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CY 2019 Medicare Physician Fee Schedule Final Rule Summary

On November 1, the Center for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule (MPFS) for 2019. The final rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here. The rule's provisions are effective January 1, 2019 unless stated otherwise. The following summarizes the major payment policies in the final rule.

Conversion Factor and Specialty Impact

The conversion factor for 2019 will be $36.0391 and remains essentially flat. This reflects the statutory update of 0.25% adjusted downward by -0.14 to maintain budget neutrality.

Table 94 (see Attachment 1), extracted from the rule, provides a summary of the impact of the changes in the final rule by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The final rule shows changes in the range of minus 5% to plus 4%, with no change in reimbursement for endocrinology.

See the attached charts with the final RVUs and payment rates for services of interest to the Endocrine Society members.

Evaluation & Management Proposals

In the proposed rule, CMS proposed significant changes to how E/M services will be paid and documented. The proposed changes to the documentation guidelines, only requiring physicians to document a level 2 visit using the current 1995/1997 guidelines, time or medical decision making, were intended to reduce administration burden. The agency proposed to create a single payment rate for level 2 through 5 new and established outpatient visit services, as well as a 30-minute prolonged service modifier and complexity add-on codes.

In response to overwhelming stakeholder opposition to the proposal, CMS will not make any E/M payment changes until January 1, 2021, having significantly revised its payment proposals which will be discussed in more detail in this summary. For 2019 and 2020, CMS will continue to use the current coding and payment structure for outpatient E/M visits, and practitioners should continue to use the 1995/1997 guidelines to document them.

On January 1, 2019, only the following documentation changes will be implemented:

- For home visits, CMS is eliminating the requirement to document the medical necessity of providing a visit at home rather than in the office.
- Physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians will no longer need to re-enter in the medical record information on the patient's chief complaint and history if it has already been entered by ancillary staff or the beneficiary.

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Payment Policy to be Implemented January 1, 2021
CMS finalized a single payment rate for level 2-4 new and established outpatient visits. Providers will still bill the existing CPT codes for the appropriate level of service (99202-99204 or 99212-99214), but Medicare will reimburse at the new consolidated rate. Level 5 visits will remain separate and retain their current value to better account for the care and needs of particularly complex patients. This policy alone is expected to have a 2% decrease in E/M reimbursement for endocrinologists.

Add-On Codes: The agency finalized the new primary care and non-procedural specialized care complexity add-on codes that can be billed with all level 2-4 new and established patient office visits. These add-on codes will not have any additional documentation requirements and are not restricted by specialty. CMS also recognizes that there may be rare instances where the primary care and non-procedural specialty add-on codes may be billed together. In addition, CMS finalized the extended visit add-on code, which can be billed with the consolidated level 2 – 4 E/M service. These new codes are described below:

- Primary Care add-on code (0.25 Work RVUs) - In response to comments, CMS revised the value of the primary care add-on so it will be valued the same as the specialty care add-on code and providers will be able to bill the add-on for new and established patients rather than just established patients as proposed. A specialist may report this add-on code whenever additional primary care services are provided separate from the specialty care being provided.

- Specialty Care Complexity add-on code (0.25 Work RVUs) – CMS revised this code descriptor to add several specialties to the code which can be billed with the consolidated level 2 through 4 E/M service for new and established patients for non-procedural specialty care. The specialties that can bill this add-on include: endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology.

- Extended Visit add-on code (1.17 Work RVUs) - CMS finalized its proposal to establish an "extended visit" add-on code that can only be billed with the consolidated level 2 – 4 E/M service for new or established patients and set the work RVUs for this service at 1.17. The code can be reported for a single range of minutes that applies to the overall duration of face-to-face time during the visit without regard to whether level 2, 3, or 4 was reported: 34-69 minutes for established patients and 38-89 minutes for new patients. CMS also states that any visits that exceed the length of time ranges for the level 2-4 visits plus the extended visit add-on could be reported using the level 5 visit E/M code and the existing prolonged services code. For audit purposes, CMS expects the medical record to reflect that the practitioner actually spent the amount of time with the patient described by the code and that the entire visit was medically necessary. However, the agency will not require additional documentation to demonstrate the difference in time between the visit code and the extended visit service to determine medical necessity.

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CMS E&M Payment Amounts Comparison Chart

	Complexity Level under CPT	Visit Code (2018 Payment Rates)	Visit Code (2019 Payment Rates)	Visit Code with Either Primary Care or Specialized Care Add-on	Visit Code with Add-on and New Extended Services Code	Current Prolonged Service Code Added
New Patient	2	$76	$130	$143	$197	
	3	$110				
	4	$167				
	5	$211	$211			$344 (at least 90 min)
Established Patient	2	$45	$90	$103	$157	
	3	$74				
	4	$109				
	5	$148	$148			$281 (at least 70 min)

E/M Documentation Requirements to be Implemented January 1, 2021

To bill the single payment level 2-4 outpatient E/M visit. CMS will require providers to document a level 2 service when using medical decision making or the 1995/1997 guidelines. If providers choose to document using time, they will have to document medical necessity and that they met the current typical time for the reported CPT code. For level 5 visits, providers will be allowed to document using the current 1995/1997 guidelines or the current level 5 definition of medical decision making. Providers can also document a level 5 visit by time, 40 minutes for an established patient and 60 minutes for a new patient.

Other Proposed E/M Policies Not Implemented

Based on stakeholder feedback, CMS chose not to implement its proposal to apply a multiple procedure payment reduction when an E/M service is billed with a procedure and reduce payment by 50% for the least expensive service.

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The agency also chose not to finalize the policy to create a single E/M practice expense (PE) per hour value because of the unintended negative impact it would have on the indirect practice expense for certain specialties. They stated that they did not believe it was in the public interest to allow the allocation of indirect PE to have such an outsized impact on payment rates.

Teaching Physician Documentation Requirements for Evaluation and Management Services

CMS finalized its proposal to allow a physician, resident, or nurse to document in the medical record that the teaching physician was present at the time the service is delivered. They also eliminated the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead allow the resident or nurse to document the extent of the teaching physician's participation.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

In this final rule, CMS aimed to increase access for beneficiaries to physicians' services that are routinely furnished via communication technology by establishing new codes These services do not replace office visits. A description of these services follows:

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G2012):

CMS believes that the more physicians leverage technology to furnish check-ins there will potentially be a reduction in unnecessary office visits. Physicians will be able to deliver this service by telephone or synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. This code cannot be billed for clinical staff phone calls. Patients' verbal consent to receiving this service must be included in the medical record since patients will be billed a co-pay for it. The agency received broad support for CMS to provide separate payment for this service and will monitor utilization to determine if any limits should be placed on the use of this code.

> CODE DESCRIPTOR: Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Remote evaluation of pre-recorded patient information (HCPCS code G2010)

Like the virtual check-in, CMS believes this service does not take the place of an office visit and may in fact reduce the number of unnecessary visits by determining whether an office visit is warranted. The agency finalized its proposal to make separate payment for this service for established patients only and will monitor its utilization. This service will also require a patient co-pay, so the agency is finalizing a requirement to receive verbal or written beneficiary consent for each service that is documented in the medical record. Follow-up with the patient could take place by phone, audio/video communication, secure text messaging, email, or patient portal communication.

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CODE DESCRIPTOR: Remote evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

Interprofessional Internet Consultation (CPT code 99451, 99452, 99446, 99447, 99448, 99449)

CPT revised 4 existing codes and created 2 new codes to describe interprofessional telephone/internet/electronic medical record consultation services. CPT codes 99446-99449 had previously considered to be bundled services and were not separately payable. CMS is finalizing its proposal to convert these to active codes based on changes in medical practice and technology and will monitor their utilization potentially making refinements to billing and documentation requirements in future rulemaking. Like the other new services, these will require a patient co-pay so providers must document verbal consent in the medical record.

Changes to Direct PE Inputs for Specific Services

Market-Based Supply and Equipment Pricing Update

CMS finalized its proposal to adopt updated direct PE input prices for supplies and equipment based on a market research study undertaken for this update. Due to the significant changes in payment (increases for many items) that will occur the new pricing policy will be phased in over a 4-year period beginning in CY 2019. The agency is proposing to use a 25/75 percent split between new and old pricing in year one, 50/50 in year two, 75/25 in year three, and 100/0 in year four. The CY 2019 PE values found in Addendum B reflect this 25/75 pricing phase in. New supply and equipment codes that are implemented during this 4-year period will be fully implemented with no transition.

Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of Hospitals

Starting in January 2017, CMS no longer recognized under the Hospital Outpatient Prospective Payment System (OPPS) certain items and services furnished by certain off-campus provider-based departments (PBDs) and paid for these services under the fee schedule. In 2017, payment for these services were paid at 50% of the OPPS payment rate and in 2018 payment was set at 40% of the OPPS rate. This payment policy is called the PFS Relativity Adjuster. In addition, all claims for these services were submitted with specific modifiers, so that CMS could determine future payment levels that would be more appropriate for PBDs.

For CY 2019, CMS finalized the proposal to continue applying the PFS Relativity Adjuster of 40%, which means that nonexcepted items and services furnished by nonexcepted off-campus PBDs will be reimbursed at 40% of the OPPS payment rate. CMS is also maintaining the same geographic adjustment and beneficiary cost sharing policies that were in effect in CY 2018. If and when they decide to change this policy, the agency will do so through rulemaking.

Note: Services that are "excepted" from this payment change are provided in: dedicated emergency departments; off-campus PBDs that were billing for covered outpatient department services furnished

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prior to November 2, 2015; in "on campus" PBDs or within 250 yards of the hospital or a remote location of the hospital. All services that do not meet these requirements are considered "non-excepted."

Part B Drugs: Application of Add-on Percentage for certain WAC-based payments

Drugs are typically reimbursed under Medicare Part B at the average sales price (ASP) for the drug or biological plus a 6% add-on payment. Part B payments are based on the wholesale acquisition cost (WAC) of the drug or biological when ASP is not available during the first quarter of sales or when Medicare Administrative Contractors (MACs) determine pricing, which is for drugs not appearing on the ASP pricing files or for new drugs. The WAC of a drug typically exceeds the ASP, as it does not include any prompt pay or other discounts, rebates or reductions in price included in the ASP.

CMS finalized the proposal, effective January 1, 2019, to reduce payment for drugs when WAC-based payments are applied by reducing the add-on percentage to 3% (from 6%). The agency clarified that the reduced add-on payment will be applied to new drugs and other drugs when MACs use WAC reimbursement, but would not apply to the add-on to ASP-based payments.

Physician Self-Referral Law

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies. The law also prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payer) for those referred services.

In this final rule, CMS clarified the requirements for written agreements and signatures and codified the agency's existing policy that allows a collection of documents to satisfy the requirement for a compensation agreement to be in writing. The agency also finalized the policy that the signature requirement can be satisfied if the compensation agreement complies with all criteria of the exception and also is obtained "90 consecutive calendar days immediately following the date" of a required signature. They agency did not receive any comments opposing these changes.

Valuation of Specific Codes

Fine Needle Aspiration: CMS is finalizing the values for the family as proposed. CPT code 10021 (initial FNA without imaging guidance) will have a work RVU of 1.03 rather than the 1.20 RVUs finalized by the RUC. CPT code 10005 (initial FNA with ultrasound guidance) will have 1.46 work RVUs rather than the RUC-recommended value of 1.63. Please see the attached chart for final values for these services.

Diabetes Management Training: CMS is finalizing the proposed work values for these services. HCPCS Code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) will be 0.90 RVUs; HCPCS Code G0109 (Diabetes outpatient self-management training, group session (2 or more), per 30 minutes) will have a final value of 0.25 RVUs. CMS also said that they would consider addressing barriers to the utilization of these services in future rulemaking.

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Potentially Misvalued Services – Update on Global Surgery Data Collection

MACRA required CMS to implement a process to collect data on the number and level of postoperative visits and to use this data to assess the valuation of surgical globals. The agency developed a process to collect data from groups with 10 or more practitioners in 9 states on the no-pay CPT code 99204 to report postoperative visits. Of practitioners that met the criteria for reporting, only 45 percent participated, varying substantially by specialty.

A set of "robust reporters" was identified in the data. Among this group, CMS found 87 percent of procedures with 90-day global periods had one or more associated postoperative visits. Only 16 percent of procedures with a 10-day global period had an associated postoperative visit reported. This data suggests that the postoperative visits included in the 10-day global periods are not being performed.

In response to the proposed rule, CMS received comments advising that they should take additional steps to make physicians aware of the reporting requirement. The agency has already taken additional steps to increase physician awareness of the reporting requirement and will consider what, if any, additional policy changes regarding surgical globals should be made in future rulemaking.

QUALITY PAYMENT PROGRAM YEAR 3 POLICIES

CMS finalized updates to the Quality Payment Program (QPP) for the 2019 performance period. The final rule continues to focus on reducing clinician burden, promoting interoperability, implementing the Meaningful Measures Initiative, supporting small and rural practices, empowering patients through the Patients Over Paperwork Initiative, and promoting price transparency. The agency is continuing its incremental approach to the implementation of MIPS by proposing to modestly increase the number of clinicians included in the program and increase both the weight of the cost component and the threshold score to avoid a penalty. The following summarizes the key provisions of the final rule.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

CMS finalized several of the key proposed changes to MIPS, including the following:

- The agency will reweight the performance categories that determine a clinician's threshold score.

Category	2018 Performance Year	Proposed 2019 Performance Year
Quality	50%	45%
Cost	10%	15%
Promoting Interoperability (formerly Advancing Care	25%	25%

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Improvement Activities	15%	15%

- CMS will add physical therapists, occupational therapists, clinical psychologists, qualified speech language pathologists, qualified audiologists, and registered dietician nutritionist as MIPS eligible clinicians. The agency did not finalize the proposal to add clinical social works.
- Addition of covered professional services as a new low-volume threshold determination criteria (more detail provided below). Clinicians or groups will be able to opt-in to MIPS if they meet or exceed one or two, but not all of the low-volume threshold criteria;
- Addition of new episode-based measures to the Cost Performance category;
- Creation of an option for facility-based scoring for the Quality and Cost Performance measures for certain facility-based clinicians

MIPS Determination Period

Beginning with the 2021 MIPS payment year/2019 performance year, CMS proposes to consolidate the determination periods to identify whether a clinician or practice qualifies for the following special statuses: low-volume threshold, non-patient facing physician, small practice, and hospital-based physician. The new consolidated determination periods will be October 1, 2017 to September 30, 2018 and October 1, 2018 to September 30, 2019.

Low-Volume Threshold for Exemption from MIPS Changes

Starting in the 2021 payment year, CMS will add a third category to the low-volume threshold that assesses the minimum number of covered professional services furnished to Part B-enrolled individuals by the clinician.

Low-Volume Threshold Qualifications for Exemption	
CY 2018 Final Policy	**CY 2019 Final Policy**
≤ $90,000 in Part B allowed charges, OR ≤ 200 Part B beneficiaries	≤ $90,000 in Part B allowed charges, OR ≤ 200 Part B beneficiaries, OR ≤ 200 professional services covered

If an eligible clinician, group or Alternative Payment Model (APM) Entity group in a MIPS APM meets or exceeds at least one, but not all three, of the low-volume threshold determinations, then the eligible clinician or group may choose to opt-in to MIPS. Those choosing to opt-in must make an affirmative election to participate. Additionally, beginning with the 2021 payment year, a virtual group election would constitute a low-volume threshold opt-in for any prospective member of the virtual group that exceeds at least one, but not all, of the low-volume threshold criteria.

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Virtual Group Eligibility Determinations

The virtual group election will remain the same as for the 2018 performance period with the following changes: physicians can inquire about their group's taxpayer identification numbers (TINs) size prior to making an election and a virtual group representative must submit an election on behalf of the solo practitioners and groups that compose a virtual group to participate in MIPS as a virtual group for a performance period in a form and matter specified by CMS.

Performance Threshold for MIPS Bonuses and Penalties

CMS finalized the proposal to increase the performance threshold from 15/100 points to 30/100 points that providers must reach to avoid a MIPS penalty. CMS finalized an increase to the exceptional performance threshold of 5 points to 75/100 points rather than the proposed increase of 10 points to 80/100 points.

Small Practice Bonus

Based on stakeholder feedback, CMS did not finalize the proposed small practice bonus of 3 points. Instead, beginning in 2021 MIPS payment year, a bonus of 6 measure points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices if the MIPS eligible clinician submits data to MIPS on at least 1 quality measure. Note that the small practice bonus had previously been added to the MIPS final score.

Facility-Based Measures Scoring Option for the 2021 MIPS Payment Year for the Quality and Cost Performance Categories

In 2019, CMS will implement its facility-based scoring, where facility-based clinicians can use their facility's Hospital Value-Based Purchasing (VBP) program score in lieu of their Quality and Cost Performance Category scores. These clinicians must still report data for the Improvement Activities and Promoting Interoperability categories. CMS will automatically apply the facility-based measurement standard to MIPS eligible clinicians and groups who are eligible for facility-based measurements and who would benefit from having a higher combined quality and cost performance score.

MIPS Scores would be established by determining the performance percentile of the facility in the VBP purchasing program for the specified year and awarding Quality and Cost Performance Category scores associated with that same performance percentile in those two MIPS performance categories.

- *Facility-Based Measurement by Individual Clinicians:* For individuals to be eligible for facility-based measurements, 75 percent or more of their covered professional services must be in an inpatient hospital, on-campus outpatient hospital, as identified by POS code 22, or an emergency room, and must be established based on claims for a period prior to the performance period. The clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room.

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- *Facility-Based Measurement by Group*: A facility-based group is one in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurements as individuals.

- *Facility Attribution for Facility-Based Measurement*: A facility-based clinician is attributed to the hospital at which they provide the most Medicare beneficiaries during the year claims are drawn. If an equal number of Medicare beneficiaries are treated at more than one facility, CMS will use the VBP score for the highest-scoring facility. A facility-based group is attributed to the hospital at which the plurality of its facility-based clinicians are attributed.

MIPS Performance Category Final Policies

Quality Performance Category: 45 percent

Meaningful Measures Initiative

CMS finalized the following updates: 1) adding 8 new MIPS quality measures that include 4 patient reported outcome measures, 6 high priority measures, and 2 measures on important clinical topics in the Meaningful Measure Framework; and 2) removing 26 measures immediately. The agency considers a high-priority measure be an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure.

The following changes to the measures set are of interest:

CMS added the following measures to the Quality measures set:

- Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

Based on stakeholder feedback, CMS did not add the following measure: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls.

All of the measures proposed for removal in Payment Year 2021 were finalized by CMS and will be removed.

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Falls: Risk Assessment
- Falls: Plan of Care
- Comprehensive Diabetes Care: Foot Exam
- Falls: Screening for Future Fall Risk

Removal of Process Measures

CMS finalized a process to remove non-high priority process measures. This will be done incrementally, since nearly 94 percent of specialty sets would be impacted. Beginning with the 2021 performance

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period, the agency proposes to incrementally remove process measures where prior to removal, considerations will be given to: whether the removal of the process measure impacts the number of measures available for a specific specialty, whether the measure addresses a priority area highlighted in the Measure Development Plan, whether the measure promotes positive outcomes in patients, considerations and evaluations of the measure's performance data, whether the measure is designated as high priority or not, and whether the measure has reached a topped out status within the 98th to 100th percentile range.

Bonus Points

CMS finalized the proposal to stop awarding bonus points to CMS Web Interface reporters for reporting high-priority measures, but would continue the high priority bonus for all other reporting types. Also, the agency will continue to assign bonus points for end-to-end reporting for the 2021 payment year to incentive reporting through electronic means.

Cost Performance Category: 15 percent

CMS finalized the proposal to change the weight of the cost performance category to 15 percent for the 2021 payment year. They are only proposing this modest increase in category weight because the agency recognizes that it is still early in the development process of these measures and that clinicians do not have the level of familiarity or understanding of cost measures that they do of comparable quality measures. CMS expects to increase the weight by 5 percentage points each year.

CMS is adding 8 episode-based measures in addition to two existing cost measures: total per capita cost and Medicare spending per beneficiary. The new episode-based cost measures include:

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

All of the measures include both Part A and Part B costs and are calculated from administrative claims. The agency is also considering increasing the length of the cost category measurement period to two years in the future so more physicians would meet minimum case thresholds to be counted in at least one cost measure. CMS appreciated the feedback provided and will consider additional changes in future rulemaking.

Improvement Activities Performance Category: 15 percent

CMS did not revise the weight of this category, it remains 15%.

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Proposed New Criteria

CMS sought comment on proposed new criteria for improvement activities, specifically a criterion around the opioid epidemic and other public health emergencies. The agency finalized the proposal to adopt a criterion entitled "Include a public health emergency as determined by the Secretary" to the criteria for nominating new improvement activities beginning with the CY 2019 performance period and future years. New activities will not be required to meet this criterion, but it will be an additional option when nominating new activities.

Weighting of Improvement Activities

In the final rule, CMS clarified that an improvement activity is by default medium-weight unless it meets considerations for high-weighting. CMS noted that they intend to more thoroughly revisit the improvement activity weighting policies in next year's rulemaking and that the submitted comments will be considered then.

Timeframe for the Annual Call for Activities

For the timeframe for the annual call for activities, improvement activity nominations received in Year 3 will be reviewed and considered for possible implementation in Year 5 of the program. The submission timeframe/due dates for nominations would be from February 1st through June 30th, providing approximately 4 additional months to submit nominations.

Promoting Interoperability Performance Category: 25 percent

CMS has changed the name of the Advancing Care Information Performance Category to Promoting Interoperability. The weight to the final score will remain the same as in year 2 of MIPS, 25%. Beginning with the 2019 performance period, CMS will require that all clinicians must use 2015 Certified Electronic Health Record Technology (CEHRT). The agency hopes moving to the 2015 Edition will reduce burden by better streamlining workflows and utilizing more comprehensive functions to meet patient safety goals and improve care coordination.

Proposed Scoring Methodology

CMS finalized the proposal for a new scoring methodology that moves away from the base, performance and bonus score methodology that is currently used. CMS believes this will provide a simpler, more flexible, less burdensome structure.

Under the updated scoring methodology, MIPS eligible clinicians will be required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual-measure level. The smaller set of objectives includes: 1) e-Prescribing; 2) Health Information Exchange; 3) Provider to Patient Exchange; and 4) Public Health and Clinical Data Exchange. The scores for each of the individual measures would be added together to calculate the score of up to 100 possible points. If exclusions are claimed, the points for those excluded measures will be reallocated. If a clinician fails to

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report or claim an exclusion for a required measure, they would receive a total score of zero for the Promoting Interoperability category.

Within the existing e-Prescribing objective, CMS added two new measures: Query of Prescription Drug Monitoring Program (PDMP); and Verify Opioid Treatment Agreement. Both of the measures would be optional for the MIPS performance period in 2019; however, clinicians may choose to report them and earn up to 5 additional bonus points for each measure. CMS will determine if these two measures should be required starting in 2020 in future rulemaking.

CMS finalized the proposal to reweight the other measures accordingly in 2019:

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Bonus in 2019: Query of PDMP	5 point bonus
	Bonus in 2019: Verify Opioid Treatment Agreement	5 point bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	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

MIPS APMs

In the 2019 performance period CMS anticipates that there will be up to six "Other MIPS APMs" in which they will use the APM scoring standard: the Oncology Care Model; Comprehensive ESRD Care Model; Comprehensive Primary Care Plus Model; the Bundled Payments for Care Improvement Advanced; Maryland Primary Care Program; and Independence at Home Demonstration.

ADVANCED ALTERNATIVE PAYMENT MODELS

In general, there are minor modification to the advanced Alternative Payment Models (APM) pathway in this year's rule.

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CEHRT Use Threshold for Advanced APMs

Of note, because CMS has prioritized interoperability, the agency finalized the proposal to increase CEHRT use criterion threshold for Advanced APMs such that at least 75 percent of eligible clinicians in each APM Entity meet CEHRT requirements to document and communicate clinical care with patients and other health professionals. This is an increase from 50 percent in 2018 to the proposed 75 percent in 2019.

MIPS Comparable Quality Measures

CMS has previously established the Advanced APM criteria that the quality measures upon which an Advanced APM bases payment must be reliable, evidence-based and valid. CMS finalized the proposal to amend the Advanced APM quality criteria to state that at least one of the quality measures upon which an Advanced APM bases payment must be: 1) on the MIPS final list; 2) endorsed by a consensus-based entity; or 3) otherwise determined by CMS to be evidence-based, reliable and valid. CMS believes that this change will better align with their regulations and inform stakeholders of the applicable quality measure requirements, while also helping non-Medicare payers to continue developing payment arrangements that mean the quality measure criterion to be an "Other Payer Advanced APM".

Generally Applicable Nominal Standard

CMS finalized the proposal maintaining the revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for QP Performance Periods 2021-2024. CMS believes that this represents an appropriate standard for more than a nominal amount of financial risk, and that maintaining a consistent standard for several more years will help APM Entities plan for multi-year Advanced APM participation.

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Table 94: CY 2019 Estimated Impact on Total Allowed Charges By Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$239	0%	-1%	0%	-1%
Anesthesiology	$1,982	0%	0%	0%	0%
Audiologist	$68	0%	1%	0%	1%
Cardiac Surgery	$293	0%	0%	0%	0%
Cardiology	$6,616	0%	0%	0%	0%
Chiropractor	$754	0%	-1%	0%	-1%
Clinical Psychologist	$776	0%	3%	0%	3%
Clinical Social Worker	$728	0%	3%	0%	2%
Colon And Rectal Surgery	$166	0%	1%	0%	1%
Critical Care	$342	0%	-1%	0%	-1%
Dermatology	$3,489	0%	1%	0%	1%
Diagnostic Testing Facility	$734	0%	-5%	0%	-5%
Emergency Medicine	$3,121	0%	0%	0%	0%
Endocrinology	$482	0%	0%	0%	0%
Family Practice	$6,207	0%	0%	0%	0%
Gastroenterology	$1,754	0%	0%	0%	0%
General Practice	$428	0%	0%	0%	0%
General Surgery	$2,090	0%	0%	0%	0%
Geriatrics	$197	0%	0%	0%	0%
Hand Surgery	$214	0%	0%	0%	0%
Hematology/Oncology	$1,741	0%	-1%	0%	-1%
Independent Laboratory	$646	0%	-2%	0%	-2%
Infectious Disease	$649	0%	0%	0%	-1%
Internal Medicine	$10,766	0%	0%	0%	0%
Interventional Pain Mgmt	$868	0%	1%	0%	1%
Interventional Radiology	$384	1%	1%	0%	2%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,188	0%	0%	0%	0%
Neurology	$1,529	0%	0%	0%	0%
Neurosurgery	$802	0%	0%	0%	0%
Nuclear Medicine	$50	0%	-1%	0%	-1%
Nurse Anes / Anes Asst	$1,242	0%	0%	0%	0%
Nurse Practitioner	$4,060	0%	0%	0%	0%
Obstetrics/Gynecology	$637	0%	0%	0%	0%
Ophthalmology	$5,451	0%	-1%	0%	-1%
Optometry	$1,309	0%	-1%	0%	-1%
Oral/Maxillofacial Surgery	$67	0%	0%	0%	0%
Orthopedic Surgery	$3,741	0%	0%	0%	0%
Other	$31	0%	4%	0%	4%
Otolarngology	$1,222	0%	0%	0%	0%
Pathology	$1,165	0%	-1%	0%	-2%
Pediatrics	$61	0%	0%	0%	0%

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(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Physical Medicine	$1,107	0%	0%	0%	0%
Physical/Occupational Therapy	$3,950	0%	-1%	0%	-1%
Physician Assistant	$2,438	0%	0%	0%	0%
Plastic Surgery	$376	0%	0%	0%	0%
Podiatry	$1,974	0%	2%	0%	2%
Portable X-Ray Supplier	$99	0%	1%	0%	1%
Psychiatry	$1,187	0%	1%	0%	1%
Pulmonary Disease	$1,714	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,765	0%	0%	0%	-1%
Radiology	$4,907	0%	0%	0%	0%
Rheumatology	$541	0%	0%	0%	0%
Thoracic Surgery	$357	0%	0%	0%	0%
Urology	$1,738	0%	1%	0%	1%
Vascular Surgery	$1,141	0%	2%	0%	2%
Total	$92,733	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.

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