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

Introduction

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

I. Updates to the Physician Fee Schedule (PFS)

Regulatory Impact Analysis

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

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

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU

Impact by Specialty

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

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

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact**
ALLERGY/IMMUNOLOGY	$239	1%	1%		

office/outpatient visits. Starting Jan. 1, 2019, w

and inherent visit complexity that require additional work. The new primary care code GPC1X is used for

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

G2012: “Virtual” office visit e.g. when a physician or other qualified health care professional has a brief (e.g. 5-10 minute) non-face-to-face check-in with a patient via communication technology to assess whether the patient’s condition necessitates an office visit.

G2010: Remote evaluation of pre-recorded video and/or images submitted by a patient including interpretation with follow-

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

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

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

Medicaid Promoting Interop

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

MIPS Determination Period

CMS streamlined the various eligibility determination periods for the low-volume threshold, non-patient facing, small practice, hospital-based, and ASC-based status into a single MIPS de

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

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

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

CMS did not change data completeness requirements for 2019, which entails 60% of eligible Part B patients for claims measures and 60% of all patients regardless of payer for eCQMs, MIPS CQMs, and QCDR measures. CMS Web interface and CAHPS for MIPS survey measures will continue to have their own unique data completeness requirements. CMS will remove the one-point floor for measures that fail to meet data completeness requirements for most practices in 2020, but extended indefinitely the three-point floor for measures that do not meet data completeness requirements for small practices. Table 50 summarizes the scoring rules based on data completeness requirements. CMS will maintain for 2019 the three-point floor for quality measures that do satisfy data completeness criteria and the 20-case minimum. For pra

CMS will apply benchmarks based on collection type rather than by submission mechanism. Benchmarks will be based on data from all available sources, including individual eligible clinicians, groups, APM Entities, and third party intermediaries.
CMS will maintain its 4-year cycle for removing measures considered "topped out." Beginning in 2019, measure benchmarks identified as "topped out" for two consecutive years will receive a maximum of 7 points in the second year. All measures subject to the 7-point cap for 2019 will be available in late 2018 when 2019 benchmarks are published. For measures considered "extremely topped out" (e.g., average performance in 98th-100th percentile), the Agency may propose removal in future rulemaking regardless of where they are in the four-year cycle for topped out measures. CMS also reserves the right "suppress" measures without rulemaking if they are significantly impacted by clinical guidelines changes or other changes that may pose patient safety concerns. CMS will give those measures a score of zero and adjust the denominator of the Quality Category to 50 points (instead of 60) so a clinician's score would not be adversely impacted. Measure stewards are expected to notify CMS of guidelines changes. CMS will post such measures to the CMS website prior to the start of the data submission period.

Cost Category

CMS will continue to calculate cost measures from claims data; the Cost Category will continue to

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

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

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

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

Objective	Measure	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Optional with Bonus: Query of PDMP Optional with Bonus: Verify Opio	5 points bonus

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

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

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

Advanced APM9( )9(b)dnts. In(M9( )9(b)dn10(s.)-8( )9(I)-8(n)3((M9(Tf1 0(A3)70TQq0.00000912 0 612 792 reW* nBT/F

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

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

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

Medicare Shared Savings Program (MSSP)

MSSP participants may now report Promoting Interoperability data at either the NPI- or TIN-level. MSSP participants will be able to access performance feedback at the TIN-level starting next year.
As part of its Meaningful Measures Initiative, CMS removed ten and added two new measures to the 2019 MSSP quality measure set, resulting in 23 total measures, down from9(frr pa612 792 reW*n]TJETQq00.00000912 0 6

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

CMS lifted certain requirements related to voluntary beneficiary assignment. Beneficiaries may select any ACO professional, regardless of specialty, as their primary clinician. Beneficiaries who select any clinician outside of an ACO will not be assigned to that ACO, even if they otherwise would have based on claims. Additionally, it is no longer a requirement that beneficiaries receive at least one primary care service from a qualifying ACO professional during the performance year in order to be assigned to an ACO. If a beneficiary does not change their primary clinician designation, the beneficiary will remain

	report to the patient's treating/requesting physician or other qualified healthcare professional; 31 minutes or more of medical consultative discussion and review			
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time	New	0.50	0.70
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 3 ≠Mprohealth			