American Hospital Association™
Advancing Health in America

Regulatory Advisory

November 16, 2018

Medicare Physician Fee Schedule: Final Rule for CY 2019

At a Glance

The Centers for Medicare & Medicaid Services (CMS) Nov. 1 issued a final rule that updates physician fee schedule (PFS) payments for calendar year (CY) 2019. The rule also finalizes several policies to implement year three of the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Our Take

The AHA is pleased the agency is reducing regulatory burden, expanding coverage of telehealth and virtual care, and keeping a gradual and flexible approach to implementing the QPP. However, we are disappointed that CMS will reduce payments for certain new drugs and continue its short-sighted "site-neutral" policies.

We also are pleased that the agency responded to our concerns and mitigated its proposal to consolidate evaluation and management (E/M) codes. We will continue to work with the agency to ensure that physicians who treat a disproportionate number of higher-acuity patients are not financially penalized.

What You Can Do

- ✓ **Participate in an AHA members-only webinar on Tuesday, Nov. 20 at 2:00 p.m. ET to discuss the final rule. To register for this 90-minute webinar, click here.**
- ✓ Share this advisory with your chief medical officer, chief financial officer and other members of your senior management team, key physician leaders, and nurse managers.
- ✓ Assess the impact of the finalized payment and quality changes on your Medicare revenue and operations.

Further Questions

For additional questions, please contact Shira Hollander, senior associate director for payment policy, at (202) 626-2329 or shollander@aha.org.

Key Takeaways

The final rule includes policies to:

- Update the PFS conversion factor to $36.04 for CY 2019.
- Immediately ease certain E/M documentation requirements and, beginning in CY 2021, blend payment rates for levels 2 through 4 E/M visits.
- Continue to pay for non-grandfathered (non-excepted) services in certain new off-campus PBDs at 40 percent of the OPPS amount.
- Pay separately for communication technology-based "check-ins" and remote evaluation of "store and forward" videos or images.
- Reduce payment for new Part B drugs to 103 percent of WAC.
- Define many hospital outreach laboratories as "applicable laboratories" under the CLFS, requiring them to collect and report private payer payment data to CMS by March 31, 2020.
- Align the promoting interoperability requirements for MIPS-eligible clinicians with those proposed for hospitals and CAHs in the FY 2019 inpatient PPS proposed rule and increase flexibility.
- Increase weight to 15 percent for CY 2021, and add eight new measures.
- Automatically apply to eligible clinicians/groups that meet the definition, and expand definition of "facility-based" services.
- Implement certain provisions of the agency's "MSSP ACOs – Pathways to Success" rule.

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BACKGROUND

On Nov. 1, the Centers for Medicare & Medicaid Services (CMS) issued its final rule for calendar year (CY) 2019 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. The final rule was published in the Nov. 14 Federal Register. The rule also finalizes several policies to implement year three of the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The provisions of the rule are generally effective Jan. 1, 2019.

CHANGES TO THE CY 2019 PFS

Conversion Factor

CMS finalized an overall update to the PFS payments of +0.11 percent in CY 2019. This increase reflects the 0.25 percent increase required by the MACRA and a budget-neutrality adjustment of -0.14 percent. These adjustments will result in an estimated conversion factor of $36.0391 for CY 2019, an increase from the CY 2018 conversion factor of $35.9996.

Evaluation & Management (E/M) Documentation and Payment

Payment Rates for E/M Visits. Throughout the E/M section of the final rule, CMS repeats its belief that the coding, payment and documentation requirements for E/M visits are overly burdensome and out of sync with current medical practice. It notes that these challenges motivated its proposal to collapse the payment rates for levels 2 through 5 E/M visits into a single blended rate for established patients and another for new patients. However, the agency said it received thousands of comments on this proposal, including from the AHA, which reflected "a broad consensus regarding the potential negative implications of the proposal for patients with the most complex needs and the clinicians who serve them."

CMS agrees that its proposal did not account for the resource costs inherent in caring for the most complex patients. **As such, to balance care for those patients with its desire that E/M payment rates better reflect modern medicine, beginning in CY 2021, it finalized a policy to pay a single, blended rate for levels 2 through 4 E/M visits (one rate for established patients and another for new patients).** Thus, there will be three levels of E/M payment rates – one for level 1 visits, one for levels 2 through 4 visits, and one for level 5 visits. CMS will develop payment amounts for the levels 2 through 4 blended rates using the weighted average of the current payment inputs assigned to the individual levels (2, 3 and 4) based on the most recent five years of utilization data. As a corollary to this policy, for levels 2 through 4 E/M visits, CMS will require providers to meet only the level 2 standard of documentation requirements, beginning in CY 2021. **The AHA is pleased that CMS responded to our concerns and mitigated its proposal to consolidate levels 2 through 5 E/M codes. We will continue to work with the agency to ensure that physicians who treat a disproportionate number of higher-acuity patients are not financially penalized.**

Also beginning in CY 2021, providers who bill levels 2 through 4 E/M visits will be able to bill one or more of the add-on codes CMS finalizes in the rule. First, CMS finalizes two add-on codes that will account for the inherent complexity in primary care and non-procedural specialty care E/M visits for both new and established patients. Any providers that furnish the relevant care will be eligible to bill the add-on codes, regardless of whether they are enrolled in a primary care specialty or in a specialty included in the code descriptor for the non-procedural specialty care add-on code.[1] The two codes will be valued equally. In addition, CMS also finalizes an additional add-on code for E/M or psychotherapy services that are prolonged 30 minutes beyond the usual service time. See Appendix A for CMS's online table of payment rates for Levels 2 through 5 E/M visits.

Accounting for Resource Overlap between Standalone Visits and Global Periods. Under PFS regulations, E/M visits are paid either as standalone visits or as part of global procedural codes. Standalone E/M visits are not billable on the same day as the procedure codes, unless the billing provider specifically indicates the visit is separately identifiable from the procedure. Due to its expectation that there are likely efficiencies from E/M visits occurring on the same day as certain global procedures, CMS proposed to reduce payment by 50 percent for the least expensive global 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. CMS received several comments on this proposal that suggested it could cause significant disruptions to patient care because it would create a strong incentive to bring patients back for necessary visits on different days to avoid triggering the payment reduction. To that end, CMS is not finalizing the proposed reduction, but in the future will consider other methods to ensure the appropriate valuation for E/M visits occurring on the same day as certain global procedures.

Eliminating Extra Documentation Requirements for Home Visits. CMS finalizes the removal of the requirement that medical records must document the medical necessity of furnishing a home visit rather than an office visit. CMS agrees with stakeholders that this change will allow providers to determine the best location for a patient visit without unnecessary rules and documentation requirements.

Eliminating the Prohibition on Billing Same-day Visits by Providers of the Same Group and Specialty. In the proposed rule, CMS solicited comments on whether it should eliminate the Medicare policy that prohibits payment for two E/M office visits billed by a physician (or a physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the visits were for unrelated problems that could not be addressed during the same encounter. CMS believes that eliminating this policy may better recognize changes in the practice of medicine, such as the increasing likelihood that providers have multiple specialty affiliations but only one primary Medicare enrollment specialty, while reducing administrative burden. CMS is not eliminating this prohibition at this time, but received many comments in response to the solicitation, which it will consider for potential future rulemaking.

[1] The specialties listed in the code descriptor include: endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology.

Choice of Supporting Documentation. For CYs 2019 and 2020, CMS will continue to use the current E/M visit coding structure. Under this structure, providers document E/M office and outpatient visits based upon the 1995 or 1997 E/M documentation guidelines, or the duration of the visit when counseling and/or coordination of care accounts for more than 50 percent of the face-to-face physician/patient encounter. **However, beginning in CY 2021, CMS will allow providers to document E/M visits using the current framework (1995 or 1997 documentation guidelines) or medical decision-making (MDM) or time with the patient.** The use of time as a basis for determining the appropriate level of E/M visit will not be limited to visits in which counseling and/or coordination of care accounts for more than 50 percent of the face-to-face physician/patient encounter.

Removing Redundancy in E/M Visit Documentation. CMS finalizes its proposal to simplify the documentation requirements for an established patient's history and physical exam by requiring providers to document only what has changed since the patient's last visit or pertinent items that have not changed, rather than re-documenting a defined list of required elements. Providers will still be expected to review prior data, update it as necessary and indicate in the medical record that they have done so. CMS also finalizes its proposal to no longer require providers to re-enter information in the medical records regarding new and established patients' chief complaint and history if that information was already entered by ancillary staff or the beneficiary. Instead, providers simply need to indicate that they reviewed this information.

Podiatry Visits. In light of commenters' opposition to CMS's proposal to create new codes to describe, and pay separately for, podiatric E/M visits, CMS is not finalizing this proposal and therefore not adopting separate codes for podiatry.

Teaching Physician Documentation Requirements for E/M Services

CMS finalizes without modification its proposed changes to teaching physician documentation requirements. Under current regulations, Medicare Part B pays for teaching physician services subject to certain conditions, including that the patient's medical record must reflect the teaching physician's review and direction of services performed by residents in teaching settings. Going forward, medical records must still document the teaching physician's presence during the time a service was furnished, and his or her participation in the review and direction of services furnished, but this information may be demonstrated by notes in the medical records made by a physician, resident, or nurse, and do not have to be documented by the teaching physician him or herself.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-based Services

Communication Technology-based Services. As detailed in both the proposed and final rules, CMS has determined that the list of "Medicare telehealth services" defined in Section 1834(m) of the Social Security Act (the Act) does not apply to all physicians' services that are delivered via remote communication technology. Rather, that list covers a discrete set of physicians' services that ordinarily involve, and are defined, coded and paid for as if they were furnished during an in-person encounter. Other communication technology-based services inherently involve and are delivered via

communication technology, and thus would not be subject to the limitations in section 1834(m). **To recognize the changing landscape of health care practice, CMS finalizes its proposal to provide separate payment under the PFS for two of these services: (1) brief communication technology-based "check-ins" between providers and patients (Healthcare Common Procedure Coding System (HCPCS) code G2012) and (2) providers' remote evaluation of patients' pre-recorded video and/or images submitting using "store and forward" technology (HCPCS code G2010).** Only physicians or other qualified health care professionals who are eligible to bill for E/M services (the providers) may bill for virtual check-ins and remote evaluations.

These services differ from one another in that the remote evaluation service involves a provider's evaluation of a patient-generated still or video image and a subsequent communication of his or her professional opinion to the patient, whereas the check-in service describes real-time communication and does not involve the transmission of any recorded image. CMS will pay for both of these services when they are utilized to determine whether or not an office visit or other service is warranted. However, both types of services will be covered only if they do not arise from or lead to an associated billable visit that occurs within the previous seven days or the next 24 hours or soonest available appointment, respectively. Both also are available only to established patients.

Interprofessional Internet Consultation. CMS believes that paying separately for interprofessional consultations performed via communications technology – rather than bundling payment for these services with other services providers are already delivering to patients – would be more consistent with trends in medical practice and patient-centered care. To that end, CMS is finalizing separate payment for six current procedural terminology (CPT) codes that describe interprofessional telephone/Internet assessment and management services provided by a consulting physician. The consultations must be performed for the benefit of a specific patient, not for the general benefit of the physician.

Remote Patient Monitoring. CMS also finalizes specific valuations for three codes that describe remote patient monitoring services, specifically for the set-up, patient education, use and interpretation of remote physiologic monitoring equipment that transmits information on patients' chronic conditions. CMS will make separate payment for these services under the PFS and, therefore, will not add them to the section 1834(m) list of Medicare telehealth services. CMS first allowed separate payment for remote patient monitoring in the CY 2018 PFS final rule via a temporary code; this rule finalizes three remote monitoring CPT codes – 99453, 99454, and 99457 – for inclusion in the CPT code set made available to all health care professionals beginning on Jan. 1, 2019.

Medicare Telehealth Services

Proposed Additions to the List of Medicare Telehealth Services. As described above, section 1834(m) of the Act contains a list of Medicare telehealth codes covered under the PFS. In this rule, CMS finalizes the addition to that of list two codes for prolonged preventive services that extend beyond the typical service time of the primary procedure and require direct patient contact. CMS also finalizes its proposal to extend the time to request services be added to the list of Medicare telehealth services from Dec. 31 of each calendar year to Feb. 10.

Expanding the Use of Telehealth under the Bipartisan Budget Act (BiBA) of 2018. CMS finalizes as proposed regulatory changes that correspond to the BiBA's expansion of telehealth services for home dialysis therapy and individuals with stroke. Specifically, CMS will consider renal dialysis facilities and individuals' homes as qualified originating sites for home dialysis monthly end-stage renal disease (ESRD)-related clinical assessments. No facility fee will be paid when the originating site for these services in the patient's home. The geographic requirements in section 1834(m) that generally apply to Medicare telehealth services will not apply to renal dialysis services furnished on or after Jan. 1, 2019 in specific originating sites.

CMS also finalizes as proposed a new modifier that will be used to identify acute stroke telehealth services. In conformity with the BiBA, CMS also adds mobile stroke units as permissible originating sites for acute telehealth services and defines mobile stroke units as "a mobile unit that furnishes services to diagnose, evaluate, and/or treat symptoms of an acute stroke." For additional information on the changes codified by the BiBA, see our Legislative Advisory.

Expanding the Use of Telehealth for Opioid Use Disorder and Other Substance Use Disorders

Requirements of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The SUPPORT Act was signed into law on Oct. 24, 2018 and includes several revisions to section 1834(m) of the Act. The revisions include removing the originating site geographic requirements for telehealth services furnished on or after July 1, 2019 for treatment of individuals diagnosed with a substance use disorder or a co-occurring mental health disorder (subject to certain other 1834(m) restrictions), and the addition of a patient's home as a permissible originating site for these services. To implement these and other provisions of the SUPPORT Act, CMS issues an interim final rule (IFR) with comment period within this rule.

CMS also includes in the rule a Request for Information (RFI) on Medicare payment for certain services furnished by opioid treatment programs (OTPs). Section 2005 of the SUPPORT Act created a new Medicare benefit category for opioid use disorder treatment services furnished by OTPs under Medicare Part B, beginning on or after Jan. 1, 2020. The provision requires that opioid use disorder treatment services would include FDA-approved opioid agonist and antagonist treatment medications, the dispensing and administration of such medications (if applicable), substance use disorder counseling, individual and group therapy, toxicology testing, and other services determined appropriate. The provision defines OTPs as those that enroll in Medicare and are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), accredited by a SAMHSA-approved entity, and meeting certain additional conditions. To implement this provision, CMS is requesting information on services furnished by OTPs, payments for those services, and any additional conditions for Medicare participation for OTPs that stakeholders believe CMS should consider in future rulemaking.

Comments on both the IFR and RFI are due 60 days after this rule is published in the Federal Register.

Request for Comments on Creation of a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorder. In the proposed rule, CMS requested public input on whether it should create a bundled episode of care for management and counseling treatment for substance use disorders, including opioid use disorder. CMS believes that making a separate payment for a bundled episode of these services could prevent the need for more acute services, provide opportunities to better leverage services used for this purpose that are furnished via communication technology and expand access to treatment. CMS received several comments, especially regarding the wide variability in patient needs for treatment of substance use disorders, which it will consider for future rulemaking. CMS welcomes additional information in response to this request during the 60-day comment period for the IFR and RFI, discussed above.

The Alliance for Recovery-Centered Addiction Health Services, of which the AHA is a member, has created an alternative payment model designed to provide patients a long-term, comprehensive and integrated pathway to addiction treatment and recovery. The Addiction Recovery Medical Home model – which incorporates bundled payments, quality targets and shared savings – promotes improved integration of treatment and recovery resources. It sets forth corresponding financial incentives that benefit all stakeholders when the patient is well managed by a multi-disciplinary care team, the Alliance said. For more information on the Alliance's work and members, visit https://www.incentivizerecovery.org/.

Radiologist Assistants

CMS finalizes its proposal to allow registered radiologist assistants and radiology practitioner assistants to perform diagnostic tests under “direct” supervision, rather than “personal” supervision, to the extent permitted by state law and state scope of practice regulations. “Personal supervision” means that a physician must be in the room during the performance of the procedure whereas “direct supervision” requires only that a physician be immediately available to provide assistance or direction during the procedure.

Payment for Therapy Services

To enact changes for therapy payments included in the BiBA, CMS establishes two modifiers to identify services furnished in whole or in part by physical therapy assistants (PTA) (CO modifier) and occupational therapy assistants (OTA) (CQ modifier). CMS proposed that these would be therapy modifiers but instead finalizes them as payment modifiers, meaning they will be appended on the same line of service with the existing, respective, physical therapy (PT) or occupational therapy (OT) therapy modifiers, rather than replacing them. Thus, CMS will not make any chances to existing therapy modifiers used for PT, OT and speech language therapy.

CMS establishes a *de minimis* standard under which it will consider services furnished “in part” by a PTA or OTA; namely, when more than 10 percent of the service is furnished by the PTA or OTA. CMS anticipates addressing more fully the application of the payment modifiers and the 10 percent standard in CY 2020 rulemaking. Under the BiBA, claims for therapy services furnished in whole or in part by therapy assistants must include CMS’s finalized modifiers beginning on Jan. 1, 2020, but the

corresponding payment cut to 85 percent of the PFS rate will not apply until Jan. 1, 2022.

CMS also finalizes its proposed changes to discontinue the functional reporting requirements for outpatient therapy services furnished on or after Jan. 1, 2019. CMS will also discontinue the requirements for the reporting and documentation of functional limitation G-codes (HCPCS codes G8978 through G8999 and G9158 through G9186) and severity modifiers (in the range CH through CN) for outpatient therapy claims with dates of service on and after Jan. 1, 2019. Instead of deleting the set of HCPCS G-codes effective for CY 2019, CMS will retain the set of 42 non-payable HCPCS G-codes until CY 2020 to allow time for therapy providers and other private insurers who currently use these HCPCS G-codes for purposes of functional reporting to update their billing systems and policies.

CHANGES TO THE QUALITY PAYMENT PROGRAM

The rule finalizes updates to the requirements of the QPP for physicians and other eligible clinicians mandated by the MACRA. The QPP includes two tracks – the default Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Data reporting for the QPP began on Jan. 1, 2017. Most of the rule's policies apply to what eligible clinicians must report for the QPP's 2019 performance period, which affects eligible clinicians' payment under the Medicare PFS in CY 2021.

Overview of the MIPS

Eligible clinicians participate in the MIPS either as individuals or as group practices. CMS assesses performance on four categories – quality measures, cost/resource use measures, improvement activities and promoting interoperability (formerly known as advancing care information). Each MIPS performance category has a weight, as outlined below in Table 1. The BiBA permits CMS to adopt a more gradual increase of the weight of the MIPS cost category until it reaches 30 percent for CY 2024. For CY 2021, CMS adopts a cost category weight of 15 percent. Absent the BiBA, CMS would have been required to raise the weight of the cost category to 30 percent for CY 2021.

Table 1: MIPS Performance Category Weights, CY 2019 – CY 2021 Payment

MIPS Performance Category	CY 2019	CY 2020	CY 2021 Final
Quality	60%	50%	45%
Cost / Resource Use	0%	10%	15%
Improvement Activities	15 %	15%	15%
Promoting Interoperability	25%	25%	25%

CMS combines the scores across the categories to create a MIPS "final score." Based on their MIPS final score, eligible clinicians and groups will receive positive, neutral or negative payment adjustments under the Medicare PFS of 4 percent in CY 2019; 5

percent in CY 2020; 7 percent in CY 2021; and a maximum of 9 percent in CY 2022 and beyond.

This section of the advisory describes CMS's finalized policies for the quality, cost / resource use and improvement activity categories of the MIPS. The next section describes the policies CMS will adopt for the promoting interoperability category of the MIPS.

Eligibility for the MIPS

Eligible Clinician Types. As required by the MACRA, the MIPS program applies to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs) that bill under the Medicare PFS. However, CMS has discretionary authority to apply the MIPS to other clinician types who may bill under the Medicare PFS. For the CY 2019 performance period (CY 2021 payment adjustments) CMS will expand the list of MIPS-eligible clinician types to include:

- Physical therapists;
- Occupational therapists;
- Clinical psychologists
- Qualified speech-language pathologists
- Qualified audiologists
- Registered dietician or nutrition professionals

Notably, the agency did not finalize its proposal to add clinical social workers and certified registered nurse midwives as MIPS eligible clinicians because of concerns about the lack of applicable measures.

Clinician and Group Identifiers. CMS does not adopt any changes to its existing policies for identifying clinicians and group practices. CMS considers each unique combination of taxpayer identification number (TIN) and national provider identifier (NPI) to be a different individual eligible clinician. Group practices will continued to be identified as a single TIN with two or more eligible clinicians (as identified by NPI) who have reassigned their billing rights to the TIN.

MIPS Exemptions. For CY 2019 reporting, CMS does not change three of its four MACRA-mandated exemptions from the MIPS, including:

- *Qualifying APM participants* – These eligible clinicians meet the proposed requirements for receiving bonuses for participating in advanced APMs (detailed in the APM section of this advisory), and are not required to participate in the MIPS.

- *Partial qualifying APM participants* – These eligible clinicians participate in advanced APMs that meet CMS's criteria, but fall just short of receiving a high enough percentage of their payments from advanced APMs to receive the bonus payment. Partial qualifying APM participants may elect not to report MIPS data.

- *New Medicare-enrolled eligible clinicians* – These are eligible clinicians who enroll in Medicare for the first time during a MIPS performance period and have not previously submitted Medicare claims.

However, the agency finalizes several changes to the low-volume threshold exemption, as described below.

MIPS Low-volume Threshold

Numerical Thresholds. The MACRA requires CMS to define a low-volume threshold below which participation in the MIPS is not required. In the CY 2018 QPP final rule, CMS adopted a low-volume threshold in which clinicians and group practices billing $90,000 or less of Medicare charges, or that see 200 or fewer Medicare patients, are not required to participate in the MIPS.

However, the BiBA requires that payment adjustments and the low-volume threshold be applied to *covered professional services* rather than items and services. To conform to the BiBA's requirements, CMS modifies the low-volume threshold **for CY 2018 reporting.** That is, clinicians would be excluded if they meet **one** of the following criteria:

- Have $90,000 or less of allowed charges for covered professional services; *or*
- Provide care to 200 or fewer Medicare beneficiaries.

In addition, for CY 2019, CMS retains the above two criteria while adding one additional criterion:

- Provide 200 or fewer covered professional services under the PFS.

CMS estimates that this policy would result in the exemption of nearly 590,000 clinicians from CY 2019 MIPS reporting requirements. **The AHA continues to support CMS's gradual approach to raising the low-volume threshold. At the same time, we recommend the agency continue to use feedback from the field to help it gauge when to lower the threshold, thereby including more clinicians.**

MIPS Opt-in. For CY 2019 reporting, CMS will allow clinicians and groups who meet or exceed **one or two – but not all –** MIPS low-volume threshold criteria to "opt in" to the MIPS. These clinicians and groups could choose to:

- Voluntarily report data and not be subject to MIPS payment adjustments; *or*
- Fully participate in the MIPS, and receive positive or negative payment adjustments.

Clinicians wishing to opt into the MIPS would be required to make an election on the QPP portal. CMS notes that the decision to participate would be irrevocable and could not be changed. CMS does not specify a deadline for opting into the MIPS for a particular performance year.

MIPS Determination Period for Low-volume Threshold and Other Special Statuses

CMS currently uses different time periods to identify and inform clinicians of whether certain MIPS policies apply to them. In an effort to streamline this process, CMS will use the same determination period for the low-volume threshold, as well as the following "special statuses" in the MIPS program: non-patient facing, small practice, hospital-based and ambulatory surgery center (ASC)-based. For CY 2019 reporting, CMS would assess claims during two 12-month periods:

- Oct. 1, 2017 – Sept. 30, 2018, including a 30-day claims run out period. This determination period would allow CMS to identify those clinicians below the low-volume threshold and who qualify for any special statuses clinicians **prior to the start** of the performance period.

- Oct. 1, 2018 – Sep. 30, 2019. This would allow CMS to identify additional clinicians below the low-volume threshold **during** the performance period. CMS would not use a 30-day claims run out for this second period.

Consistent with prior policy, CMS will not change the status of any group identified as below the low-volume threshold or special status during the first determination period based on the results of the second determination period. In other words, clinicians could only gain a special status, or be identified as below the low-volume threshold based on the second determination period.

CMS would continue to use separate determination period processes to identify those clinicians qualifying for the MIPS facility-based measurement option as well as virtual groups.

MIPS Facility-based Measurement Option

As long urged by the AHA, CMS adopted a facility-based measurement option starting with the CY 2019 performance period that will allow those clinicians who spend most of their time in hospitals to have their MIPS quality and cost scores tied to their hospital's CMS value-based purchasing (VBP) program total performance score (TPS). CMS adopted many policies in last year's QPP final rule – see the AHA's Nov. 30, 2017 Regulatory Advisory. However, the agency modifies the option's eligibility criteria, and finalizes the details for electing to use the approach.

Eligibility. In response to feedback from the AHA and others, CMS will expand which hospital sites of service they consider to be "facility-based." That is, CMS will also include services in on-campus hospital outpatient settings (as identified by place of service (POS) code 22), as long as the clinician also bills at least one service using POS code 21 (inpatient hospital) or 23 (emergency department). CMS believes this approach will help capture those clinicians who are primarily inpatient, but spend small but significant time providing care in settings, such as observation units or same-day surgical units based in hospitals.

As a result, for CY 2019, CMS facility-based measurement will be available to individual clinicians (of any specialty) that have at least 75 percent of their covered professional services provided in the inpatient hospital, on-campus outpatient hospital or emergency department settings. For group practices, CMS requires that at least 75 percent of

clinicians in the group (as defined by TIN) meet the "facility-based" threshold for individual clinicians. CMS will determine whether clinicians and groups have met these threshold by reviewing claims to determine what percentage of covered professional service claims are identified by POS 21, 22 and 23. **The AHA applauds CMS for heeding our recommendation to expand the definition of facility-based.**

CMS also will modify the timeframe of claims data it would review to determine whether clinicians are facility-based. Specifically, CMS will review data from Oct. 1 two calendar years prior to the performance period through Sep. 30 of the calendar year prior to the performance period, including a 30-day claims run out period. For the CY 2019 performance period, CMS will review claims data from Oct. 1, 2017 to Sep. 30, 2018.

Facility Attribution. CMS makes no changes to the policies it adopted for attributing clinicians and groups to hospitals – that is, clinicians would be attributed to the hospital where they provide services to the most Medicare beneficiaries. However, the agency notes that if it cannot identify a facility with a VBP score to which it should (?) attribute a clinician, then the clinician would be ineligible for facility-based measurement and must participate in the MIPS using other methods.

Automatic Application of Facility-based Measurement. CMS will automatically apply facility-based scoring to those clinicians and groups that meet the definition of facility-based unless their performance is better under the MIPS data they choose to submit. CMS believes this approach would result in the least administrative burden.

Translating VBP TPS Scores into MIPS Quality and Cost Scores. Rather than scoring clinicians on individual measures from the hospital VBP program, CMS converts hospitals' VBP TPS into MIPS quality and cost category scores. Clinicians and groups would receive the same percentile of performance on the MIPS quality and cost categories as their hospital receives on the TPS in the hospital VBP program. For example, if hospital A receives the median (i.e., 50th percentile) TPS on the hospital VBP, the clinicians and groups attributed to that hospital would then receive MIPS quality and cost scores corresponding to the 50th percentiles of those categories.

CMS will make the performance period for facility-based measurement the fiscal year (FY) that begins during the applicable MIPS performance period. For example, for the MIPS 2019 performance period, CMS will use results from the VBP's FY 2020 program, which begins Oct. 1, 2019.

MIPS Virtual Group Reporting Option

The MACRA permits individual clinicians and group practices of 10 or fewer clinicians to form "virtual groups" to participate jointly in the MIPS. Most of the policies CMS finalized in the CY 2018 QPP final rule for virtual group reporting carry over into 2019. However, CMS adopts two minor changes starting with the CY 2019 performance period:

- CMS will determine virtual group eligibility using a time period aligned with the first MIPS eligibility determination period. For CY 2019, the period will be Oct. 1, 2017 through Sep. 30, 2018, with a 30-day claims run out period

- CMS will permit virtual groups to inquire about whether they meet the size requirement for virtual groups from Oct. 1 through Dec. 31 of the calendar year prior to the applicable performance period.

CMS's QPP website offers a toolkit with additional information on how to use the virtual group reporting option.

MIPS Data Reporting

CY 2019 Performance Periods. CMS retains the same performance period lengths it adopted in last year's QPP final rule. That is, CMS would require clinicians to report a full 12 months of quality data and use 12 months of claims data for the cost category. However, CMS will retain a reporting period of any continuous 90 days for the improvement activity and promoting interoperability categories.

Reporting Mechanisms. For CY 2019 MIPS reporting, CMS retains all of the options for submitting MIPS data it finalized last year. However, CMS proposes to revise the nomenclature it uses to describe MIPS data submission. Specifically, CMS would describe data reporting using three terms:

- "Submission type," which describes the way in which data are submitted to CMS;
- "Submitter type," which refers to which entity – a clinician, group or a third party – submits data on MIPS measures and activities; and
- "Collection type," which refers to quality measures with comparable specifications and data completeness requirements.

The revised MIPS reporting mechanisms are outlined below in Table 2. In addition, starting in CY 2019, clinicians and groups may use more than one submission type for each MIPS performance category. Lastly, CMS will make Medicare Part B claims reporting available to small group practices (i.e., 15 or fewer clinicians); the option was available only to individual clinicians in prior years.

Table 2: MIPS Data Reporting Mechanisms for Individual Eligible Clinicians and Groups, CY 2019 Reporting

MIPS Category	Submission Type	Submitter Type	Collection Type
Quality	• Direct • Log in and upload • CMS web interface (for groups of 25 or more	Individual, group practice, or third-party intermediary	• Electronic clinical quality measures (eCQMs) • MIPS CQMs (formerly qualified registry) • Qualified Clinical Data Registry (QCDR) • CMS web interface measures (groups of 25 or more only) • Survey vendor measures (i.e., Consumer Assessment

MIPS Category	Submission Type	Submitter Type	Collection Type
			of Healthcare Providers and Systems (CAHPS), groups of 25 or more only)
	Medicare Part B claims (individual clinicians and small group practices of 15 or fewer clinicians only)	Individual or group practice	Medicare Part B claims measures
Cost	No data submission necessary – calculated using Medicare claims data		
Improvement Activities	Direct Log in and upload Log in and attest	Individual, group practice, or third-party intermediary	N/A
Promoting interoperability	Direct Log in and upload Log in and attest	Individual, group practice, or third-party intermediary	N/A

Submission Deadlines. CMS retains the data submission deadlines it finalized in the CY 2018 QPP final rule. That is, most data will be due by March 31 of the year immediately following the performance period. Thus, for CY 2019 data, the deadline would be March 31, 2020.

MIPS Quality Category

For CY 2019 quality reporting, CMS mostly carries over CY 2018 reporting requirements. In addition, consistent with its "Meaningful Measures" framework, CMS removes 26 measures from the CY 2019 MIPS measure set. The measures will be retired for being "low-value" or "low-priority" for improvement. **The AHA continues to be encouraged by CMS's efforts to streamline and focus the measures in its quality programs.** Table 3 below outlines the reporting requirements organized by reporting mechanism.

Table 3: MIPS Quality Data Submission Requirements for CY 2019 Performance Period

Collection Type	Submission Requirements	Data Completeness Requirements
MIPS CQM, QCDR, and eCQM	-Report at least six measures, including one outcome measure -If no outcome measure is available, then report another "high-priority" measure (i.e.,	Report on 60% of eligible clinician or group's patients from all payers that meet measures' denominator criteria

Collection Type	Submission Requirements	Data Completeness Requirements
	appropriate use, patient safety, efficiency, patient experience or care coordination) -If fewer than six measures apply, report on as many applicable measures as possible -If reporting a specialty measure set that contains fewer than six measures, report on all applicable measures -Report on **both** Medicare and non-Medicare patients	
Part B claims-based reporting (individual and small group only)	Same as MIPS CQM, eCQM and QCDR except report on Medicare patients only	Report on 60% of eligible clinician's patients
CMS web interface (groups of 25 or more only)	Report on all measures included in CMS web interface	Web interface uses an attribution and sampling approach to assign patients to particular practices. Groups report on assigned beneficiaries: - Groups populate the data fields for first 248 assigned Medicare beneficiaries. - If fewer than 248 beneficiaries are assigned, report on 100% of assigned patients
CAHPS (groups of 25 or more only)	Use a CMS-approved vendor to collect and submit CAHPS for MIPS survey ***Note: The CAHPS survey counts as one measure*	CMS applies an attribution and sampling approach to assign beneficiaries to particular practices. CAHPS vendor would collect survey on assigned Medicare Part B patients.

MIPS Cost / Resource Use Category

Overall Cost Measures. CMS will continue to score clinicians and groups on two overall cost measures – Medicare spending per beneficiary (MSPB) and total cost per capita – that it finalized in the CY 2017 QPP final rule. Detailed descriptions of those measures are available in the AHA's Dec. 5, 2016 Regulatory Advisory.

Episode-based Cost Measures. For the CY 2019 performance period, CMS also adopts eight condition and treatment-specific episode cost measures. In contrast to the MSPB and total cost per capita measures, the episode-based measures include only the items and services related to the episode of care for a particular treatment or condition. The eight proposed measures – comprising a mix of procedural and acute inpatient care – are listed below. Detailed measure specifications are available on CMS's website. Note that clinicians and groups will be scored on only the measures for which they have a sufficient number of cases.

Measure	Measure Type	Case Minimum
Elective outpatient percutaneous coronary intervention (PCI)	Procedural	10 cases
Knee arthroplasty	Procedural	10 cases
Revascularization for lower extremity chronic critical limb ischemia	Procedural	10 cases
Routine cataract removal with intraocular lens implantation	Procedural	10 cases
Screening / surveillance colonoscopy	Procedural	10 cases
Intracranial hemorrhage or cerebral infarction	Acute inpatient	20 cases
Simple pneumonia with hospitalization	Acute inpatient	20 cases
ST-elevation myocardial infarction (STEMI) with PCI	Acute inpatient	20 cases

Care episodes are “triggered” by the occurrence of a particular event (e.g., a Medicare Part B claim for knee arthroplasty), and can encompass time periods before (e.g., 30 days) and after (e.g., 90 days) the trigger event. CMS will identify attributed clinicians groups using TIN/NPI information from the trigger claims. For procedural episode groups, episodes are attributed to the clinician(s) rendering the trigger services (HCPCS/CPT procedure codes). For example, an orthopedic surgeon billing HCPCS/CPT code 27446 would be attributed a Knee Arthroplasty episode. For acute inpatient medical condition episode groups, episodes are attributed to the clinician(s) rendering least 30 percent of inpatient E/M claim lines during an inpatient hospitalization.

To calculate the measure scores, CMS will perform the following steps using all episodes in an episode group that are attributed to a clinician or group:

- Determine observed costs for each episode by aggregating Part A and Part B standardized allowed amounts for services related to a given condition or procedure that occur within the episode window.

- Determine expected costs for each episode through risk adjustment. CMS uses hierarchical condition categories (HCCs) and other risk adjustors as needed.

- Sum the ratio of observed to expected payment-standardized cost to Medicare for all episodes attributed to a provider and divide that sum by the total number of episodes attributed to the provider. This is then multiplied by the national average observed episode cost to generate the risk-adjusted average episode costs, which represents the cost measure score.

MIPS Improvement Activity Category

The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. Most of the requirements for the improvement activity category finalized in the CY 2018 QPP final would carry over for CY 2019. CMS also proposes to modify existing activities and to add new activities to its inventory of improvement activities.

MIPS – Promoting Interoperability Category

For CY 2019 and subsequent years, to emphasize the focus on interoperability and patient access to their health information, CMS renamed the advancing care information (ACI) performance category to the promoting interoperability performance category.

Certified Electronic Health Record (EHR) Requirements. Beginning in CY 2019. CMS requires all MIPS-eligible clinicians use the 2015 Edition certified EHR. CMS acknowledged receipt of comments expressing concern with the requirement and may consider the comments to inform future policy making. The AHA is concerned about this requirement because not all vendors have certified products available and the process of implementing upgrades, modifying workflows and ensuring that new systems are safe for patients takes considerable time to accomplish.

Promoting Interoperability Performance Category Reporting Period. CMS finalizes a reporting period of a minimum of any continuous 90-day period in CYs 2019. This replaces the policy requiring a reporting period of a full calendar year beginning in CY 2019. CMS states the proposed reporting period permits time to test and implement the 2015 Edition certified EHR and become familiar with the new scoring methodology.

Promoting Interoperability Performance Category Scoring Methodology for CY 2019. CMS finalizes a new scoring methodology that replaces the previous base, performance and bonus score methodology for the former ACI category. CMS finalizes a scoring approach to provide increased flexibility, reduce provider burden and align the Promoting Interoperability performance category with the requirements of the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals (CAHs) as finalized in the FY 2019 Inpatient PPS proposed rule.

The new scoring methodology will be applied to four objectives derived from objectives found in Stage 3: Electronic Prescribing, Patient Electronic Access to Health Information, Health Information Exchange and Public Health and Clinical Data Registry Reporting. The Protect Patient Health Information objective would continue as a required yes/no attestation.

The scoring approach assigns weights to individual measures under each objective, with performance-based scoring for each measure. The individual measure scores contribute to the total Promoting Interoperability performance category score.
A MIPS-eligible clinician will receive a score from zero to 100 points, depending on performance on individual measures. The Promoting Interoperability category score will be multiplied by the performance category weight to determine the points for the final score. The Promoting Interoperability performance category score makes up 25 percent of the MIPS final score. Unless an exclusion applies, failure to report any required measure or reporting a “no” response on a yes/no measure would result in the clinician receiving a total score of zero for the Promoting Interoperability performance category.

Table 4 lists the performance based objectives and scoring methodology.

Table 4: Promoting Interoperability Performance Category Scoring Methodology for the CY 2019 MIPS Performance Period

Objective	Maximum Points
e-Prescribing	20 points in 2019 (includes 10 bonus points for two new opioid measures)
Health Information Exchange	40 points
Provider to Patient Exchange	40 points
Public Health and Clinical Data Exchange	10 points
MIPS-eligible clinicians must report on all required objectives and measures (see Table X for measures). *The Protecting Patient Health Information objective does not have a performance-based measure but eligible clinicians are required to attest to meeting the Security Risk Analysis measure requirements.*	

Promoting Interoperability Objectives and Measures for CY 2019. This section describes the individual objectives and measures. For CY 2019, CMS finalizes four objectives with measures associated with performance-based scoring that are derived from the objectives and measures included in the Medicare and Medicaid EHR Incentive Program Stage 3 requirements, as well as a required objective to protecting patient health information that would not contribute to the score.

Exclusions: Some, but not all, measures have an exclusion to account for challenging situations that prevent meeting the measure. If an exclusion is claimed, points for that measure will be redistributed to other measures.

Protect Patient Health Information. CMS retains the Protect Patient Health Information objective and the Security Risk Analysis measure previously finalized in EHR Incentive Program for Stage 3. CMS reiterated that the Security Risk Analysis measure includes relevant actions that may occur any time during the calendar year and are not limited to the performance period selected to report the performance-based measures.

Exclusions: No exclusions.

Electronic Prescribing. This objective focuses on generation and transmittal of permissible discharge prescriptions electronically. For CY 2019, CMS finalizes one e-prescribing measure and two opioid-related measures available for bonus points. For the e-prescribing measure, at least one permissible prescription written by the MIPS-eligible clinician is queried for a drug formulary and transmitted electronically using a certified EHR.

The CY 2019 opioid measures available for bonus points include:

- The ability of the MIPS-eligible clinician to use data from the certified EHR to query a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law; and

- The ability of the MIPS-eligible clinician to identify the existence of a signed opioid treatment agreement and incorporate it into the patient's EHR for at least one unique patient for whom a Schedule II opioid was e-prescribed if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month look-back period.

- CMS acknowledged that certified EHRs lack certified functionality specific to connecting to a PDMP and that support for integration between PDMP systems and EHRs varies widely across States due to variations in laws and technical approaches.

Exclusions: No exclusions are available for these measures for CY 2019.

Health Information Exchange. CMS finalizes two measures for the health information exchange objective that a MIPS-eligible clinician provide a summary of care record when transitioning or referring their patient to another setting of care; receive or retrieve a summary of care record upon receipt of transition or referral or upon the first patient encounter with a new patient; and incorporate information into their EHRs.
For the Sending a Summary of Care measure, for at least one transition of care or referral, the MIPS-eligible clinician that transitions or refers its patient to another setting of care or provider of care: (1) creates a summary of care record using a certified EHR; and (2) electronically exchanges the summary of care record. CMS states that MIPS-eligible clinicians may use any document template within the Consolidated Clinical Document Architecture (CCDA) standard to meet the measure.

For the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, for at least one electronic summary of care record received for patient encounters during the EHR reporting period for which MIPS-eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the EHR reporting period in which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.

Exclusions: CMS finalizes an exclusion for the Send a Summary of Care measure for any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. CMS finalizes two exclusions for the Support Electronic Referral Loops by Receiving and Incorporating Health Information exchange measure. MIPS-eligible clinicians may receive an exclusion if they are unable to implement the measure for the MIPS CY 2019 performance period or if they receive fewer than 100 transitions of care or referrals or have fewer than 100 encounters with patients never before encountered during the performance period. An exclusion from the second measure will redistribute the points to the Send a Summary of Care Measure.

Provider to Patient Exchange. CMS finalizes one measure for this objective to provide patients (or patient-authorized representative) with timely electronic access to their health information. For the Provide Patients Electronic Access to Their Health Information measure, for at least one unique patient (1) the patient (or patient-

authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) the MIPS-eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the application programming interface (API) in the certified EHR of the MIPS-eligible clinician.

Exclusions. No exclusions are available for this measure.

Public Health and Clinical Data Exchange. CMS finalizes that the MIPS-eligible clinician would report on two measures of their choice from the five measures available for reporting. For the Immunization Registry Reporting measure, the MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). For the Electronic Case Registry Reporting measure, the MIPS-eligible clinician is in active engagement with a public health agency to submit case reporting of reportable conditions. For the Public Health Registry Reporting measure, the MIPS-eligible clinician is in active engagement with a public health agency to submit data to public health registries. For the Clinical Data Registry Reporting measure, the MIPS-eligible clinician is in active engagement to submit data to a clinical data registry. For the Syndromic Surveillance Reporting measure, the MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

CMS states that MIPS-eligible clinicians have the flexibility to report to two different public health agencies or clinical data registries for purposes of the same measure and receive full credit for the measure reporting requirements for this objective. The agency also states they are working with the Agency for Health Care Research and Quality (AHRQ) and the Centers for Disease Control on the AHRQ Registry of Patient Registries so that available registries can be easily located. CMS also states that reporting more than two measures for this objective will not earn the MIPS-eligible clinician any bonus points.

Exclusions: If a MIPS-eligible clinician obtains an exclusion for one measure and reports a second measure, the MIPS-eligible clinician will earn the full 10 points available. If a MIPS-eligible clinician claims two exclusions, the 10 points would be redistributed to the Provide Patients Electronic Access to their Health Information measure under the Provider to Patient Exchange objective, making that measure worth 50 points in 2019. Any MIPS-eligible clinician may be excluded from the syndromic surveillance reporting measure if one of these conditions is met: the public health agency cannot receive electronic syndromic surveillance data in the EHR specified standards at the start of the reporting period; or the public health agency has not declared readiness to receive syndromic surveillance data as of six months prior to the start of the EHR reporting period.

Table 5 contains the objectives, measures, scoring methodology for CY2019 performance period. Appendix A contains the proposed objectives, measures, points, and exclusions for CY 2019.

Table 5: Proposed Scoring Methodology for the MIPS Performance Period in 2019

Objective	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Query of PDMP	5 bonus points
	Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information (sending a Summary of Care)	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information (receiving a Summary of Care and Clinical Information Reconciliation)	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Choose two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Potential New Measures. CMS received comments on potential new measures for the Health Information Exchange across the care continuum and will consider them as they develop future policy.

MIPS Final Performance Score

Overview of MIPS Final Score. As required by the MACRA, CMS calculates a final composite score of 0 to 100 points for each eligible clinician and group in the MIPS. The MIPS final score is used to determine whether the clinician or group receives positive, neutral or negative payment adjustments under the MIPS.

CMS carries over most aspects of the scoring approach finalized in the CY 2018 QPP final rule. The AHA's 2018 OPP final rule Regulatory Advisory includes more details on the approach. There are three significant changes. First, CMS adopts changes to the scoring approach for the Promoting Interoperability category, as outlined in the previous section of this advisory. Second, CMS will not score improvement on the cost category until the CY 2024 payment year. Lastly, CMS will add bonus points for small practices to the quality category score, rather than to the MIPS overall score.

MIPS Payment Adjustment Approach

As required by the MACRA, CMS must implement MIPS payment adjustments in a budget-neutral manner. That is, the agency may not pay out more in incentive payments

than it recoups in penalties. However, for CYs 2019 through 2024, CMS also must pay out $500 million in “exceptional performance bonuses” to groups that perform exceptionally well on the MIPS. This exceptional performance bonus is above and beyond the budget-neutral MIPS payment adjustment.

As outlined in Figure 1, CMS is required by law to identify several final score thresholds to translate MIPS final scores into a payment adjustment:

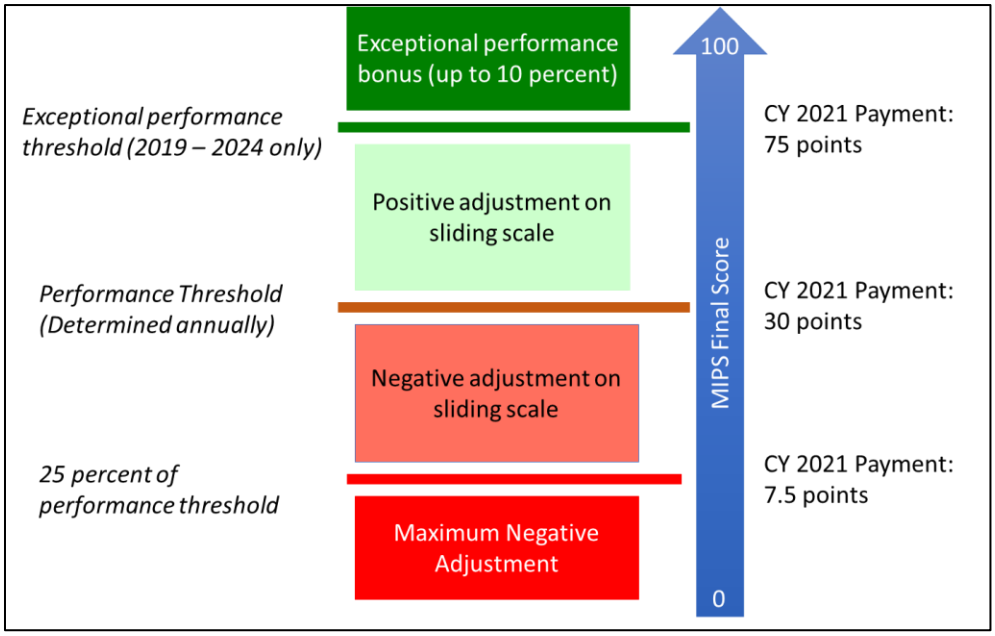
- **A performance threshold** above which there are positive payment adjustments on a sliding scale, and below which there are negative payment adjustments on a sliding scale. The MACRA requires that CMS publish this number prior to the start of the performance period so that MIPS participants know what level of performance is expected in order to receive positive or negative adjustments. For the CY 2021 MIPS payment adjustments, the performance period is CY 2019.

  For CY 2021 payment, CMS sets the performance threshold at 30 points. CMS notes that this is an increase over the CY 2020 threshold of 15 points. CMS intends for the increase in the threshold to incentivize the reporting of more measures and more complete data into the MIPS.

- **25 percent of the performance threshold final score,** at or below which MIPS-eligible clinicians and groups receive the maximum negative payment adjustment (-7 percent in CY 2021). For CY 2021, the value would be 7.5 points.

- **An exceptional performance threshold final score** at or above which MIPS-eligible clinicians and groups are eligible for an additional bonus beyond their positive MIPS adjustment. For CY 2021, CMS sets the threshold at 75 points. Clinicians and groups receiving a score at or above 75 would be eligible for exceptional performance bonuses of up to 10 percent on a sliding scale.

Figure 1: Translating MIPS Final Score into Payment Adjustments for 2021 based on CY 2019 Performance



Scaling Factor for Positive Payment Adjustments. CMS will continue, as required by the MACRA, to apply a scaling factor of up to 3.0 to positive payment adjustments to maintain the budget neutrality of the MIPS. The scaling factor likely will be applied in years where CMS is taking in a significant amount in MIPS performance penalties. In CY 2021, this means that clinicians and groups could receive positive payment adjustments as high as 21 percent. However, CMS believes it is unlikely the agency would need to apply the full scaling factor.

Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration

In conjunction with the release of the proposed rule, CMS announced the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. **The demonstration is designed to test whether excluding MIPS-eligible clinicians who participate in certain payment arrangements with Medicare Advantage Organizations (MAOs) from the MIPS reporting requirements and payment adjustment will increase or maintain participation in these payment arrangements, which are similar to Advanced APMs, and change the delivery of care.** In this rule, CMS finalizes regulations to implement the demonstration using the authority in section 402(b) of the Social Security Amendments of 1967. Through this authority, CMS will waive the required payment consequences (positive, negative or neutral adjustments) of the MIPS and associated MIPS reporting requirements adopted to implement the payment consequences, subject to demonstration-specific considerations. CMS is also using this authority to waive the provision that allows any eligible clinician to voluntarily participate in MIPS reporting so as to ensure the demonstration will prohibit reporting under the MIPS by eligible clinicians that participate in the demonstration.

CMS also finalizes its proposed eligibility policies for the MAQI demonstration. Specifically, to qualify for the MIPS exclusion under the demonstration, clinicians will be required to participate to a sufficient degree in a combination of Qualifying Payment Arrangements with MAOs and Advanced APMs with fee-for-service Medicare without meeting the criteria to be Qualified Participants (QPs) or otherwise meeting a MIPS exclusion criteria under the QPP. The thresholds for participation to a "sufficient degree" – i.e., having a certain percentage of payments or patients tied to participation in a combination of Qualifying Payment Arrangements and Advanced APMs – will mirror those for participation in Advanced APMs under the Medicare Option of the QPP. For 2018, those thresholds are 25 percent of payments and 20 percent of patients. Clinicians who enroll in the MAQI demonstration but fail to meet these thresholds will continue to be MIPS-eligible clinicians who are subject to the standard MIPS reporting requirements and payment adjustments.

CMS will identify Qualifying Payment Arrangements under the demonstration using criteria consistent with those used to identify Other Payer Advanced APMs under the QPP. Providers that participate in Other Payer Advanced APMs with payers such as Medicare Advantage (MA) and Medicaid can become QPs through MACRA's All-Payer Combination Option, beginning in 2019. **The proposed demonstration will enable participation in Qualifying Payment Arrangements with MA plans that meet the criteria of Other Payer Advanced APMs a year before the All-payer Combination Option is available.** For additional details about the all-payer option, please see our Regulatory Advisory on the MACRA Physician Quality Payment Program Final Rule for CY 2018.

Advanced APMs

The MACRA provides incentives for physicians who participate in advanced APMs. These include a lump-sum bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and payment adjustments; and higher base payment updates beginning in 2026. In 2016, CMS finalized the criteria by which clinicians will be determined to be qualified APM participants to receive these incentives. CMS will assess clinicians' participation in APMs in 2019 for the 2021 incentive payment. For the most part, advanced APM criteria and processes carry over from the CY 2018 QPP final rule.

Advanced APM Determinations. The MACRA defines broad categories of Medicare payment models that may qualify as advanced APMs. Those include a demonstration model under Center for Medicare and Medicaid Innovation (CMMI) authority; the Medicare Shared Savings Program (MSSP); and certain other demonstrations under federal law. Further, the statute requires that, to qualify as an advanced APM, a model must:

- Require participants to use certified EHR technology;
- Condition some amount of payment for covered professional services on quality measures comparable to those in the MIPS quality performance category; and

- Require that APM entities bear risk for monetary losses of more than a nominal amount. Alternatively, the APM entity may be a medical home under a model expanded under CMMI authority.

In this year's rule, CMS adopts minor changes to the standards it will use to determine whether an APM qualifies as an advanced APM for purposes of the APM incentive payment.

Use of Certified EHR Technology. Beginning with the CY 2019 performance period, CMS will increase the percentage of eligible clinicians within an APM entity that must use certified EHR technology from 50 percent to 75 percent. This criterion applies to both Medicare advanced APMs, and other payer advanced APMs (described in the next section of this advisory). CMS states this proposal aligns with its agency-wide priority of enhancing interoperability to promote better exchange of health information. **The AHA remains concerned this increase may be too much, too soon.**

Quality Measures. Beginning with the CY 2019 performance period, CMS will require that advanced APM models use at least one outcome measure that is 1) on the MIPS measure list, 2) endorsed by a consensus-based entity, or 3) is otherwise determined to be evidence-based, reliable and valid by CMS. This final policy eliminates the exception for models where there are no available outcome measures applicable to the model.

Generally Applicable Financial Risk Standard. In 2016, CMS finalized a standard that sets the total potential risk (i.e., the maximum potential payment for which an entity could be liable under the model) that most models must require to be considered an advanced APM. Specifically, under the standard finalized by CMS, the standard is met if the terms of the APM require that an APM entity potentially owes or forgoes the following amount:

- 3 percent of the expected expenditures for which an APM entity is responsible under the APM, such as through a benchmark or target price (the "benchmark standard"), or

- 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM entities (the "revenue-based standard").

CMS previously finalized the revenue-based standard only for the CY 2017 through CY 2020 performance periods, stating that it intended to increase the standard in subsequent years. However, CMS will now extend the 8-percent revenue-based standard through CY 2024.

Multi-year Other Payer Advanced APM Determination. In the CY 2018 QPP final rule, CMS established a "determination process" allowing for payers such as Medicare Advantage, Medicaid, multi-payer models and private payers -- to submit their models to qualify as advanced APMs. These other models would enable clinicians to qualify for advanced APM status under the "all-payer advanced APM option," in which CMS considers participation in both Medicare advanced APMs and other payer APMs.

The policy adopted last year would require other payer APMs to re-submit all information on annual basis. However, CMS finalizes its proposal to revise the policy so that an advanced APM submitting a multi-year arrangement would not have to re-submit information unless the arrangement was changing substantially.

TIN-level All-payer QP Determination. CMS previously finalized that it would determine whether QPs using the all-payer combination meet the advanced APM participation thresholds at only the individual clinician and APM entity levels. However, as the agency noted, contracting often is executed at the TIN level. Thus CMS will allow all payer advanced APM determinations at the TIN level beginning with the 2019 performance period.

OTHER PROPOSED CHANGES FOR CY 2019

Payments for Non-Excepted Services in Certain Off-campus Hospital Provider-based Departments (PBDs)

Section 603 of the BiBA requires that, with the exception of dedicated emergency department services, services furnished in off-campus PBDs that began billing under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015 (referred to as "non-excepted services") are no longer to be paid under the OPPS, but rather under another applicable Part B payment system.

For CY 2019, CMS make no changes to the "site-neutral" payment rate under the PFS. Specifically, CMS will allow non-grandfathered (non-excepted) off-campus PBDs to continue to bill for non-excepted services on the institutional claim using a "PN" modifier and maintains the "site-neutral" rate for non-excepted services at 40 percent of the OPPS amount for CY 2019 and future years. The agency also maintains the same policies as 2018 related to supervision, beneficiary cost sharing, geographic payment adjustments and partial hospitalization services. See our Regulatory Advisory on the OPPS rule for more policies on off-campus PBDs.

While the AHA's comments to CMS had supported the agency's intent to retain the fundamental methodology it used since 2017 for determining the PFS relativity adjuster, we expressed disappointment that the agency did not propose to improve the accuracy of its methodology to explicitly account for differences in packaging across the OPPS and the PFS and ensure that both indirect and direct practice expense are accounted for in nonexcepted PBDs.

Reduction in Payment for New Part B Drugs

Currently, Medicare reimburses new Part B drugs for which average sales price (ASP) price data is unavailable during the first quarter of sales at the rate of 106 percent of wholesale acquisition cost (WAC). The WAC is the manufacturer's list price and does not incorporate prompt-pay or other discounts.

In the final rule, CMS reduces payment for new Part B drugs and biologicals from the rate of 106 percent of WAC to 103 percent of WAC. This rate only applies during the period of time when ASP data for the new drug are unavailable. This policy is consistent with recommendations included in the fiscal year 2019 President's Budget

Proposal and the Medicare Payment Advisory Commission's June 2017 report to Congress. CMS notes this payment reduction will not apply to single source drugs that are required under law to be paid at 106 percent of the lesser of ASP or WAC. The AHA continues to oppose this payment reduction because it unfairly shifts the burden for the high list prices imposed by drug manufacturers onto hospitals and physicians.

Appropriate-use Criteria (AUC) for Advanced Diagnostic Imaging Services

AUC are a set of individual criteria that present information linking a specific clinical condition or presentation with one or more services and an assessment of the appropriateness of the services. The Protecting Access to Medicare Act (PAMA) of 2014 required CMS to establish a program to promote the use of AUC for advanced diagnostic imaging that integrates the AUC into the clinical workflow.

CMS finalizes several of its proposals related to the existing requirements and criteria of the AUC program, including the following:

- CMS adds independent diagnostic testing facilities to the list of applicable settings to which AUC consultation and reporting requirements apply.

- With regard to the ordering professional to whom the AUC consultation requirement applies, CMS finalizes a modified version of its proposal to allow auxiliary personnel incident to the ordering professional's services to perform the required AUC consultation with a clinical decision support mechanism (CDSM). Specifically, CMS will permit clinical staff under the direction of the ordering professional to perform the CDSM consultation.

- **CMS will revise applicable regulations to clarify that AUC consultation information must be reported on all relevant claims from both furnishing professionals and facilities. However, the AHA will continue to advocate with the agency for a more sensible reporting and billing policy for AUC consultation information.**

- Having concluded that the creation of a unique consultation identifier (UCI) to report AUC consultation information is not feasible at this time, CMS finalizes its proposal to use established coding methodology, including G-codes and modifiers, to report the required AUC information on Medicare claims.

- CMS also finalizes revisions to the significant hardship exception criteria in the AUC program. Specifically, CMS finalizes AUC-specific criteria for meeting the hardship exception including (1) insufficient internet access; (2) EHR or CDSM vendor issues; and (3) extreme and uncontrollable circumstances, such as natural disasters, that have a significant negative impact on health care operations, area infrastructure, or communication systems. CMS also finalizes its proposal to allow ordering professionals experiencing a significant hardship to self-attest and include that information on the order for the advanced diagnostic imaging service, which furnishing facilities and professionals would then communicate to CMS with a modifier on their claims for payment.

Changes to Clinical Laboratory Fee Schedule

Background. Under a provision of law implemented Jan. 1, 2018, CMS sets clinical laboratory fee schedule (CLFS) payment rates based on the weighted median of private payer rates and volumes for covered clinical laboratory tests reported by each "applicable laboratory" during a designated data reporting period. CMS currently defines an applicable laboratory as a laboratory that bills Medicare Part B under its own NPI and receives more than 50 percent of its Medicare revenues during the six-month data collection period from PFS and CLFS services. CMS also employs a "low expenditure threshold" under which clinical laboratories receiving less than $12,500 in Medicare revenues for CLFS services during the six-month data collection period are exempted from having to report. Most hospital laboratories were not required to report their private payer data during the last data reporting period because they did not meet the definition of an "applicable laboratory."

Some laboratory stakeholders have expressed concerns that the CY 2018 CLFS payments rates are based on reporting from a relatively small and non-representative sample of laboratories and thus do not reflect private payer payment rates for the entire spectrum of clinical laboratories. They believe that unless more laboratories, particularly hospital outreach laboratories[2], are required to report, the CLFS rates will continue to be non-representative.

The next CLFS data collection period is Jan. 1, 2019 through June 30, 2019. Applicable laboratories will be required to report to CMS the private payer rate and volume data they collect during the data reporting period, which takes place from Jan. 1, 2020 to March 31, 2020.

Revised Applicable Laboratory Definition To Include Hospital Outreach Laboratories. In the final rule CMS amends the definition of an applicable laboratory to include hospital laboratories that bill Medicare for their non-patient laboratory services on the CMS 1450 14X Type of Bill (TOB).This bill type is only used by hospital outreach laboratories.

This policy change means that all hospital outreach laboratories, except for those that receive less than $12,500 in CLFS revenues on the 14X TOB during the upcoming data collection period, will be required to report their private payer rate and volume data to CMS by the end of the next data reporting period (Mar. 31, 2020). CMS will use subregulatory guidance and provider education materials to provide more detail on how to report the applicable data to CMS.

In comments to the agency, the AHA had opposed this change due to the significant operational burden this data collection would impose on hospitals, the concern that it would not be justified by what CMS itself expects to be a minimal impact on the CLFS rates, as well as our belief that Congress did not intend hospital outreach laboratories to qualify as applicable laboratories.

[2] CMS describes hospital outreach laboratories as "laboratories that furnish laboratory tests for patients who are not admitted hospital inpatients or registered outpatients of the hospital and who are enrolled in Medicare separately from the hospital of which they are a part as independent laboratories that do not serve hospital patients."

Removing Medicare Advantage Plan Revenues from Denominator of the "Majority of Medicare Revenues" Threshold. CMS will remove payments from Medicare Advantage plans from the denominator of the fraction that is used to determine whether a laboratory received more than 50 percent of its revenues from PFS and CLFS services. CMS believes this will result in more laboratories of all types meeting the majority of Medicare revenues threshold and thus being required to reporting private payer rates.

Extension of Ambulance Add-ons

The rule finalizes the BiBA extensions to the existing add-on payments for ground ambulance services (a 3 percent add-on for rural areas and a 2 percent add-on for urban areas), as well as the "super rural" ambulance add-on through Dec. 31, 2022. It also implements a required reduction in the amount that Medicare would otherwise pay for ambulance transports to and from a dialysis facility in non-emergency situations – payments will be reduced by an additional 13 percentage points (for a total reduction of 23 percent), beginning in FY 2019.

Medicaid Promoting Interoperability Program

Revisions to the EHR Reporting Period and eCQM Reporting Period in 2021 for Eligible Professionals (EPs) Participating in the Medicaid Promoting Interoperability Program. The July 2010 Medicare and Medicaid Programs; Electronic Health Record Incentive Program final rule states in no case may any Medicaid EP receive an incentive after 2021. Therefore, CMS finalizes that the reporting period for CY2021 for all EPs in the Medicaid Promoting Interoperability Program is a minimum of any continuous 90-day period, provided the end date for the period falls before Oct. 31, 2021. This deadline helps to ensure that states issue Medicaid Promoting Interoperability Program payments on or before Dec. 31, 2021. CMS also finalizes that the CY 2021 eCQM reporting period for all EPs in the Medicaid Promoting Interoperability Program is a minimum of any continuous 90-day period, provided the end date for the period falls before Oct. 31, 2021. CMS states they are aware that reporting deadlines early in a year can place burden on Medicaid EPs. CMS states they are considering whether to propose in future rulemaking that a state may not set a reporting deadline for CY 2021 that is prior to June 30, 2021 or an attestation deadline that is earlier than July 1, 2021.

Proposed Revisions to Stage 3 Meaningful Use Measures for Medicaid EPs. CMS proposes to revise measures for two of the objectives in Stage 3 meaningful use.

Coordination of Care through Patient Engagement. CMS finalizes a revision in thresholds for two of the measures for the Coordination of Care through Patient Engagement objective. Specifically, CMS finalizes that the Measure 1 (View, Download, or Transmit) and Measure 2 (Secure Electronic Messaging) thresholds will be five percent for CY 2019 and subsequent years in the program. Current regulations require an increase in the Measure 1 threshold from five percent in 2018 to 10 percent in 2019 and an increase in the Measure 2 threshold from five percent in 2018 to 25 percent in 2019. CMS acknowledges that Medicaid EPs struggle to meet the objective due to factors outside of their control; the decision to retain the lower threshold addresses this concern.

Public Health and Clinical Data Registry Reporting. CMS finalizes a revision to the Public Health and Clinical Data Registry Reporting Measure 2 (Syndromic Surveillance

Reporting) to include any EP in an urgent care setting and any other setting from which ambulatory syndromic surveillance data are collected by the state or local public health agency. An exclusion remains for EPs who are not in a category of health care providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system. CMS states that the change does not create any requirements for syndromic surveillance registries to include all EPs.

Electronic Clinical Quality Measures for EPs under the Medicaid Promoting Interoperability Program. CMS finalizes an alignment of the electronic clinical quality measures (eCQMs) available for Medicaid EPs in 2019 with those available for MIPS-eligible clinicians for the CY 2019 performance period. Specifically, the eCQMs available for Medicaid EPs in 2019 will consist of the list of quality measures available under the eCQM collection type on the final list of quality measures established under MIPS for the CY 2019 performance period. Medicaid EPs will report on any six eCQMs that are relevant to the EPs' scope of practice regardless of whether they report via attestation or electronically.

eCQM reporting period for EPs under the Medicaid Promoting Interoperability Program. CMS finalizes that for EPs who demonstrated meaningful use in a prior year, the eCQM reporting period would be a full calendar year in 2019. CMS states this proposal aligns with the corresponding performance period in MIPS for the quality performance category. The reporting period for Medicaid EPs reporting for the first time will be any continuous 90 days.

CMS did not specify the eCQM reporting period for CY 2020 but acknowledged that a reporting period of a full year for CY 2020 might create an attestation challenge for 2020 and 2021 and difficulties for states to issue payments by statutory deadlines. CMS will monitor the issue as proposed rules for the Medicaid Promoting Interoperability program are developed for CY 2020.

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

As described above, CMS finalizes separate payment under the PFS for communication technology-based "check-ins" and remote evaluation of patient-transmitted and recorded "store and forward" videos or images. CMS also finalizes payment for these services when at least five minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has been seen in the RHC or FQHC within the past year. Providers will bill for these services using newly created HCPCS code G0071, but they will only be billable without an associated billable visit. CMS will waive the RHC and FQHC face-to-face requirements when these services are furnished to an RHC or FQHC patient.

Physician Self-Referral Law

CMS finalizes as proposed several policies to implement certain sections of the BiBA pertaining to the physician self-referral, or Stark, law, address any actual or perceived differences between the statutory and regulatory language, and codify its existing policy on certain Stark exceptions. Specifically, CMS creates a new special rule to codify existing policy that the writing requirement in various compensation exceptions to the Stark law can be satisfied by a collection of documents, including contemporaneous

documents evidencing the course of conduct between the parties. CMS also finalizes its proposal to adjust its special rule for certain arrangements involving temporary noncompliance with signature requirements to conform to the slightly different version of that special rule that was included in the BiBA. The BiBA provision is not limited to specific Stark exceptions and does not limit entities to using the special rule once every three years for the same referring physicians. Thus, CMS amends its Stark law regulations to broadly apply the signature requirements and delete the limitation on use of the rule once every three years with respect to the same physician. CMS also removes references in the regulation to occurrence of referrals or payment of compensation during the 90-day period when the signature requirement is not met.

Finally, CMS provides its annual update to the list of codes that will be considered "designated health services" (DHS) in CY 2019. The Stark law generally prohibits a physician from referring a Medicare beneficiary for certain DHS to an entity with which the physician (or an immediate family member) has a financial relationship.

CHANGES TO THE MEDICARE SHARED SAVINGS PROGRAM (MSSP)

MSSP Quality Measures

CMS recently unveiled its "Meaningful Measures" framework that seeks to streamline and prioritize the quality measures used across all CMS quality reporting and value programs so that they focus on the issues that matter the most to improving care. Consistent with this framework, CMS removes 10 measures from, while adding two measures to, the MSSP quality measures from the CY 2019 MSSP measure set. CMS declines to add the three measures related to opioid use that it included in the August 2018 "Pathways to Success" proposed rule, but it will consider the feedback it received on the measures in connection with any future proposals on the addition of opioid use measures.

Tables 7 and 8 list the measures finalized for removal and addition, and describes CMS's rationale for adopting or removing the measures.

Table 7: Measures Removed from MSSP Beginning with CY 2019 Performance Year

Measure Removed	CMS Rationale
ACO-35: Skilled nursing facility 30-day all cause readmission measure	Overlaps substantially with ACO-8 (risk standardized all condition readmission)
ACO-36: All-cause unplanned admissions for patients with diabetes	Overlaps substantially with ACO-38 (Risk standardized acute care admission rates for patients with multiple chronic conditions)
ACO-37: All-cause unplanned admissions for patients with heart failure	
ACO-44: Use of imaging studies for low back pain	Measure includes patients aged 18-50, resulting in low denominators in MSSP. Not a valuable reflection of care for MSSP population.

Measure Removed	CMS Rationale
ACO-12: Medication reconciliation post-discharge	Also removed from CMS web interface in the MIPS – measures deemed low-value
ACO-15: Pneumonia vaccination rates for older adults	
ACO-16: Preventive care and screening - Body mass index screening and follow up	
ACO-41: Diabetes – eye exam	
ACO-30: Ischemic vascular disease – use of aspirin or another antithrombotic	
ACO-11: Percent of primary care physicians who successfully meet meaningful use requirements	Proposed for removal via the "MSSP ACOs Pathways to Success" proposed rule and finalized in this rule (see below). No longer aligns with the Promoting Interoperability program.

Table 8: New Measures for MSSP Beginning with CY 2019 Performance Year

New Measure Added	CMS Rationale
ACO-45: Courteous and helpful office staff (ACO CAHPS survey measure)	Measures already have been collected in ACO CAHPS survey and results shared with ACOs on informational basis. Tying payment to them would place greater emphasis on outcomes

Finalization of Certain Procedures of the Shared Savings Program August 2018 Proposed Rule ("Pathways to Success")

Participation Options for Agreement Periods Beginning in 2019. In this rule, **CMS finalizes a voluntary extension for ACOs that entered a first or second agreement period beginning on Jan. 1, 2016.** This extension will allow those ACOs to enter into a fourth performance year (PY) that will run from Jan. 1, 2019 through June 30, 2019 and will serve as a bridge from the current MSSP to CMS's proposed redesign of the program. CMS will address the PY that will run from July 1, 2019 through Dec. 31, 2019 in a forthcoming final rule.

CMS also finalizes its proposal to use a full 12-month calendar year to calculate financial and quality performance for the ACOs that participate in the six-month PY from Jan. 1, 2019 through June 30, 2019. Specifically, CMS will reconcile performance during the entire CY 2019, then pro-rate the CY shared savings or losses to reflect the ACO's participation for half of the year. CMS continues to believe this methodology allows the most continuity in the MSSP due to the calendar year-basis for calculate benchmark expenditures, trend and update factors, risk adjustment and other factors. CMS also finalizes its proposed methodology to determine beneficiary assignment for the Jan. 1, 2019 through June 30, 2019 PY and the applicability of program policies to ACOs participating in that six-month PY.

Revisions to Policies on Voluntary Alignment. In order to execute certain BiBA provisions related to voluntary alignment, CMS finalizes as proposed the following policies:

- Assign beneficiaries to ACOs based upon their selection of any ACO professional (including nurse practitioners, physicians assistants, or clinical nurse specialists) as their "primary clinician," regardless of the professional's specialty.

- Remove the requirement that a beneficiary must have received at least one primary service from an ACO professional within the 12-month assignment window in order to be assigned to that ACO.

- Revise existing regulations to clarify that a beneficiary who designates a primary clinician that is outside an ACO will not be added to the ACO's list of assigned beneficiaries.

- Override voluntary alignment when a beneficiary is eligible for assignment to an entity participating in a model tested or expanded by the CMMI under its section 1115(A) waiver authority, and the model's claims-based assignment is based solely on claims for services other than primary care.

CMS is not finalizing at this time its proposals regarding beneficiary notification of the option to designate a primary clinician. The agency will summarize and respond to comments on this proposal in a forthcoming final rule.

Revisions to the Definition of Primary Care Services used in Beneficiary Assignment. In accordance with certain provisions of the BiBA and the 21st Century Cures Act, CMS updates its definition of primary care services by adding to the definition existing CPT codes and HCPCS G-codes that describe a range of primary care services. Those services include: advance care planning; administration of health risk assessment; prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure; annual depression screening; alcohol misuse screening; and alcohol misuse counseling.

CMS also revises its method for excluding E&M SNF services from the definition of primary care services for the purpose of beneficiary assignment. Currently, these services are identified by CPT codes 99304 through 99318 reported on claims with place of service code 31 appended to the claim. CMS and commenters agree it would be more accurate to determine whether services identified by CPT codes 99304 through 99318 were furnished in a SNF by assessing whether the beneficiary also received SNF services on the same day that those codes were billed.

Because CMS's proposed E&M add-on codes, discussed above, will not be available to providers until CY 2021, CMS does not add those codes to the definition of primary care services at this time.

Extreme and Uncontrollable Circumstances Policies. **CMS finalizes several policies to address the effects of extreme and uncontrollable circumstances on ACO performance in PYs 2018 and beyond.** These policies include the following:

Triggering Criteria. CMS finalizes its proposal to continue using the criteria it defined in its Dec. 2017 interim final rule with comment period (IFC) as automatic triggering events for the MSSP's extreme circumstances policy for PY 2018 and beyond. These triggers

will continue to be aligned with those applicable to MIPS-eligible clinicians as adopted under the QPP. Once triggered, the extreme circumstances policy will apply to any MSSP ACO within an affected area if CMS determines that 20 percent or more of an ACO's assigned beneficiaries resided in the affected area and/or the ACO's legal entity was located in the affected area.

ACO Quality Performance Scoring. To calculate the quality score for a given PY of an ACO affected by extreme and uncontrollable circumstances, CMS will set the ACO's minimum quality score at the mean quality performance score for all MSSP ACOs in that year. However, if the ACO can completely and accurately report all quality measures, CMS will use the higher of the mean MSSP score or the ACO's own score. For ACOs that receive the mean MSSP score, CMS will calculate quality improvement for the first post-disaster year by comparing the most recently available ACO-specific, pre-disaster, quality score to the ACO-specific score for the year immediately following the disaster.

Interaction of Alternative Quality Scoring Methodology and MIPS. In the situation described above in which an ACO affected by extreme and uncontrollable circumstances receives the mean quality score, the MIPS quality performance category for that ACO's MIPS-eligible clinicians will be reweighted to zero. This reweighting results in additional reweighting of MIPS category score weights of 75 percent for the Promoting Interoperability category and 25 percent for the Improvement Activities category.

Mitigating Shared Losses. CMS finalizes without modification its proposal to extend to PY 2018 and beyond the formula for mitigating shared losses owed by ACOs experiencing extreme and uncontrollable circumstances that it adopted in the IFC. According to this formula, CMS calculates a reduction in shared losses by multiplying the shared losses by two factors: (1) the percentage of the total months in the PY affected by an extreme and uncontrollable circumstance; and (2) the percentage of the ACO's assigned beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance. CMS also finalizes its proposal to adjust shared losses for ACOs that participate in the six-month performance year from Jan. 1, 2019 through June 30, 2019. For these ACOs, CMS will determine shared losses for the ACO over the full calendar year, reduce the ACO's shared losses for the calendar year for extreme and uncontrollable circumstances, and then determine the portion of shared losses for the six-month performance year.

Historical Benchmark Calculations for Affected ACOs. At this time, CMS will not make any changes to the benchmarking methodology for ACOs affected by extreme and uncontrollable circumstances. CMS continues to believe that if finalized, its proposal to use regional factors when determining ACOs' historical benchmarks starting with an ACO's first agreement period would provide an inherent adjustment to regional variations in expenditures related to extreme and uncontrollable circumstances. CMS will continue to monitor the impact of extreme and uncontrollable circumstances on benchmark expenditures and propose modifications to the methodology, if necessary, in a future rulemaking.

Promoting Interoperability. CMS finalizes, with some modifications, several of its proposed changes to align participation in the MSSP with provisions in the QPP that promote the use of certified EHRs and the interoperable access, exchange and use of health information. CMS had proposed to require ACOs to certify upon application that they meet applicable certified EHR technology requirements; CMS will instead require annual certification from ACOs for PYs beginning on Jan. 1, 2019 and all subsequent performance years. ACOs in a track that does not meet the financial risk standard to be an Advanced APM must certify that at least 50 percent of the eligible clinicians in the ACO use certified EHR technology to document and communicate clinical care to their patients or other health care providers. ACOs that are considered Advanced APMs must certify that they meet the applicable threshold under the QPP, which is 75 percent of eligible clinicians for CY 2019. Because ACOs will now annually certify the extent to which its eligible clinicians are using certified EHR technology, CMS finalizes the removal of the use of certified EHR technology measure (ACO-11) from the MSSP quality measure set beginning Jan. 1, 2019.

NEXT STEPS

The AHA will host a members-only webinar on Nov. 20 at 2:00 p.m. ET to discuss the provisions of the final rule. To register for this 90-minute webinar, click here.

FURTHER QUESTIONS

For further questions, please contact Shira Hollander, senior associate director for payment policy, at (202) 626-2329 or shollander@aha.org, or Akin Demehin, director for quality policy, at (202) 626-2365 or ademehin@aha.org.

APPENDIX A

E&M Payment Amounts

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	***Visit Code Alone****	***Visit Code Alone Payment***	***Visit Code With Either Primary or specialized care add-on code*** **	***Visit Code with New Extended Services Code (Minutes Required to Bill)***	***Visit with Both Add-on and Extended Services Code Added*** **	***Current Prolonged Code Added (Minutes Required to Bill)****
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.
**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

APPENDIX B

Promoting Interoperability Performance Category Scoring Methodology, CY 2019

Objective	Measure(s)	Points	Exclusions
Electronic Prescribing	**ePrescribing**: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically a certified EHR.	10 points in 2019	An exclusion claimed for all measures in the ePrescribing objective will equally distribute the points to the measures available for Health Information Exchange and the Provide Patients Electronic Access objectives.
	Query of Prescription Drug Monitoring Program (PDMP): For at least one Schedule II opioid electronically prescribed using a certified EHR during the performance period, the MIPS eligible clinician uses data from a certified EHR to conduct a query of a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law.	5 bonus points available in 2019	*Exclusion for Query PDMP and Verify Opioid Treatment Agreement*: no exclusions for measures available for bonus points
	Verify Opioid Treatment Agreement: For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using a certified EHR during the EHR reporting period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's electronic health record using a certified EHR.	5 points available in 2019	.

Objective	Measure(s)	Points	Exclusions
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers its patient to another setting of care or provider of care (1) Creates a summary of care record using certified EHR; and (2) Electronically exchanges the summary of care record. **Support Electronic Referral Loops by Receiving and Incorporating Health Information**: For at least one electronic summary of care record received for patient encounters during the EHR reporting period for which the MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the EHR reporting period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, mediation allergy, and current problem list.	20 points 20 points	*Exclusions:* No exclusions for the Support Electronic Referral Loops by Sending Health Information Measure. *Exclusions for Receiving and Incorporating Health Information*: 1. Any MIPS eligible clinicians who could not implement the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure for a performance period in 2019. 2. Any MIPS eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period. An exclusion claimed for the Receiving and Incorporating Measure will redistribute the 20 points to the Sending Health Information Measure.
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**. For at least one unique patient discharged from the MIPS eligible clinician, (1) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) the MIPS eligible clinician ensures the patient's health information is available for the patient	40 points in 2019	*Exclusions*: No exclusions for the Provide Patients Electronic Access to Their Health Information Measure.

Objective	Measure(s)	Points	Exclusions
	(or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the MIPS eligible clinician's certified EHR.		
Public Health and Clinical Data Exchange	<u>Select two registries for required reporting</u>: **Immunization Registry Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). **Electronic Case Registry Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit case reporting of reportable conditions. **Public Health Registry Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries. **Clinical Data Registry Reporting**: The MIPS eligible clinician is in active engagement to submit data to a clinical data registry. **Syndromic Surveillance Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.	10 points	An exclusion claimed for one measure but successful attestation of a second measure will earn the MIPS-eligible clinician 10 points. An exclusion claimed for two measures will redistribute the 10 points to the Provide Patients Electronic Access to Their Health Information measure.