Quality Payment
PROGRAM

2019 MEDICARE PHYSICIAN FEE SCHEDULE AND MIPS YEAR 3 PROPOSED RULES

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2019 MEDICARE PHYSICIAN FEE SCHEDULE (PFS) PROPOSED RULE

Documentation Requirements and Payment for Evaluation and Management (E/M) Visits & Advancing Virtual Care

Patients Over Paperwork

- The Patients Over Paperwork initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.

Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.

Documenting E/M Requires Choosing the Appropriate Code

- Currently, documentation requirements differ for each level and are informed by the 1995 and 1997 E/M documentation guidelines.
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type (new v. established),
  - Setting of service (e.g. outpatient setting v. or inpatient setting), and
  - Level of E/M service performed.

Level of E/M Visits

- The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.
- The three key components when selecting the appropriate level of E/M services provided are **history**, **examination**, and **medical decision making**. For visits that consist predominantly of counseling and/or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.

How to Streamline E/M Payment and Reduce Clinician Burden

- Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.
- Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on **what has changed** since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Proposing to allow practitioners to **review and verify** certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.

Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	$22	$24
2	$45	$93
3	$74	
4	$109	
5	$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	$45	$44
2	$76	$135
3	$110	
4	$167	
5	$211	

*Current Payment for CY 2018

**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

Proposed Payment for Office/Outpatient Based E/M Visits

- Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).
- Proposing a **minimum documentation** standard where, for Medicare PFS payment purposes, practitioners would only need to document the information to support a level 2 E/M visit.

Proposed Additional Payment Codes

- Proposing **~$5 add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with primary care services.
- Proposing **~$14 add-on payment** to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.
- Proposing a **multiple procedure payment adjustment** that would reduce the payment when an E/M visit is furnished in combination with a procedure on the same day.
- Proposing an **~$67 add-on payment for a 30 minute prolonged E/M visit**.

Advancing Virtual Care

- In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that support technological developments in healthcare.
- We are interested in recognizing changes in healthcare practice that incorporates innovation and technology in managing patient care.
- We are aiming to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.

Advancing Virtual Care

- To support access to care using communication technology, we are proposing to:
  - Pay clinicians for virtual check-ins –brief, non-face-to-face assessments via communication technology;
  - Pay for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
  - Pay clinicians for evaluation of patient-submitted photos or recorded video; and
  - Expand Medicare-covered telehealth services to include prolonged preventive services.

For Further Information

See the Physician Fee Schedule website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

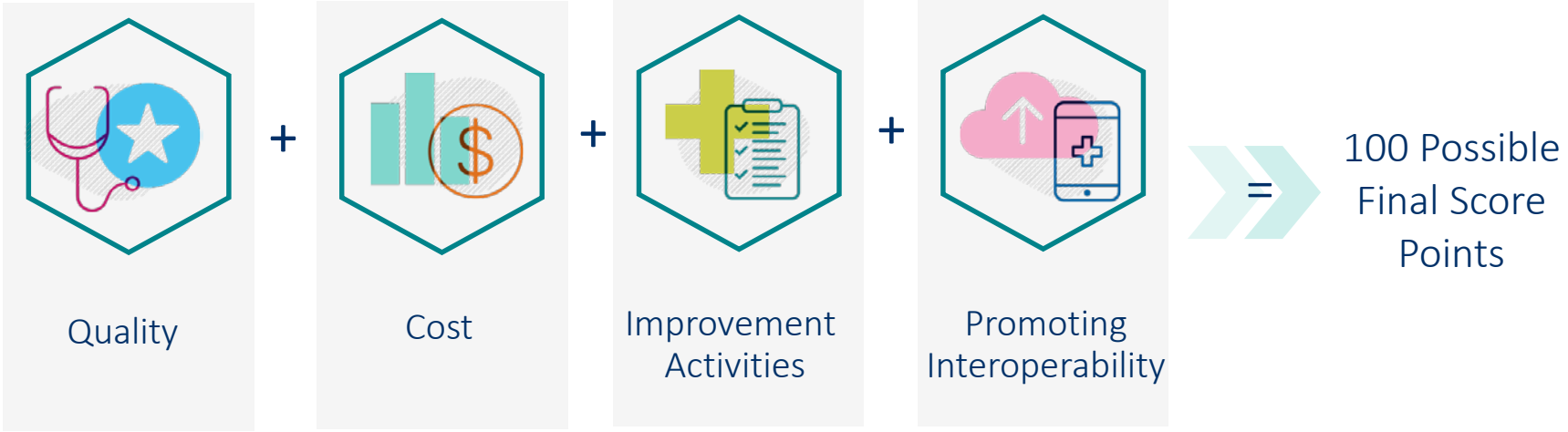
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories



- Comprised of **four** performance categories.
- So what? *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Merit-based Incentive Payment System (MIPS)

Timeline for 2019 Performance Year

2019
Performance Year

- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year

March 31, 2020
Data Submission

- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early

Feedback

- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

January 1, 2021
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

Merit-based Incentive Payment System (MIPS)

Bipartisan Budget Act of 2018

Provides additional authority to continue the gradual transition in MIPS, including:

- Changing the application of MIPS payment adjustments, so adjustments will *not* apply to all items and services under Medicare Part B, but will now apply only to **covered professional services** under the Physician Fee Schedule (PFS) beginning in 2019, which is the first payment year for MIPS.

- Changing the way MIPS eligibility is determined with respect to low-volume threshold. Beginning in 2018 (current performance period), low-volume threshold determinations are based on allowed charges for **covered professional services** under the PFS, *not* all Medicare Part B allowed charges.

- Providing flexibility in the weighting of the Cost performance category for three additional years.

- Allowing flexibility in establishing the performance threshold for three additional years to ensure gradual and incremental transition to the estimated performance threshold based on the mean or median of final scores from prior year that will apply in 6th year of program.

PROPOSED RULE FOR YEAR 3 - MIPS

Eligibility

MIPS Year 3 (2019) Proposed

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists

Year 3 (2019) Proposed

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers

MIPS Year 3 (2019) Proposed

Low-Volume Threshold Criteria

What do I need to know?

1. Continued compliance with the Bipartisan Budget Act of 2018.
    - The Year 3 (2019) low-volume threshold determinations will only be made on **covered professional services** under the **Physician Fee Schedule** (PFS).
    - Different from the 2017 Transition Year where the low-volume threshold determinations were made on all Medicare Part B allowed charges.

2. **Proposing** to add a third element – Number of Services – to the low-volume threshold determination criteria.
    - The proposed criteria includes:
        - Dollar amount
        - Number of beneficiaries
        - Number of services (Newly proposed)

3. **Proposing** to add an opt-in option for clinicians who are excluded from MIPS.
    - This proposal gives clinicians who would have been excluded in previous years the choice to participate in MIPS.

MIPS Year 3 (2019) Proposed

Low-Volume Threshold Determination

Proposing that to be included in MIPS in Year 3 (2019), clinicians must:

1. Be a MIPS eligible clinician type

2. **Exceed all three elements** of the low-volume threshold criteria:

   - ✓ Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

   AND

   - ✓ Furnish covered professional services to more than 200 Medicare beneficiaries

   AND

   - ✓ Provide more than 200 covered professional services under the PFS (Newly Proposed)

MIPS Year 3 (2019) Proposed

Opt-in Policy

Proposing an opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

- MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (New-proposed)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 3 (2019) Proposed

MIPS Determination Period

Year 2 (2018) Final

Low Volume Threshold Determination Period:

- First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out)
- Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)

Special Status

- Use various determination periods to identify MIPS eligible clinicians with a special status and apply the designation.
- Special status includes:
  - Non-Patient Facing
  - Small Practice
  - Rural Practice
  - Health Professional Shortage Area (HPSA)
  - Hospital-based
  - Ambulatory Surgical Center-based (ASC-based)

Year 3 (2019) Proposed

Change to the MIPS Determination Period:

- First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out)
- Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out)
- Goal: consolidate the multiple timeframes and align the determination period with the fiscal year.
- Goal: streamlined period will also identify MIPS eligible clinicians with the following special status:
  - Non-Patient Facing
  - Small Practice
  - Hospital-based
  - ASC-based

Note: Rural and HPSA status continue to apply in 2019

Quick Tip: MIPS eligible clinicians with a special status are included in MIPS and qualify for special rules. Having a special status does not exempt a clinician from MIPS.

MIPS Year 3 (2019) Proposed

Reporting Options – General

Same reporting options as Year 2. Clinicians can report:

1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

PROPOSED RULE FOR YEAR 3 - MIPS

Performance Categories

MIPS Year 3 (2019) Proposed

Performance Periods

Year 2 (2018) Final

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 3 (2019)– *No Change*

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

MIPS Year 3 (2019) Proposed

Quality Performance Category

Basics:

- *Proposed Change*: **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Year 2 (2018) Final	Year 3 (2019) Proposed
Bonus Points	
• 2 points for outcome or patient experience • 1 point for other high-priority measures • 1 point for each measure submitted using electronic end-to-end reporting • Cap bonus points at 10% of category denominator	**Same requirements** as Year 2, with the following change: • Add **small practice bonus** of 3 points for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure Quick Tip: A small practice is defined as 15 or fewer eligible clinicians.
Data Completeness	
• 60% for submission mechanisms except for Web Interface and CAHPS • Measures that do not meet the data completeness criteria earn 1 point • Small practices continue to receive 3 points	**Same requirements** as Year 2

MIPS Year 3 (2019) Proposed

Cost Performance Category

Basics:

- *Proposed Change*: **15%** of Final Score in 2019
- Measures:
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost
  - Adding 8 episode-based measures
- No reporting requirement; data pulled from administrative claims
- No improvement scoring in Year 3

Year 2 (2018) Final	Year 3 (2019) Proposed
Measure Case Minimums	
• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB	**Same requirements** as Year 2, with the following additions: • Case minimum of 10 for procedural episodes • Case minimum of 20 for acute inpatient medical condition episodes
Measure Attribution	
• Plurality of primary care services rendered by the clinician to determine attribution for the Total per Capita Cost measure • Plurality of Part B services billed during the index admission to determination attribution for the MSPB measure • Added two CPT codes to the list of primary care services used to determine attribution under the Total per Capita Cost measure	**Same requirements** as Year 2, with the following additions: • For procedural episodes: CMS will attribute episodes to the clinician that performs the procedure • For acute inpatient medical condition episodes: CMS will attribute episodes to clinicians who bill at least 30 percent of the inpatient evaluation and management claim during hospitalization

MIPS Year 3 (2019) Proposed

Improvement Activities Performance Category

Basics:

- ***Proposed:*** **15%** of Final Score in 2019
- Select Improvement Activities and attest "yes" to completing
- Activity weights remain the same:
  - Medium = 10 points
  - High = 20 points
- **Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs** continue to receive double-weight and report on no more than 2 activities to receive the highest score

Activity Inventory

- Adding 6 new Improvement Activities
- Modifying 5 existing Improvement Activities
- Removing 1 existing Improvement Activity

CEHRT Bonus

- Proposing to remove the bonus to align with the new Promoting Interoperability scoring requirements, which no longer consists of a bonus score component.*

**Contingent upon the new Promoting Interoperability scoring methodology being finalized*

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Reporting Requirements

Year 2 (2018) Final	Year 3 (2019) Proposed
• Comprised of a base, performance, and bonus score • Must fulfill the base score requirements to earn a Promoting Interoperability score	• Eliminate the base, performance, and bonus scores • Propose a **new performance-based scoring** at the individual measure level • Must report the required measures under each Objective, or claim the exclusions

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Objectives and Measures

Year 2 (2018) Final	Year 3 (2019) Proposed
• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	• One set of Objectives and Measures based on 2015 Edition CEHRT • Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Add two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Scoring

Year 2 (2018) Final	Year 3 (2019) Proposed
• Fulfill the base score (worth 50%) by submitting at least a 1 in the numerator of certain measures AND submit "yes" for the Security Risk Analysis measure • Performance score (worth 90%) is determined by a performance rate for each submitted measure • Bonus score (worth 10%) is available • Maximum score is 165%, but is capped at 100%	• Performance-based scoring at the individual measure level • Each measure would be scored on performance for that measure based on the submission of a numerator or denominator, or a "yes or no" ◦ Must submit a numerator of at least one or a "yes" to fulfill the required measures • The scores for each of the individual measures would be added together to calculate a final score • If exclusions are claimed, the points would be allocated to other measures

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Reweighting

Year 2 (2018) Final	Year 3 (2019) Proposed
• Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs • Application based reweighting also available for certain circumstances • Example: clinicians who are in small practices	**Same requirements** as Year 2, with the following additions: • Extend the automatic reweighting to Physical Therapists, Occupational Therapists, Clinical Social Workers, and Clinical Psychologists

MIPS Year 3 (2019) Proposed

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Proposed

Final Score 2019	Payment Adjustment 2021
≥80 points	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
30.01-79.99 points	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

QPP Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Comments due September 10

When and Where to Submit Comments

- See proposed rule for information on submitting comments by close of 60-day comment period on **September 10** (When commenting **refer to file code CMS 2018-1693-P**)
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted
- You must officially submit your comments in one of following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

Questions