annual submission and determination of whether an Other Payer APM qualifies as Advanced. In response to NAACOS concerns, in this rule CMS proposes that after the first year a requestor (i.e., payer, APM Entity or EC) submits information about a multi-year payment arrangement that is determined to qualify as an Other Payer Advanced APM, in subsequent years the requestor would only need to submit information on any relevant changes to the payment arrangement. For multi-year payment arrangements submissions, CMS proposes to require that the requestor's certifying official agree to review the submission at least annually to assess whether there have been any changes and to submit updated information notifying CMS of any changes relevant to the Other Payer Advanced APM criteria for each successive year of the arrangement. Absent a submission of updated information, CMS would continue to apply the original Other Payer Advanced APM determination until the arrangement ends or expires or it has been five years since the determination was made. Table 59 on page 891 shows the proposed and updated timeframes for Other Payer payment arrangement submissions and determinations.

#### *Other Payer QP Calculation*

CMS will make QP determinations sequentially with Medicare QP calculations first, and for those who fall short the agency would then calculate the All-Payer Combination Option QP thresholds. Current policy allows an EC or APM Entity to request a QP determination under the All-Payer Combination Option, and in this rule, CMS proposes an option for a TIN-level QP determination. If finalized, this would be available in instances where all clinicians who have reassigned billing rights under the TIN participate in a single APM Entity, meaning it would be an option for MSSP ACOs. Should the TIN-level Medicare QP score be lower when based on the TIN-level calculation as opposed to the APM Entity calculation, CMS proposes to apply the higher score. If requests at multiple levels (i.e., EC, TIN or APM Entity) are received by CMS, the agency proposes to calculate all requests and apply the most advantageous determination.

#### Medicare Advantage (MA) Qualifying Payment Arrangement Incentive

In late June, CMS issued a Request for Information ([RFI](#)) soliciting feedback on a demonstration focused on participation in MA Advanced APMs. The agency takes additional steps in this proposed rule to implement the demonstration, titled the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI). CMS proposes that this would allow participating ECs who are not QPs or Partial QPs but who meet certain criteria related to the demonstration to be exempt from MIPS reporting and payment adjustments. For purposes of the demonstration, CMS would apply requirements for Qualifying Payment Arrangements consistent with the criteria for Other Payer Advanced APMs, which are detailed in NAACOS's ACO Guide to MACRA, available [here](#). CMS proposes the thresholds for Medicare payments or patients through Qualifying Payment Arrangements with MA organizations, which must be met to attain a MIPS waiver, and those thresholds are proposed to be set at 25 percent for payments and 20 percent for patient count. CMS notes that this demonstration is designed for ECs that do not meet QP or Partial QP thresholds, which is unlikely for ECs in most ACOs. CMS proposes to begin the MAQI demonstration in 2018 and run it for five years.

## **MIPS Proposals**

### **Overview**

CMS proposes a number of changes to MIPS for 2019, increasing the performance thresholds in the program while continuing to exempt a significant number of clinicians through the "low volume" exception. Notably, CMS does not propose significant changes to the Alternative Payment Model (APM) Scoring Standard, which is used to evaluate ACOs subject to MIPS. Therefore, ACOs will continue to receive favorable benefits from their APM participation in MIPS such as no additional quality reporting, no Improvement Activities reporting, and no cost evaluation. NAACOS [projects](#) that ACOs will continue to be among the top performers in MIPS based on these proposals. CMS also proposes a number of significant changes to the ACI performance category, which has been re-named the Promoting Interoperability (PI) performance category. Notably, CMS does not

propose to delay the requirement to move to 2015 CCEHRT beginning in 2019. This affects all ACOs who must report ACO quality measure 11, Use of CEHRT, which is based on MIPS PI requirements.

**COMPARISON OF PERFORMANCE CATEGORY WEIGHTS FOR ACOs vs. MIPS ELIGIBLE CLINICIANS (ECs) AS PROPOSED FOR 2019**

	<b>ACOs</b> 2018 PY (finalized)	<b>ACOs</b> 2019 PY (proposed)	<b>MIPS ECs</b> 2018 PY (finalized)	<b>MIPS ECs</b> 2019 (proposed)
<b>Quality</b>	50%	50%	50%	45%
<b>Cost</b>	0%	0%	10%	15%
<b>Improvement Activities</b>	20%	20%	15%	15%
<b>Promoting Interoperability</b>	30%	30%	25%	25%

### **MIPS Performance Thresholds**

CMS proposes to increase the MIPS performance threshold from 15 points (for 2018) to 30 points in 2019. This means an EC must meet or exceed 30 points in MIPS to avoid penalties in the program. CMS also proposes to increase the exceptional performance threshold from 70 points (for 2018) to 80 points in 2019. Additional bonus opportunities are available to those that meet or exceed the exceptional performance threshold. MACRA originally required CMS to increase the MIPS performance threshold to either the mean or median performance beginning with the 2019 performance year, however the Bipartisan Budget Act of 2018 afforded the agency with additional flexibility in raising the performance threshold over time to provide clinicians with an additional three years to transition to use of mean/median performance as the established threshold in MIPS. NAACOS has consistently [urged](#) CMS to continue its commitment to transitioning clinicians to value-based payments by increasing the performance thresholds and criteria in MIPS as required by MACRA and will continue to do so going forward.

### **MIPS ECs and Exclusions**

#### Eligible Clinicians

CMS proposes to modify the definition of MIPS ECs beginning in 2019 to include the following types of clinicians: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, clinical social workers and clinical psychologists.

#### Low Volume Exclusion

CMS proposes to modify the timeframe used to make such determinations. Beginning in 2019, CMS proposes that the MIPS determination period would be a 24-month assessment period including a

two-segment analysis of claims data consisting of: (1) an initial 12-month segment beginning on October 1 of the calendar year two years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period; and (2) a second 12-month segment beginning on October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the applicable performance period occurs. The first segment would include a 30-day claims run out. The second segment would not include a claims run out, but would include quarterly snapshots for informational use only, if technically feasible. This timeframe will also be used to determine those that meet the definition of non-patient facing clinicians, hospital-based clinicians, ambulatory surgical center-based clinicians, and those determined to be a small practice.

CMS also proposes to add a criterion to the low volume exclusion criteria. CMS proposes to add a “covered professional services” criterion for those who provide 200 or fewer covered professional services to Part B enrolled individuals. Therefore, if finalized, beginning in 2019 those who meet at least one of the three low volume threshold criteria would be excluded from MIPS. As a reminder, in 2018 CMS finalized the remaining two criterion, which are: those who see 200 or fewer Medicare patients or have \$90,000 or fewer Medicare Part B charges during the specified measurement period.

Finally, CMS also proposes a new “opt-in option” that would allow those who meet or exceed at least one, but not all of the low volume threshold criteria to choose to opt-in and participate in MIPS. CMS estimates approximately 650,000 ECs would be subject to MIPS based on these proposals. CMS estimates more than 42,000 additional clinicians will elect to participate in MIPS given the “opt-in” option.

### **Quality**

ACOs will continue to be exempt from any additional quality reporting requirements in MIPS. CMS will continue to rely on the ACO’s MSSP and Next Generation Model quality reporting for purposes of MIPS.

#### **Policy for clinicians in ACOs who fail to report quality measures**

CMS proposes to make a slight change to its policy regarding alternative reporting options for clinicians in MIPS in the rare case that an ACO fails to report quality measures for the MSSP or Next Generation Model. CMS proposes starting in 2019, when an MSSP ACO fails to report quality measures, CMS will allow an individual clinician who is also a solo practitioner to report on any available MIPS measures, including individual quality measures.

CMS also proposes that, beginning with the 2019 performance period, the complete reporting requirement for Web Interface reporters is modified to specify that if an APM Entity (in this case, an ACO) fails to complete reporting for Web Interface measures but successfully reports the CAHPS for



ACOs survey, CMS will score the CAHPS for ACOs survey and apply it towards the APM Entity's quality performance category score. In this scenario the Shared Savings Program TIN-level reporting exception would not be triggered and all MIPS ECs within the ACO would receive the APM Entity score.

### Quality Benchmarks

CMS also proposes changes to how quality benchmarks are established in the MIPS program. Specifically, beginning with the 2019 performance year CMS proposes to establish separate benchmarks for the following collection types: electronic Clinical Quality Measures (eCQMs); Qualified Clinical Data Registry (QCDR) measures; MIPS CQMs; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures. CMS would apply benchmarks based on collection type rather than submission mechanism. For example, for an eCQM, CMS would apply the eCQM benchmark regardless of submitter type (MIPS EC, group, third party intermediary). In addition, CMS would establish separate benchmarks for QCDR measures and MIPS CQMs since these measures do not have comparable specifications.

This proposal is a direct result of NAACOS advocacy and if finalized will result in more fair comparisons in MIPS, particularly for ACOs who have previously been held to higher quality standards due to the fact that they are scored on Web Interface measures, which have higher benchmarks than the same measure submitted via a different mechanism (such as claims). We are pleased to see this proposal and will strongly advocate that CMS finalize this much needed change.

### Bonus Points

Previously, CMS has provided ACOs with bonus points for reporting Web Interface measures categorized as "high priority" by MIPS. Beginning in 2019, CMS proposes to no longer award ACOs with these bonus points. CMS also notes it may remove bonus opportunities for high priority measures altogether in future program years. CMS does not propose to eliminate bonus points awarded to those who report quality using end-to-end electronic reporting.

### **Clinical Practice Improvement Activities**

CMS does not propose changes to the way ACOs are evaluated in the Clinical Practice Improvement Activities performance category for 2019. CMS states that the agency will continue to post an evaluation annually to determine what credit is provided automatically to each APM. As of the publication of this summary, CMS had not yet released that fact sheet for 2019. More information on how ACOs are currently scored in this performance category is available [here](#). In both 2017 and 2018, ACOs do not report any improvement activities and instead are awarded full points in this category automatically.

### **Promoting Interoperability**

CMS also proposes a number of significant changes to the PI performance category. Notably, CMS does not propose to delay the requirement to move to 2015 CEHRT beginning in 2019. This affects all ACOs who must report ACO quality measure 11, Use of CEHRT, which is based on MIPS PI requirements. Therefore, the 2019 performance year will be a critical year for ACOs reporting PI.

#### ACOs and PI

Beginning in 2019, CMS proposes to allow clinicians in ACOs to report PI measures either as an individual or as a group (TIN). Therefore, if finalized, ACOs would no longer be restricted to group/TIN level reporting for PI, though unfortunately the agency does not propose to allow ACO-level reporting as advocated by NAACOS. As a reminder, CMS continues to hold all ACOs accountable for CEHRT use via the ACO quality measure 11, Use of CEHRT for MSSP ACOs and via contractual obligations for Next Generation ACOs. For 2017 and 2018, ACO-11 has been a pay-for-reporting measure. Beginning in 2019, ACO-11 is a pay-for-performance measure.

#### Moving to Performance-based Measurement

CMS proposes to eliminate the previous Base Score and Performance Score components of the PI performance category score and instead move to a performance-based measurement for this category. CMS also proposes a number of changes to certain measures and specifications in this performance category, as outlined in the tables below. Because CMS would require the use of 2015 CEHRT beginning in 2019, the transition objectives and measures would no longer be available.

CMS proposes to instead require ECs to report at least six measures across four objectives including: e-prescribing, health information exchange, provider to patient exchange, and clinical data exchange. Clinicians would be scored based on their performance on each measure, worth up to 40 points. As an alternative proposal, CMS seeks feedback on instead scoring based on each objective rather than on each individual measure (clinicians would be required to report one measure from each objective). For an overview of these changes, please refer to Tables 36 on page 35917 and Table 40 on page 35930-35931.

Finally, CMS also proposes to provide a zero PI score for nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and physical therapists, occupational therapists, clinical social workers and clinical psychologists for 2019. They do not specify how this affects ACO scores specifically; ACOs will instead need to refer to the 2019 measure specifications for ACO measure 11, Use of CEHRT to understand how these clinicians are treated for purposes of that measure.

#### **Cost**

CMS does not propose changes to its current policy which excludes ACOs from receiving a cost performance category score in MIPS. For non-ACOs, the cost performance category weight is proposed to increase from 10 percent (for the 2018 performance year) to 15 percent for the 2019

performance year. CMS also proposes to increase the cost performance category by 5 percent each year until the cost category is worth 30 percent of a MIPS EC's overall score.

Additionally, CMS proposes to begin implementing eight-episode cost measures for MIPS ECs beginning in 2019 (non-ACOs). CMS provided some ECs with feedback on these episode cost measures through select field testing completed in 2017. These measures are supported by the National Quality Forum's Measure Applications Partnership (MAP). The proposed episode cost measures include the following and are listed in Table 33 on page 35903:

- Elective Outpatient Percutaneous Coronary Intervention
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction with Percutaneous Coronary Intervention

The attribution method being proposed for such measures will be available on the CMS [website](#). In sum, for acute inpatient medical condition episodes, CMS proposes to attribute episodes to each EC who bills inpatient E/M claims during a trigger inpatient hospitalization under a TIN rendering at least 30 percent of the claims in the hospitalization. While for procedural episodes, CMS would attribute to each EC who renders a trigger service as identified by procedure codes.

### **Other changes**

#### **Complex Patient Bonus**

CMS proposes to maintain the complex patient bonus and to change the dates used to determine eligibility for this bonus to align with changes to the MIPS eligibility determination timeframe. CMS proposes to assess eligibility for this bonus by looking at claims October 1 of the calendar year preceding the applicable performance period and ending September 30 of the calendar year in which the applicable performance period occurs.

#### **Small Practice Bonus**

Beginning in 2019, CMS also proposes to eliminate the small practice bonus, which was formerly added to final MIPS scores for those who qualify. ACOs were not previously eligible for this bonus given the size limitations imposed.

### **Final MIPS Score and Resulting Payment Adjustments**

As a reminder, in MIPS the 2019 performance year corresponds to 2021 payment adjustments. CMS estimates \$372 million will be available in the budget-neutral pool for MIPS based on these

proposals, which is in addition to the \$500 million in the exceptional performance incentive payment pool for those that meet or exceed the proposed 80-point exceptional performance threshold. This amount (\$372 million) is an increase from 2018 due to the fact that the maximum penalty amount in performance year 2019 raises to 7 percent (from 5 percent in performance year 2018). For more information, please refer to Figure A on page 35978.

CMS also proposes that the agency would not apply MIPS adjustments to certain model-specific payments for the duration of an 1115 A model testing, beginning in 2019 such as Oncology Care Model per member per month payments. NAACOS will continue to urge CMS to reverse their current policy which counts MIPS adjustments as ACO expenditures. Finally, as a result of the Balanced Budget Act of 2018, CMS will not apply MIPS payment adjustments to Part B drugs.

### **MIPS Performance Feedback**

CMS confirms that MSSP ACOs will be able to view TIN-level performance data for MIPS. CMS also outlines the MIPS information to be displayed on the Physician Compare [website](#) including:

- Final MIPS score for each National Provider Identifier (NPI)
- Aggregate information on MIPS, to be displayed periodically as feasible
- Quality measure information for clinicians and groups
- A subset of cost measures
- A subset of improvement activities
- Successful PI reporters (those meeting the minimum base score criteria)
- High performers (starting with 2018 performance year)
- Advanced APM participant names

### **Conclusion**

As a reminder, these policies are proposed; CMS typically finalizes the MPFS rule around November 1 and NAACOS will alert members when the final rule is released. CMS will accept comments on these proposed policies until September 10, 2018. Comments may be submitted at [regulations.gov](https://www.regulations.gov). Should you have any questions, please email our advocacy team at [advocacy@naacos.com](mailto:advocacy@naacos.com).