



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

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released a Medicare annual payment rule for calendar year (CY) 2019 that proposes potential changes to Medicare payments for physicians and other health care practitioners. This year, the rule combines proposed policies for the Medicare Part B physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA).

Found below is a summary of key proposals, separated out by proposed PFS and QPP policies. Over the next several weeks, ACEP will be working on a comprehensive response to CMS offering our input to the agency's proposed changes. We expect CMS to then publish a final rule in November of this year.

Physician Fee Schedule (PFS)

The PFS sections of the rule include the following major proposals. Emergency physician payments are expected to remain relatively flat, as these proposals, along with other proposed refinements to physician codes, will cause the PFS conversion factor (which converts the relative value units for each code to dollars) to just slightly increase in 2019 by 0.13% from \$35.99 in 2018 to \$36.05.

1. Restructuring Evaluation and Management (E/M) Codes and Streamlining Documentation Requirements (**NOTE: This only impacts a defined set of codes that DO NOT impact E/M codes for emergency medicine as described below**).
 - For codes 99201 through 99215 ****ONLY****, CMS proposes a new, single blended payment rate for new and established patients for office/outpatient E/M level 2 through 5 visits, and a series of add-on codes (called "G" codes) to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services.
 - Alongside this proposal, CMS is proposing to apply a minimum documentation standard that allows practitioners to choose, as an alternative to the current E/M guidelines, either medical decision making (MDM) or time as a basis to determine the appropriate level of E/M visit.
 - By giving providers a choice between: 1) the current guidelines; 2) MDM; or 3) Time, different practitioners in different specialties will be able to choose to document the factor(s) that matter most given the nature of their clinical practice.
 - Practitioners could choose to document additional information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished. However, no matter what kind of documentation a practitioner reports, the practitioner will still be paid at the new blended rate.
 - The effective date of the proposals will be **January 1, 2020**.

- For E/M visits furnished by teaching physicians, CMS proposes to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team. No clarity is given in the rule on whether this would apply to medical students.

2. Payment for the Use of Remote Communications Technology:

- In an effort to expand the use of telehealth in Medicare, CMS is proposing to pay separately for two newly defined physicians' services furnished using communication technology:
 - Brief Communication Technology-based Service: This service would cover a “virtual check-in” by a patient via telephone or other telecommunications device to decide whether an office visit or other service is needed.
 - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient: This service would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information (such as by text message) to assess whether a visit is needed.

3. Request for Information on Price Transparency

- CMS includes a nearly identical request for information (RFI) in this rule to the one that was included in the proposed Inpatient Prospective Payment System (IPPS) rule.

CMS discusses current hospital requirements around making standard charges available to the public, and states that CMS remains concerned that patients are “being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits.”

The RFI seeks comment on what role providers should play in making prices available to their patients. ACEP submitted [comments](#) to this RFI in the IPPS rule as part of a broader coalition of medical specialties and submitted our own individual [comments](#) as well.

4. Appropriate Use Criteria (AUC) Program

- CMS proposes minor changes to the Appropriate Use Criteria (AUC) Program, including revising the hardship criteria include 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances.

However, CMS once again fails to address ACEP's concerns about the lack of clarity around the exemption for emergency medical conditions. ACEP believes that, due to a drafting error in the legislation, CMS is only exempting imaging services for emergency services when provided to individuals with emergency medical conditions—and is NOT exempting all services delivered in the emergency department. ACEP will continue to work with CMS on this issue.

The Quality Payment Program

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

MIPS Policies

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly EHR Meaningful Use). Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2019 will impact Medicare payments in 2021). In 2019, in addition to the performance in the four categories, a bonus of 5 points for providers in small practices will be added to the final score.

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

1. Length of Performance Period

- Despite significant pressure from a number of physician groups, CMS is maintaining the 12-month reporting period for the Quality and Cost categories. Language in the rule used signals that CMS would likely want to do similarly beyond 2019. The length of the performance period for the Improvement Activities and Promoting Interoperability categories will continue to be 90-days.

2. Low-Volume Threshold

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

3. Performance Category Weighting in Final Score:

- As noted above, each performance category is weighted at a specific percentage when rolled up into the final score. CMS is proposing to reduce the Quality category weight from 50 to 45%, and increase the Cost category from 10 to 15%.

- The Cost category increase is still much less than original 30% it was statutorily mandated to be increased to in 2019 under the original MACRA legislation. Through the Balanced Budget Act, Congress gave CMS flexibility for the next few years to keep the percentage at less than 30%.
- General Performance Category Weights Proposed for 2019:
 - Quality: 45% (down from 50% in 2018)
 - Cost: 15% (up from 10% in 2018)
 - Promoting Interoperability (EHR): 25% (same as 2018)
 - Improvement Activities: 15% (same as 2018)

4. The Performance Threshold

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

In the rule, CMS provides an example of what the positive adjustments could be in 2021 (based on performance in 2019). CMS estimates that the 7% payment update would be scaled down to 1.6% and that the maximum bonus for exceptional performance would be 4.07%. Therefore, the total maximum payment adjustment a provider could receive in 2021 if they received a perfect MIPS score in 2019 would be 5.67% (1.6% + 4.07%).

5. Facility Scoring Option

- In last year's rule, CMS delayed the use of a facility-based scoring option. In the rule, CMS is allowing the option of facility-based scoring starting in 2019.
- To qualify for facility-based reporting, clinicians must furnish 75 percent or more of their services in inpatient hospital, on-campus outpatient hospital, or an emergency room, based on claims for a period prior to the performance period.

- Clinicians must also have billed at least a single service in an inpatient hospital or emergency room. In other words, clinicians who bill every single one of their services in an on-campus outpatient hospital department (which is “Place of Service” 22) would not be eligible. Facility-based reporting is based on the Hospital Value-based Purchasing Program (HVBP) measure set for the provider’s hospital. Clinicians eligible for facility-based reporting can still report to MIPS. CMS will automatically take the higher score.
6. Quality Performance Category
- To report under the Quality performance category, CMS will allow individuals or groups to submit data using multiple collection types (for example, electronic clinical quality measures (eCQMs), Qualified Clinical Data Registry (QCDR) measures, and Medicare Part B claims measures)
 - Bonus points for high priority measures will applied in 2019, just like in 2018. Providers will also still be eligible for additional bonus points based on improvement.
7. Cost Category
- CMS is proposing to keep the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures and will add 8 episode-based cost measures. In our previous comments, ACEP had expressed serious concerns with the total per capita cost and MSPB measures, and had encouraged CMS to develop new episode-based measures.
 - The Cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.
8. Improvement Activities
- CMS is proposing some modifications, which include:
 - The addition of one new criterion for nominating new improvement activities called “Include a public health emergency as determined by the Secretary,” and the removal one called “Activities that may be considered for a Promoting Interoperability bonus;”
 - The addition of 6 new Improvement Activities;
 - The modification of 5 existing Improvement Activities; and
 - The removal of 1 existing Improvement Activity
9. Promoting Interoperability
- CMS is proposing similar changes to the Meaningful Use category of MIPS (now called Promoting Interoperability) that were included in the IPPS rule for the hospital electronic health record (EHR) program. Like the proposed policies found in the IPPS proposed rule, CMS is requiring that clinicians use 2015 Edition certified EHR technology (CEHRT) starting in 2019. CMS is also eliminating the base, performance and bonus scores, and proposing a new simplified scoring methodology.
 - CMS is proposing to create four overall objectives: e-Prescribing; Health Information Exchange; Provider to Patient Exchange; and Public Health and Clinical Data Exchange

- CMS is also proposing to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement.

10. Other Policies of Interest

- CMS is not changing the definition of “hospital-based” clinician.
- CMS makes a few proposals related to its public reporting website, Physician Compare. CMS had previously established that Physician Compare would report all measures under the MIPS Quality performance category, but exclude new measures for a year. CMS is now going to exclude new measures for two years.

Alternative Payment Model (APM) Policies

1. Use of Certified EHR Technology (CEHRT)

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

2. Definition of Nominal Financial Risk

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

3. Proposed New Demonstration for Providers Participating in Medicare Advantage (MA) APMs

- CMS is proposing to create a new demonstration, called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration, that would allow providers that participate in certain APMs through their Medicare Advantage Organizations to be exempt from MIPS.